# ANALYSIS OF LICENSURE LAWS, RULES AND PROCEDURES AS THEY RELATE TO E-HEALTH AND TELEHEALTH

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## PART A

## I. Introduction

There has been an increase in the practice of health care across state lines via telehealth and other means. Physicians, nurses, and pharmacists are all examples of health care professionals who are engaged in seeing patients that are not located in the same state as they are located. The practice of health care has been changing to meet the needs of consumers. Patients may not have access to medical experts in their hometown, but this does not mean that they do not need expert care. The development of advanced communications technologies enables people everywhere, including those in rural and underserved areas, to have access to the best possible health care. Patients can be linked to medical experts around the country. For these reasons, there has been an increase in the number of health care professionals practicing across state boundaries. This number is expected to continue to increase.

Even though the practice of health care is changing dramatically, the underlying structure for regulating the provision of health services has not changed dramatically in recent years. Under the Tenth Amendment to the Constitution, those powers not specifically given to the federal government are reserved to the states. States have long exercised authority to regulate the health, safety, and general welfare of their citizens.[1] They use this authority to regulate health care professionals through their state boards of medicine, nursing, pharmacy, and other health care practitioners. States set standards for and grant licenses to health care professionals. They discipline these professionals and if necessary, revoke their licenses.

Over the last fifty years, the basic requirements set by states to practice medicine have become largely uniform. The testing and education requirements for physicians are almost the same in all states. Almost every state requires applicants to have passed a licensing exam. Almost every state requires applicants to have completed a certified training program such as a residency or internship. Likewise, nursing requirements and standards are similar among the states. The requirements and standards for pharmacist licensure are also fairly uniform in all states. While state licensure laws are similar in many aspects, there is still the requirement that health care professionals be licensed in the state where the patient is located. Thus, a health care professional may meet the standards necessary to obtain a license in all fifty states. But, that does not actually give them the authority to practice. Health care professionals must apply for and receive a license in each state they want to practice; this includes the practice of telehealth. For this reason, state licensure of health care professionals is seen as major barrier to the practice of telehealth. In fact, the Office for the Advancement of Telehealth wrote reports for Congress

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[1] U.S. Const. Amend. X; Dent v. West Virginia, 129 U.S. 114 (1888), *see also* People v. Mulford, 125 NYS 680 (1910), *aff'd*, 202 N.Y. 614, 96 N.E. 1125 (1911).

on Telemedicine in 1997 and 2001. Both of these reports came to the same conclusion; they cite licensure as a major barrier to the telehealth.[2]

## II. Background on Licensure

### *a. State Licensure of Health Care Professionals*

States have the authority to regulate health care professionals through their state boards of medicine, nursing, and pharmacy. The Tenth Amendment of the Constitution gives power to the states to regulate the health, safety and general welfare of their citizens.[3] Thus, each state has enacted practice acts that define the practice of medicine, nursing, and pharmacy and delegate the responsibility for enforcement of the practice act to a state board of medicine, nursing, and pharmacy. For example, most of the state physician licensure statutes were adopted before the turn of the 20th century.[4] During that time period, there were large variations in the training and skills of health care professionals. It was difficult for the average citizen to verify if a health care professional and the treatments he or she were touting were reliable. In response to the inconsistencies, states intervened and set standards for the practice of health care. Since then, basic standards in education and competency necessary to obtain a state medical license have become more or less standardized across the country.

In addition to state statutes that govern the practices of health care professionals, state boards have adopted rules and standards that govern the health care professionals within their state. By doing so, state boards establish standards for the safe practice of health care and for issuing licenses. State boards also monitor compliance with these rules and discipline health care professionals when necessary.

Most state board members are appointed to their position for a specific period of time, and most boards consist of both health care professionals and non-health professionals. Nursing boards, for example, generally consist of registered nurses, licensed practical/vocational nurses, advanced practice registered nurses, and consumers. Medical boards generally consist of volunteer physicians and consumers. Most state boards have administrative staff which can include attorneys, investigators and licensing staff. Some boards are independent, while others are part of a larger state agency such as a state department of health. Some boards receive financial assistance from state government and some boards self fund through their registration and licensing fees.

