STATE LICENSURE REGULATIONS EVOLVE TO MEET THE DEMANDS OF MODERN MEDICAL PRACTICE

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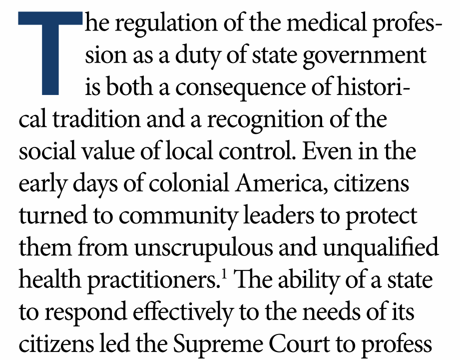

The regulation of the medical profession as a duty of state government is both a consequence of historical tradition and a recognition of the social value of local control. Even in the early days of colonial America, citizens turned to community leaders to protect them from unscrupulous and unqualified health practitioners.[1] The ability of a state to respond effectively to the needs of its citizens led the Supreme Court to profess

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that the states have "a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect public health, safety and other valid interests, they have broad power to establish standards for licensing practitioners and regulating the practice of the professions."[2]

Perhaps predictably, deference to the states in matters of regulation results in statutes and regulations as diverse as the nation itself. Although the diversity of regulation serves to support parochial interests, it frustrates health professionals who must abide by a panoply of requirements when they seek to shift their practice to a different state or wish to practice in multiple states. This frustration is only growing as practitioners and patients make increased calls for license portability within the modern health care system.

In conjunction with the demand for enhanced physician mobility, changes in federal and state laws are fueling demand for access to care and enlarging the health care marketplace. These recent and historic reforms will expand the demand for physicians, accelerating the stress on a system already projected to require an additional 90,000 physicians by 2020.[3] At the same time, providers are embracing technological innovations to provide more affordable, efficient, and accessible health care.

Increasingly, physicians engage patients through digital platforms and electronic media in a variation of medicine generally referred to as telemedicine or telehealth. Telemedicine is used by hospitals that lack resources to access a wider range of specialists and provide immediate care. Patients are forgoing visits to crowded waiting rooms by enlisting technology to connect instantly to health care providers without leaving the comforts of their own home. And for those who live in rural or other underserved areas, telemedicine may be the only option to accessible care, routine or otherwise.

The convergence of these developments—increased mobility, expanding access to care, and technological change—challenges regulators to strike an appropriate balance between enabling the delivery of health care while ensuring patient safety.

This article highlights efforts by the Federation of State Medical Boards (FSMB) and its member boards (the state medical and osteopathic boards in the United States and its territories) to streamline the licensing process for physicians desiring to practice in multiple states. It also introduces recent efforts to harmonize standards of practice related to the use of telemedicine. Ultimately, recent progress toward the development of an Interstate Medical Licensure Compact and revisions to guidelines addressing the use of technological advancements in the physician-patient relationship should accommodate changing approaches to the delivery of care, benefiting both the provider and the public.

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Previous State Efforts to Improve License Portability

Inextricably linked to the growing use of technology to transcend distance and state borders is the need for enhanced license portability. The principle that the practice of medicine occurs in the state where the patient is located is a fundamental component of medical regulation. This principle allows a medical board to exercise jurisdiction over the physician providing care and fully exhaust all disciplinary resources necessary to protect patients located in its state. Given this fact, the physician must also abide by all regulations found in the medical practice act in the state where the patient is located.

The FSMB first addressed the practice of telemedicine and its impact on state licensure and discipline in 1996 when it released the *Model Act to Regulate the Practice of Medicine Across State Lines.*[4] Incorporating the principle that the practice of medicine occurs where the patient resides, the Model Act recommended that state boards issue telemedicine licenses to only those physicians planning to practice telemedicine. A physician would not have to apply for a full and unrestricted license, the policy reasoned, thereby providing a less expensive and less burdensome avenue for a physician to practice in a limited capacity within a state while ensuring that the physician comes under the jurisdiction and regulatory authority of the medical board in the state in which the patient resides.

