

Telehealth has existed for decades in some form or another, but it is only in the last few years it has received increasing attention as a means to achieving the goals of the Triple Aim: efficiency, better health outcomes and better care. However, the ubiquitous adoption of telehealth continues to lag despite improved technology and increasing amounts of evidence. Existing policy barriers on both federal and state levels contribute to the limited use of telehealth. Below are some of the major barriers that currently exist.

### Reimbursement

One of the major barriers to telehealth adoption is lack of or minimal reimbursement of services delivered via telehealth. Federal reimbursement is centered on Medicare.

Telehealth restrictions in the Medicare program include limitations on where telehealth services may take place, both geographically and facility-wise, the limited number of providers who may bill for services delivered via telehealth, a limited list of services that can be billed, and restricting, for the most part, to only allowing live video to be reimbursed. These limitations, which are for the majority statutorily dictated, have helped impede the growth of telehealth.

State Medicaid policies have been more progressive, however, each state dictates what their policies are which creates a patchwork quilt of telehealth laws and regulations across the nation. Currently, as of June 2016, forty-eight state Medicaid programs have some type of live video reimbursement, nine reimburse for

store-and-forward and 16 have some form of reimbursement for remote patient monitoring (RPM). But each of those policies contains their own qualifiers, limitations and restrictions.

Over the last few years, states have also begun to pass legislation to either encourage or mandate private payers to reimburse for telehealth delivered services. These policies also vary across states and some contain their own limitations, depending on how the laws have been crafted. Additionally, the laws may also be written in such a way where there may be parity in coverage of services, but not necessarily parity in payment amount. In other words, a state law may require an insurer to pay for services if they are delivered via telehealth if those same services were covered if delivered in-person, but the law may not require the insurer to necessarily pay the same amount for that service in both cases.

For more information on telehealth reimbursement policies, see NOSORH's Telehealth Reimbursement Factsheet.

### Malpractice

Many providers have concerns around malpractice and telehealth. There have been few cases that involve telehealth and many have revolved around teleradiology. The low number of cases, however, is likely due to the low adoption of telehealth. Additionally, there have been a few negligence cases that involve the non-use of telehealth. Theoretically, telehealth malpractice cases are likely to increase the more it is widely used. However, one thing related to malpractice that providers should be aware of and which has become an issue to some providers is malpractice coverage.

Not all carriers will cover for malpractice involving telehealth delivered services and not all coverage a provider has will be viable in another state. Additionally, some carriers will provide malpractice coverage, but may charge high premiums. Very little policy has been related to addressing these issues. Hawaii recently passed legislation that would require malpractice carriers in the state to offer telehealth malpractice coverage, but this is the only example that currently exists as of July 2016. Providers should ensure that their malpractice insurance does cover telehealth delivered services and that it is viable in any other states they wish to practice in. A provider may find he or she will need to purchase additional insurance.

## Licensing

One major policy barrier frequently cited in inhibiting the adoption of telehealth is licensing. Licensing is under the purview of states to control and regulate. During a telehealth encounter, the service is considered to take place at the physical location of the patient (as opposed to the provider). This requires providers to comply with the laws and regulations associated with the appropriate professional licensing board in the patient's state. As with the aforementioned Medicaid reimbursement policy, policies vary across states and often requires providers to obtain some form of licensure, whether a full license or a specially issued one (for example, a telemedicine license), in each state the provider wishes to practice. A few states allow providers in contiguous states to practice on an infrequent basis in their state as long as they don't open an office. However, this is not the norm and applying for licenses in multiple states can result in enormous costs and time to the provider as they submit multiple applications.

Two attempts have been made to address this issue on a multi-state level. The Nurses Licensing Compact (NLC) has been accepted in 25 states (as of July 2016) that allows a nurse with a license in a compact member state

to practice in another compact member state without having to obtain another state license.

The Federation of State Medical Boards (FSMB) offered their own type of solution for physicians by creating model language for an Interstate Medical Licensure Compact that would allow member states to create an expedited process to obtain a license in a member states. This model language has been adopted by 17 states (as of July 2016) and work on creating the entity that would administer the Compact has begun. Whether it will help alleviate some of the current licensing concerns remain to be seen.

In addition to the licensing issue, regulatory boards also hold key control over other aspects that impact telehealth policy. Increasingly, regulatory boards are looking to develop regulations, policies, or guidelines on how providers they regulate utilize telehealth in their practices. Some of these guidelines have mirrored what licensees would need to do if they had provided the services in-person, others have included additional requirements. These regulations/policies create yet another layer of rules of which telehealth providers must be aware.

## HIPAA/Privacy/Security

Utilizers of telehealth often have questions around HIPAA, privacy and security issues. Frequently, they will encounter vendors who say their equipment or software is HIPAA compliant. The technology alone cannot make one HIPAA compliant. Human action is required in order to meet the necessary level of compliance that is required. HIPAA does not have specific requirements related to telehealth. Therefore, a telehealth provider must meet the same requirements of HIPAA as would be needed if the services were delivered in-person. However, to meet those requirements an entity may need to take different or additional steps that may not have been necessary if the service was delivered in-person. For example, a tech support person who would not be exposed to protected health information if a practice was strictly in-person may be in a different situation where telehealth is involved because that tech support person may be required to enter an exam room to help with the equipment.

Additionally, states may have their own privacy and security laws with which providers must be familiar. HIPAA is a baseline to protecting health information and some states may actually have a higher bar a provider must meet in order to be compliant. Additionally, states may have specific internet vendor laws that may not be directed at health services, but nonetheless impact them because they are services sold via the Internet. If a provider is offering services in another state, it would be prudent to look into the state laws covering these areas.