According to the Federation of State Medical Boards, "State medical boards license physicians, investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate rehabilitation of physicians where appropriate." State medical boards consider these

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[2] Telemedicine report to the Congress, GPO No: 0126-E-04 (MF), Washington, DC. U.S. Department of Health and Human Services; 2001 Telemedicine Report to Congress, GPO No: 619-261/65410, Washington, DC. U.S. Department of Health and Human Services.

[3] U.S. Const. Amend. X; Dent v. West Virginia, 129 U.S. 114 (1888), *see also* People v. Mulford, 125 NYS 680 (1910), *aff'd*, 202 N.Y. 614, 96 N.E. 1125 (1911).

[4] Robert C. Derbyshire, *Medical Licensure and Discipline in the United States* 1-7 (1969); Richard H. Shryock, *Medical Licensure in America,* 1650-1965 (1969).

tasks as a way for the public to "enforce basic standards of competence and ethical behavior in their physicians, and physicians a way to protect the integrity of their profession." There are currently 70 state boards authorized to regulate osteopaths or physicians; some states use the same board to regulate osteopaths and physicians. Others use separate boards.

According to the National Council of State Boards of Nursing, there are boards of nursing in the 50 states, the District of Columbia, as well as in four United States territories-Guam, Virgin Islands, American Samoa, and the Northern Mariana Islands.

According to the National Association of Boards of Pharmacy, there are boards of pharmacy in the 50 states, the District of Columbia, as well as the Virgin Islands, Guam and Puerto Rico.

***b. Relationship of Credentialing and Licensure***

As part of this paper, we were asked to incorporate a discussion on the relationship of credentialing and licensure. The term credentialing can apply to activities of a state board to review and assess the credentials of a licensure applicant. Candidates for licensure submit copies of their educational transcripts and other information for review and approval to receive a license. The credential review process can be burdensome for health care professionals who are applying for licenses in many states. In some cases, they will need to provide an original copy of their transcript and might be required to participate in an on-site interview with the state board. These types of requirements can be a barrier to obtaining multiple state licenses due to the administrative burden. Professional organizations are taking steps to develop mechanisms to simplify and expedite the review of credentials.

The term credentialing can also apply to health facilities. As a prerequisite to providing clinical services to patients of a hospital or health facility, a health care professional must obtain clinical privileges at such hospital or health facility. The health facility's process of selecting, reviewing and periodically evaluating the competency of a health care professional is referred to as credentialing. The process of credentialing evolved as a response to the corporate negligence doctrine. The Illinois Supreme Court case of *Darling v. Charleston Community Memorial Hospital* was the genesis of the corporate negligence doctrine, which states that a hospital has an independent and direct duty to protect its patients from the acts of incompetent physicians, whether those physicians are the hospital's employees or not.[5]

Under the umbrella of corporate negligence doctrine, a hospital specifically may be held liable for its negligence in granting medical staff membership or clinical privileges to physicians (referred to as "negligent credentialing"). The basis for a negligent credentialing claim rests on the assumption that if the hospital created and followed adequate credentialing procedures, the hospital would not grant privileges to a physician who negligently treated patients within the hospital.[6] In order to determine the adequacy of credentialing procedures, The Joint

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[5] *Darling v. Charleston Community Memorial Hosp*., 211 N.E.2d 253 (Ill. 1965). *See also* Health Law Practice Guide §1:6, National Health Lawyers Association (West 2007).
[6] 18 *Causes of Action* 2d 329, § 1 (2006).