The Model Act strongly influenced the policy decisions of state medical boards as they responded to the use of telemedicine in regular medical practice. Fifty-seven state medical and osteopathic boards and the District of Columbia Board of Medicine now require physicians engaging in telemedicine to be licensed in the state in which the patient is located. Ten state boards issue a special purpose license or certificate, or a limited license to practice medicine across state lines, allowing for the practice of telemedicine. These changes provided pathways facilitating the practice of telemedicine, but calls for enhanced portability for all physicians, not just those using telemedicine, are driving new initiatives at both the federal and state levels.

Federal Attempts at Addressing Licensure Issues

Despite a long-standing deference to a state-based system of medical regulation that imposes requirements as determined by the "judgment of the State as to their necessity,"[5] the federal government has become more interested in considering national licensure standards with the intent of removing regulatory impediments perceived to hamper those physicians desiring to practice across state lines. As early as 1997, congressional leaders investigated the creation of a federal telemedicine license as means of reducing barriers to the use of technology to provide health care to underserved constituencies.[6] Since that time, Congress has implemented licensure standards that go beyond state licensure requirements if the health care provider engages in the delivery of health care through certain federal programs and is currently looking to use this nexus to expand the scope of federal regulation into areas of traditional state jurisdiction.

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The Servicemembers' Telemedicine and E-Health Portability (STEP) Act was included as part of the National Defense Authorization Act for Fiscal Year 2012.[7] The act created state licensure exceptions for Department of Defense health care professionals that allowed the professional, licensed in at least one state, to practice at a location in any state regardless of where the health care professionals or the patients are located. Subsequent language expanded this exception to include civilian employees of the Department of Defense, personal services' contractors, and other health care professionals credentialed and privileged at a federal health care institution.

Recent legislation introduced in the 113th Congress addresses perceived obstacles to licensure that affect the delivery of health care to servicemembers and veterans. The Veterans E-Health & Telemedicine Support (VETS) Act of 2013[8] would allow for a licensed health care professional, either authorized or contracted with the Department of Veterans Affairs, to provide treatment to a patient using telemedicine regardless of where the health care professional or the patient is located. The 21st Century Care for Military & Veterans Act[9] would expand insurance coverage of telehealth services for service members, veterans, retirees, and dependents by creating parity in coverage between telehealth and in-person services. It contains additional provisions that would allow physicians to provide services across multiple states with a single state medical license. In a departure from existing state licensure and professional liability standards, health care practitioners using telemedicine in this way would be considered to be furnishing services at their location and not at the site of the patient.

Other legislative initiatives mirror the licensure exceptions related to the treatment of servicemembers and create licensure exceptions utilizing a physician's relationship to Medicare. The TELE-MED Act of 2013[10] would allow for a Medicare provider to treat any Medicare beneficiary in another state via telemedicine without first obtaining an additional state licensure in the state where the patient is located. The provider would fall under the jurisdiction of the state medical board where he or she is licensed for the purposes of discipline, effectively eliminating the widely adopted principle that the practice of medicine occurs where the patient is located. The bill also calls for the creation of a federal definition of telemedicine services, an issue that state medical boards are also currently addressing.

The efforts in Congress to address issues of medical licensure lead to several questions worthy of consideration. One question is whether the proposed federal legislation provides the appropriate mechanisms to adequately protect the public within existing regulatory structures. A larger, more fundamental question is to what extent federal law should trump state authority in the regulation of the practice of medicine.

Utilizing Interstate Compacts to Improve License Portability

Recognizing that divergent federal and state solutions may ultimately frustrate the regulation of medical practice, the FSMB, together with its member boards and other stakeholders, began exploring new mechanisms that could streamline current licensing processes for physicians and better accommodate the use of telemedicine in the delivery of health care while protecting the public. In April 2013, the FSMB's House of Delegates unanimously approved Resolution 13-5: Development of an Interstate Compact to Expedite Medical Licensure and Facilitate Multi-State Practice. The resolution, introduced by the Wyoming Board of Medicine, directed the FSMB to convene representatives from state medical boards and special experts to aggressively study the development of an interstate compact to facilitate license portability.