## Prescribing

In order to fully treat a patient, a provider must have the ability to prescribe. A relationship entirely built via telehealth may not be considered a valid means of establishing a relationship, limiting the ability of a provider to do so. The Ryan Haight Act dictates how telehealth (telemedicine is the term used in the Act) may be used to prescribe controlled substances. The Act provides specific scenarios on how the interaction between patient and provider must take place that include:

- A patient is being treated and physically located in a hospital or clinic registered to distribute under the Controlled Substance Act
- Is conducted when the patient is being treated and in the physical presence of a practitioner registered to distribute under the Controlled Substance Act
- The practitioner is an employee or contractor of the Indian Health Service (IHS) or working for an Indian tribe or tribal organization under contract or compact with IHS
- Has obtained a special registration from the US Attorney General
- In an emergency situation (21 USC 802(54).)

States have control over how everything else is prescribed when telehealth is used and as mentioned in earlier sections, the policies vary across states. Some states have very specific rules for the use of telehealth in prescribing while others are more vague or silent. Some of the rules center on whether telehealth is adequate to establish a patient-provider relationship which, again, vary across the states. This question of telehealth and prescribing has gained increasing attention in the last few years and will likely continue to be an area where states continue to develop their policies.

## Credentialing and Privileging

Credentialing is the process used by health care organizations to obtain, verify, assess and validate previous experience and qualifications. Privileging is the process used by organizations, after review of credentials, to grant authorization for a practitioner to provide a specific scope of patient care services. Small and/or rural clinics may need certain specialists but not have the resources or demand to hire one as a full-time staff member. Telehealth would be an option to these organizations, but the process to credential a provider can tax already limited resources.

CMS approved regulations to allow hospitals and critical access hospitals (CAH) to credential by proxy which allows a clinic (the originating site) to contract with another hospital, CAH or telemedicine entity (the distant site) to provide services via telehealth and credential those providers by relying on the credentialing work done by the distant site, if certain conditions are met. This creates a faster, more cost effective method for clinics and hospitals to access needed specialty care. The Joint Commission created parallel guidelines to the federal regulations. Both are optional to use and a clinic or hospital may still utilize a full credentialing process.

## Other Influences on Policy

As noted above, Medicare, Medicaid, Congress, state legislatures and regulatory boards play an important part in developing telehealth policy. However, there are other entities that can greatly impact telehealth policy.

### National Organizations

As noted earlier, the FSMB offered model legislation for their Interstate Medical Licensure Compact that has been adopted by a third of the states over the past two years. National organizations are increasingly stepping in to address issues around telehealth and like the FSMB offering their views on policy that could eventually influence or directly impact what gets enacted. Organizations such as the American Medical Association (AMA), AARP and the National Conference of State Legislatures (NCSL) have all offered their own viewpoints that may or may not be incorporated into specific legislation or regulations. It will be important to see what these national groups develop.

## Other Influencers on Policy (cont.)

### The Courts

Court decisions can impact how telehealth policy develops in many ways that may not seem obvious. In 2015, the Supreme Court ruled in *North Carolina Board of Dental Examiners v. The Federal Trade Commission (FTC)* that the make-up of a licensing board was important. In this case, the North Carolina Board of Dental Examiners was made up of a majority of dentists still practicing. The FTC argued that these practicing dentists (“active market participants”) had the ability to influence the market place to their benefit. The Supreme Court agreed with the FTC, and has since provided [guidance](#) clarifying what is meant by an “active market participant” so that professional licensing boards can avoid coming into conflict with FTC rules in the future. This case is now the main argument behind a current Texas case involving a telehealth provider who is arguing certain telehealth policies passed by the Texas Board of Medical Examiners should be invalid because the makeup of that board contains too many practicing physicians. This case is still pending.

### The Federal Trade Commission (FTC)

As noted previously, the actions of the FTC can have a decided impact on telehealth policy. In addition to the North Carolina case, the FTC appears to have taken some interest in telehealth. In 2016, the FTC submitted [comments](#) on an Alaskan state telehealth bill (SB 75), the first time it has done so. Among their comments, the FTC noted that requiring a state board to create telehealth specific guidelines and policies without a good reason for doing so may create an undue burden that may limit the market place and choices for consumers. The FTC stopped short of saying such an action was prohibited, but its comments do indicate the FTC is looking at this issue and raises the possibility that some telehealth regulations and policies passed by state regulatory boards may be looked upon in the future with a critical eye by the agency.

## Future Trends

For 2017 and going forward, several policy areas that bear watching besides the ones listed above include:

### Mobile Health (mHealth)

Policy around mHealth remains almost non-existent. Aside from guidance on apps issued by the Federal Drug Administration (FDA), only Hawaii in their recently passed SB 2395 has said anything directly related to mHealth (it is included in their definition of telehealth). As apps continue to be developed and our society becomes more mobile, mHealth will continue to be increasingly accessed as an option, but the policy has been slow to catch up.

### Abortion

In recent years, the prescribing issue and abortion have become entwined because of the use of telemedicine by some programs to issue abortion inducing drugs. In the 2015-2016 state legislative year, several bills were introduced linking these two issues together. Also in that period, several court cases challenging laws that would limit the use of telehealth in prescribing abortion inducing drugs were brought forward. This issue has already been the subject of an Iowa case in 2014. We will likely see more debate around this subject.

## Resources

- **Center for Connected Health Policy ([cchpca.org](http://cchpca.org))**
- **Telehealth Resource Centers ([telehealthresourcecenter.org](http://telehealthresourcecenter.org))**
- **Centers for Medicare and Medicaid (<https://www.cms.gov/Medicare/Medicare-General-information/telehealth/>)**