Commission, an accrediting agency for hospitals and health facilities, has set forth standards for credentialing and privileging physicians. [7]

Generally, The Joint Commission standards require a health facility's organized medical staff to review the following items when credentialing a physician for medical staff membership or clinical privileges at the health facility: (1) verification of current licensure to ensure that that a physician is appropriately licensed to practice as required by state and/or federal law; (2) verification of education and relevant training to inform the health facility of the physician's clinical knowledge and skill set; (3) verification with the physician's peers who have knowledge about the physician's experience, ability and current competence.[8]

The Joint Commission standard for credentialing also requires that, whenever feasible, the health facility verify license status, education and relevant training with an original source of the specific credential or with a credentials verification organization (CVO). The Federation of State Medical Boards (FSMB) is designated by The Joint Commission as equivalent to a primary source for verification of all actions against a physician's medical license. Further, the hospital must query the National Practitioner Data Bank at the time of initial credentialing of a physician, at the time of renewal of privileges (at least once every two years for a physician who is already on the medical staff), and when a new privilege is requested.[9]

The National Practitioner Data Bank was established by the Health Care Quality Improvement Act of 1986 ("HCQIA").[10] HCQIA requires health facilities to report to their state board of medical examiners any quality-related adverse peer review decisions that affect a physician's clinical privileges for more than thirty days. The state medical board must then report to the National Practitioner Data Bank any adverse peer revision decisions from health facilities and any actions taken by the state medical board to restrict a physician's license or to discipline a physician for reasons related to professional competence or improper conduct. If a health care entity fails to make the required reports, it can lose the HCQIA's immunity protection for professional review activities.[11]

For those physicians who seek to provide patient care, treatment or services via a telemedicine link, The Joint Commission has set forth specific standards for hospitals on how to credential physicians for telemedicine privileges. The Joint Commission defines telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services.[12]

For most patient care services provided via a telemedicine link, The Joint Commission's standards for telemedicine privileges require the hospital where the patient is located at the time the telemedicine service is provided (the "Originating Site") to credential and privilege

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[7] Most hospitals and health facilities have obtained accreditation from The Joint Commission, and thus, follow the telemedicine credentialing and privileges standards of The Joint Commission.
[8] The Joint Commission's Hospital Accreditation Standards, 2007 ed., Standard MS.4.10, p.373 – 375.
[9] The Joint Commission's Hospital Accreditation Standards, 2007 ed., Standard MS.4.15, p.376 – 378.
[10] 42 U.S.C. §§ 11101 et seq.
[11] See Health Law Practice Guide §1:57, National Health Lawyers Association (West 2007).
[12] The Joint Commission's Hospital Accreditation Standards, 2007 ed., Standard MS.4.120 – 4.130 p. 391- 393.

physicians. The standards for credentialing physicians for telemedicine privileges differ from non-telemedicine clinical privileges. The Joint Commission recognized that the Originating Site may have little experience in privileging in certain specialties and the site where the practitioner providing the service is located (the "Distant Site") may have more relevant information upon which to base its privileging decisions. Thus, The Joint Commission introduced the concept of credentialing by proxy, which allows the Originating Site to privilege physicians for telemedicine by using credentialing information from the Distant Site, as long as the Distant Site is also accredited by The Joint Commission.[13]

For licensed physicians who provide only interpretive services through a telemedicine link, including the official readings of images, tracings, or specimens, the Originating Site must credential and privilege the physician by following The Joint Commission standard for "services provided by consultation and contractual arrangements."[14] This standard requires that services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.

For an Originating Site hospital to meet this standard, the leaders of the hospital must approve of the person or entity providing the clinical service to the hospital, the nature and scope of the services as defined in writing, the services provided must meet applicable Joint Commission standards, the hospital must evaluate the telemedicine services to determine whether they are being provided according to the contract and the level of safety and quality that the hospital expects, and the hospital must retain overall responsibility and authority for services furnished under the contractual or consultation arrangement.

Accordingly, credentialing is a key factor in determining whether a physician is able to practice medicine at a health facility. The health facility is required to verify the licensure status of the physician before credentialing a physician for clinical privileges at the hospital. In order to grant telemedicine privileges to a physician, an Originating Site may use the credentialing information and/or the credentialing decision of a Distant Site. The Joint Commission standards for telemedicine credentialing assume that the health facility is following applicable law and regulations such as verifying a physician's license to practice medicine or telemedicine in the state where the Originating Site and Distant Sites are located.[15]

### *c. The Future of Telehealth and the Existing Challenges and Barriers to the Practice of Telehealth*

Telehealth involves using telecommunications devices to link patients and health care professionals. Telehealth advocates argue that telehealth provides the potential for patients to have access to specialized medical expertise, regardless of where the patient is located. Advocates state that telehealth will address specialization gaps in underserved areas. However, it is difficult to achieve this vision if experts must be licensed in every state. If a health care professional obtains more than one license, the additional licenses are most likely to be either in adjoining states or in highly populated and more economically prosperous areas.