The Compact Clause of the United States Constitution[11] allows states to address issues of shared interest, thereby negating the need for federal intervention. A compact exists simultaneously as a contract among contracting states and as a standalone statute within state law.[12] On issues of traditional state jurisdiction, "compacts afford states the opportunity to develop dynamic, self-regulatory systems, over which the member states can maintain control through a coordinated legislative and administrative process."[13] Although compacts are subject to the authorization of Congress, the Supreme Court has held that if the compact accomplishes a recognized function of the state—such as regulation of professions—and does not intrude on federal interests, congressional consent is not necessary.[14]

The emergence of compacts as a possible solution to increased license portability is not surprising, as throughout the nation's history "the pressure of modern interstate problems [reveal] the rich potentialities of this device."[15] The FSMB is not alone in investigating the utility of compacts to address licensure issues. In 1997, the National Council of State Boards of Nursing approved the Nurse Licensure Compact.[16] This compact, enacted in 24 states, employs a process of mutual recognition between member states, allowing a nurse to practice in another member state as long as he or she maintains a license in a home state that is also a member state to the compact. The nurse can freely move among states without registering in the new state. The National Association of State EMS Officials is currently working on a compact that addresses problems associated with deployment of EMS personnel across state borders.[17] Interstate compacts, in short, provide a dynamic solution that can address shared regulatory issues and, if drafted properly, provide flexibility to evolve and meet the challenges that may arise as telemedicine and the cross-border practice of medicine becomes more widespread.

In pursuit of its study of what would constitute a feasible interstate compact for medical licensure, the FSMB joined with the Council of State Governments (CSG) to host a series of meetings to explore the core principles that should be included in an interstate compact. A diverse collection of stakeholders, representing both members of state medical boards and their executive directors, as well as experts in interstate compact law, were present at these meetings.

After extensive deliberation, participants shared concerns that the creation of a national license would overburden and compound existing regulatory structures. It was agreed that the compact should not create a new license but another pathway

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for licensure, one that would not otherwise change a state's existing medical practice act. Through participation in the compact, state medical boards will offer an expedited licensure process for physicians meeting identified and accepted standards. Under the proposed standards, the majority of currently licensed physicians would be eligible for expedited licensure through the proposed process. However, the compact will not preclude physicians who do not meet these standards from obtaining licensure in multiple states through traditional processes.

Citing serious concern that any structure that affects the ability of state medical boards to assess fees would frustrate the ability to fund investigations as part of the physician disciplinary process, the compact committee determined that the compact should not compromise existing fee structures. At a minimum, any fees for licensure through the compact should be equal to the fees already charged for renewal of a license (generally less than the cost of initial licensure). It was also agreed that the compact should include a cooperative system of information-sharing and rapid adjudication of disciplinary issues among states. Ultimately, the compact should demonstrate to state medical boards and the public that the oversight of physician activity remains well-coordinated, strong, and effective.

Considerable progress has been made in developing the structure for a compact that incorporates these guiding principles. The first draft of a compact was shared with certain stakeholders in December 2013. The comments received from state medical boards, representatives of the practitioner community, and other stakeholders will help strike a salable balance between the needs of practitioners, regulators, and ultimately, the public. Initial comments are positive and constructive, suggesting that the use of a compact may be a feasible approach to creating a mechanism that ensures the portability of licenses in a robust and expanding health care system.

Telemedicine Standards of Practice Continue to Evolve

The need for increased license portability and the growing use of telemedicine presents not only complex regulatory challenges related to jurisdiction, but also necessitates improvement of the terms and standards of practice that used to regulate new delivery models involving telemedicine and cross-border practice. The challenges faced by regulators include determining when a physician-patient relationship is established, assuring the privacy of patient data, guaranteeing proper evaluation and treatment of the patient, and limiting the prescribing and dispensing of certain medications. Uniform and consistent standards will improve accessibility to health care and ensure patient safety.

In 2002, responding to the growing number of physicians utilizing the Internet to treat patients, the FSMB's Special Committee on Professional Conduct and Ethics reexamined its 1996 Model Act to Regulate the Practice of Medicine Across State Lines and saw the need for guidelines that accounted for the profound impact the Internet was beginning to have on the practice of medicine beyond questions of regulatory jurisdiction. The resulting policy, the *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*,[18] required physicians who provide medical care, electronically or otherwise, to maintain a high degree of professionalism. Electronic communications and interactions between the physician and patients should place the welfare of the patient first and enhance, but not replace, the traditional physician-patient relationship. The guidelines also directed physicians to adhere to recognized ethical codes, properly supervise nonphysician clinicians who may be using electronic means to interact with patients, and protect patient confidentiality.