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[13] Id.
[14] Id., Standard LD.3.50 at p. 272.
[15] The Joint Commission's Hospital Accreditation Standards, 2007 ed., p. 391.

There are many specific barriers preventing a health care professional from obtaining a license to practice in every state in America. There are fees to apply for a license. State application and licensure fees for physicians vary from $125 to $1300, with an average of $500. Thus, if a physician applied for a license in 25 states, it would cost on average, $12,500. This is a significant impediment to obtaining multiple licenses. There are also administrative burdens. There is a separate application for each state license and many states require in-person interviews. If one applies to many different states, then one is essentially filling out the same information on each individual state's application. In order to reduce licensure as a barrier to the practice of telehealth, there are many options we will discuss in detail later in the paper. However, we will provide a brief overview of the various options to reduce licensure as a barrier to the practice of telehealth.

One option is to reduce the administrative burden for applicants. An electronic application process would reduce the paperwork burden so that the same form can be used in every state, without the time needed to fill out the same form again and again. Another option is for states to work together. This can be done through the process of endorsement, in which a state expedites the licensure process if a health care professional is already licensed in another state. This can also be done by states entering in reciprocal agreements or compacts with one another, stating that if a health care professional is licensed in a participating state, then other participating states must consider them as being licensed in their own state.

However, there is a tension between the challenges faced by health care professionals and the challenges faced by state boards. From the state board perspective, the challenge lies in maintaining state authority over the health care professional and maintaining the need for individual state boards. States have the duty to protect their citizens' health, safety, and welfare. States have created boards to create rules and standards for their health care professionals; states enforce these rules. In addition, state boards are often funded by the administrative fees paid for by the applicants for state licensure. If states enter into compacts or reciprocal agreements with other states that no longer require the administration of an application and the associated fees for licensure, states may not be able to maintain the state boards. State boards' sole purpose is not to grant licenses, but to protect the health and welfare of its citizens as it relates to the work practiced by its licensed health care professionals. If the funding source for state boards is reduced, fulfilling this important purpose would require a separate funding source that allows the state boards to enforce rules and discipline health care professionals.

Thus, as we consider solutions for reducing licensure as a barrier to telehealth, the competing needs of the health care professionals and the state boards must be addressed. This will be discussed in Part B of this paper.

## V. Examination of Licensure Laws in the Physician Profession

### <u>Medical Boards</u>:

#### *a. State Licensure Differences for Physicians Seeking to Practice Telemedicine*

Generally, in order for a physician to provide medical services to a patient, the physician must be licensed in the state where the patient is located. This is due, in large part, to each state's duty to

protect the health and safety of its residents. The licensure requirements to practice telemedicine vary greatly among the states. For a majority of states, a physician, seeking to practice telemedicine in a state in which he or she is not currently licensed (an "out-of-state physician"), will need to obtain either a full license or a special license to practice telemedicine in the state in which the patient is located.

Currently, twenty-five states require a full license to specifically practice telemedicine, as provided for under the state statute governing the practice of medicine ("Medical Practice Act") or the state Medical Board regulations or policies. An additional nine states require special purpose licenses, registrations or certificates from the state Medical Board in order to practice telemedicine.[16] The remaining seventeen states do not specifically address telemedicine in statute, but most have indicated that they interpret their laws to require full licensure to practice telemedicine on in-state patients, unless exceptions apply.

| State | Full License Required; Telehealth Not Specifically Addressed | Full License For Telehealth Required By *Statute* | Full License For Telehealth Required By *Regulation/Policy* | Special Purpose License For Telehealth |
|---|---|---|---|---|
| **Alabama** | | | | X |
| **Alaska** | X | | | |
| **Arizona** | X | | | |
| **Arkansas** | | X | | |
| **California** | | X | | |
| **Colorado** | | X | | X (Shriners Only) |
| **Connecticut** | | X | | |
| **Delaware** | | X | | |
| **District of Columbia** | X | | | |
| **Florida** | | X | | |
| **Georgia** | | X | | |
| **Hawaii** | | X | | |
| **Idaho** | X | | | |
| **Illinois** | | X | | |
| **Indiana** | | X | | |
| **Iowa** | | | X | |
| **Kansas** | | | X | |
| **Kentucky** | X | | | |
| **Louisiana** | | | X | |
| **Maine** | | | X | |
| **Maryland** | X | | | |
| **Massachusetts** | X | | | |
| **Michigan** | X | | | |
| **Minnesota** | | | | X (Registration) |
| **Mississippi** | | X | | |
| **Missouri** | | X | | |
| **Montana** | | | | X |
| **Nebraska** | | X | | |
| **Nevada** | | | | X |
| **New Hampshire** | | X (Teleradiology) | | |
| **New Jersey** | X | | | |
| **New Mexico** | | | | X |

[16] Colorado also requires a special purpose license to practice telemedicine for the Shriners children's hospitals.

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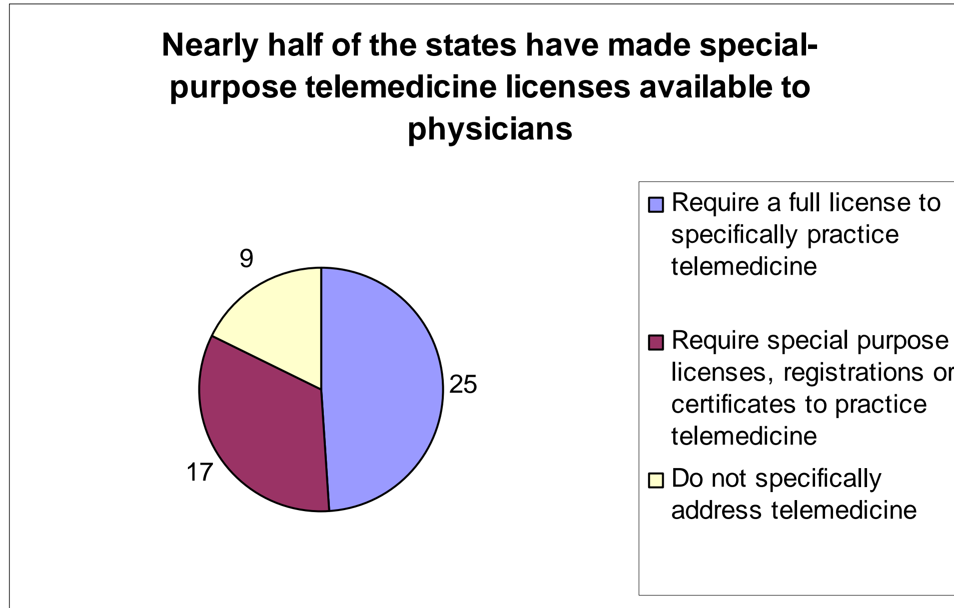
|---|---|---|---|---|
| **New York** | X | | | |
| **North Carolina** | | X | | |
| **North Dakota** | X | | | |
| **Ohio** | | | | X (Certificate) |
| **Oklahoma** | | X | | |
| **Oregon** | | | | X |
| **Pennsylvania** | X | | | |
| **Rhode Island** | X | | | |
| **South Carolina** | | X | | |
| **South Dakota** | | X | | |
| **Tennessee** | | | | X |
| **Texas** | | | | X |
| **Utah** | | X | | |
| **Vermont** | X | | | |
| **Virginia** | X | | | |
| **Washington** | X* | | | |
| **West Virginia** | | X | | |
| **Wisconsin** | X | | | |
| **Wyoming** | | | X | |

* Wash. Code Rev. §18.71.030(6) permits however, "[t]he practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within [Washington]."