Technological developments not envisioned at the time of drafting the Model Guidelines, as well as new capabilities of previously existing technology, have caused states to contemplate revising existing policies. Broadly available consumer applications such as Skype are allowing patients improved and contemporaneous accessibility to physicians, but may lack security and monitoring features required under federal laws and possibly more stringent state laws. Use of telemedicine to skirt regulations designed to limit the overprescription of opioids and drugs is becoming more prevalent. Sensing that outdated and inconsistent policies will hinder access to care and compromise patient safety, the FSMB convened the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup in May 2013 to review existing state policies and offer improved guidelines addressing the impact of new technologies.

As a result of this study, the SMART Workgroup drafted the *Model Policy on the Appropriate Use of Telemedicine Technologies* for use by state medical boards in evaluating the appropriate standards of care using telemedicine technologies. These standards govern the interaction between a physician in one location and a patient in another, regardless of whether that interaction is interstate or intrastate. In developing the model guidelines, the workgroup conducted a comprehensive review of existing and proposed state board rules and regulations, the 2002 Model Guidelines, as well as relevant policies from other organizations, including the American Medical Association (AMA), American Osteopathic Association (AOA), American Telemedicine Association (ATA), and the Center for Telehealth and e-health Law (CTeL).

The SMART Workgroup found that many of the key principles from the FSMB's 2002 policy remain relevant but warranted revision to reflect current terminology and expand standards that will apply to both intrastate and interstate telemedicine practices. The new model guidelines do not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. Consistent with the principle of an unaltered scope of practice, the guidelines require parity between delivering care via telemedicine and the delivery of care during an in-person encounter. It remains a part of the revised policy that a physician must be licensed by, or otherwise under the jurisdiction of, the medical board of the state where the patient is located. The new guidelines adopt a uniform definition of telemedicine that has not changed from the FSMB's prior policy document. The

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guidelines define telemedicine as "the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider."

In a significant departure from prior policy, and in recognition of current practices in telemedicine and connected health, the new guidelines do not mandate an in-person physician-patient encounter before the delivery of the practice of medicine by electronic means. Coupled with this change in policy, the guidelines offer more explicit procedures to ensure that a remote encounter facilitated by telemedicine remains as similar to a traditional in-person encounter as possible. A physician must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. The Model Guidelines discourage a physician from rendering medical care using telemedicine technologies without first obtaining consent from requesting patients, verifying the patient's identity, and disclosing facts related to any treatment option. Beyond obtaining informed consent, a physician practicing telemedicine must create a record of relevant clinical history that includes copies of all physician-patient communications and consents. Medical records must be kept in a manner consistent with all existing laws and regulations in the state where the patient is located.

The new guidelines also enhance safeguards related to patient safety. Online services must have accurate and logical domain name registrations and must further provide accurate information about the website owner/operator, location, and contact information. Additionally, the online services used by the physician practicing telemedicine technology must clearly disclose how the encounter will be facilitated and must include a clear mechanism for patients to provide feedback and supplement any patient-provided health information provided in the encounter. Such measures guarantee that the identity of the provider is clearly established and that all treatments are tailored to the needs of the patient.

Conclusion

Improved license portability and revised standards of practice for those physicians utilizing telemedicine are part of an evolving regulatory rubric that will ensure that innovations in the delivery of care coexist with state-based medical regulation and a robust system of patient protection. To meet the demands that improved technology places on state regulators, the time line for the completion and implementation of the changes highlighted in this article is necessarily bold. The *Model Policy on the Appropriate Use of Telemedicine Technologies* will be considered for adoption by the FSMB House of Delegates at its annual meeting in Spring 2014. Also at this meeting, regulators will review and discuss an interim draft of the medical licensure compact. Commentary and suggested improvements will then be incorporated into subsequent drafts that will be released more broadly later in 2014, with a target completion date by year's end. Both initiatives represent the continued efforts of the FSMB and its member boards to strengthen state-based licensure, protect the public, and promote quality health care. ◆

Endnotes

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11. United States Constitution, Art. I, § 10, cl. 3.

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