The most common exception to the full or special licensure mandate is the "consultation exception." Under the consultation exception, states do not require an out-of-state physician to obtain a full or special licensure if the out-of-state physician is in actual consultation with a physician licensed in the state where the patient is located. Several states, however, impose limitations on the consultation exception. For example, most states allow physicians to take advantage of the consultation exception only if the consultation is provided on an infrequent basis. Minnesota and West Virginia specifically define what constitutes "infrequent." The Minnesota Medical Practice Act defines infrequent as less than once per month or fewer than ten patients per year. Similarly, the West Virginia Medical Practice Act defines infrequent as less than once a month or as less than twelve times per year. On the other hand, several states, including Alaska, California, Washington D.C., Florida, Hawaii, Idaho, Maine, Maryland, Missouri, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, Wisconsin and Wyoming, have broad consultation exceptions that are not limited by the frequency of the consultation.




***b. States' Definition of Practice of Medicine***

The definition of the practice of medicine is typically found in the definition section of the state's Medical Practice Act. A typical definition of the practice of medicine, such as the one in the North Dakota Medical Practice Act,[17] includes two main elements: the action of (1) diagnosing and treating diseases or injuries; and (2) holding oneself out as a physician by maintaining an office and/or attaching the title of "physician" or an abbreviation indicating that the person is engaged in treating and diagnosing diseases and injuries.[18] Twenty states expand this definition by adding treatment or diagnosis by "any means," thereby allowing telemedicine to be included in the definition of the practice of medicine.[19] Another thirteen states specifically reference either treatment or diagnosis by "electronic transmission" or by "telemedicine."[20] Further, the Medical Practice Acts of New Mexico and Oregon separately define "the practice of medicine across state lines" via electronic transmission.

***c. Potential Liability Issues that May Arise as a Result of Current Licensure Requirements***

As stated above, the majority of states require a full license or special purpose license to practice telemedicine in the state. Thus, physicians who desire to practice telemedicine in a state where

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[17] N.D. Cent. Code Ann. §43-17-01(3).

[18] The following states include these elements in their definition of the "practice of medicine": Alabama, Alaska, Arkansas, Colorado, Delaware, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

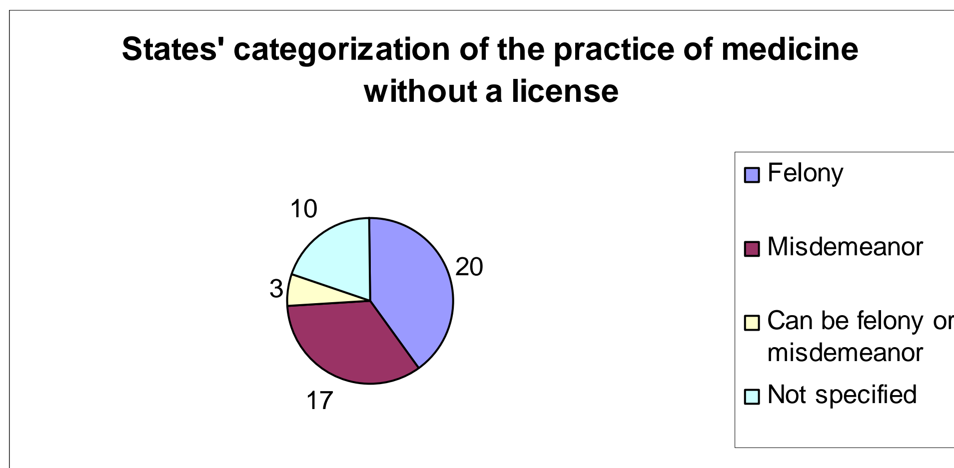
[19] See the definition of the "practice of medicine" under the Medical Practice Acts of Alabama, Arizona, Arkansas, Hawaii, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

[20] See the definition of the "practice of medicine" under the Medical Practice Acts of Colorado, Delaware, Indiana, Mississippi, Missouri, Nebraska, Nevada, New Mexico, North Carolina, Oklahoma, Ohio, Oregon and South Carolina.

they are not licensed may open themselves up to liability. Physicians practicing without a license may face both tort liability for medical malpractice and regulatory liability. Tort liability arises from the physician's breach of the common law duty to practice medicine consistent with a professional standard of care. Simply being licensed does not protect a physician from liability. The fact that a physician is not licensed in a state, by itself, does not produce tort liability. But, it could be used as further indication that a physician was not complying with the standard of care set forth by the state.

Physicians may also be held liable for penalties promulgated under the Medical Practice Acts of the states. Most states provide for criminal penalties against a physician for practicing medicine in the state without a license. Twenty states categorize the crime as a felony and seventeen states categorize the crime as a misdemeanor. Colorado and Washington have both categories, categorizing the first violation as a misdemeanor and the second or subsequent violation as a felony. North Carolina elevates the crime from a misdemeanor to a felony if the physician is specifically an out-of-state physician practicing without a license in the state.[21] Ten other states do not specify whether the crime is a misdemeanor or a felony.

Nonetheless, an overwhelming majority of the states (45 in total) specify a violation that imposes a fine and/or imprisonment for practicing without a license in the state. The fines range from $50 in Vermont up to $50,000 in South Carolina. The length of imprisonment also ranges from ten days in Louisiana up to five years in Georgia or Idaho. Some states go even further and impose a fine and/or imprisonment for each violation or each day of violation.[22]




### *d. Post Graduate Training Requirements for Licensure*

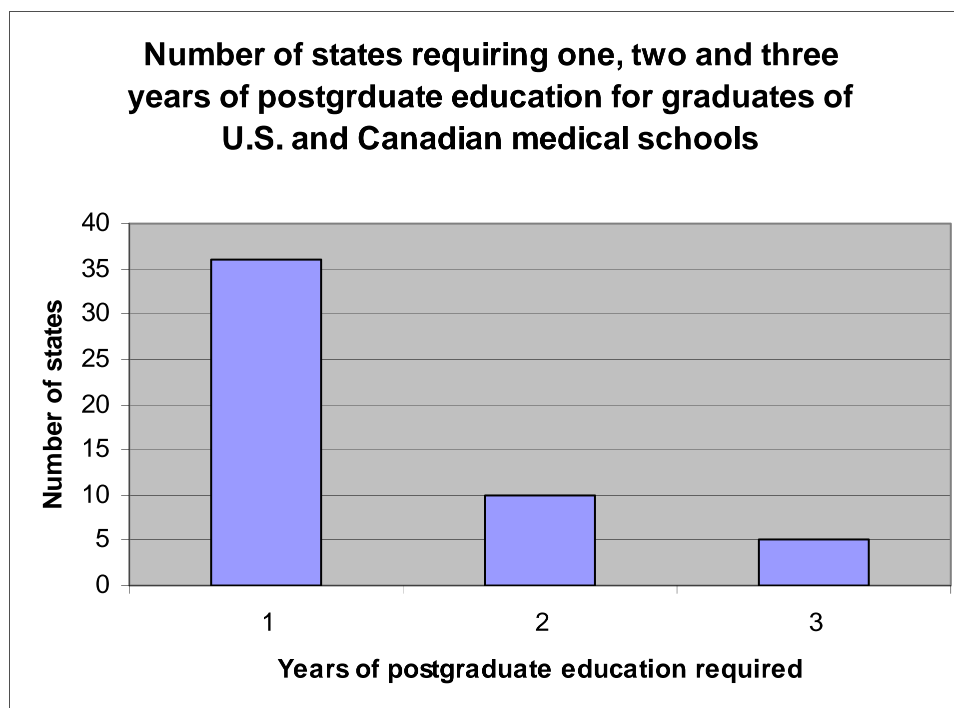
Post-graduate training requirements for licensure usually entail a certain number of years of certified training (i.e. internship or residency) after graduating from a medical school. Most state medical boards differentiate the post-graduate training requirements between those physicians who graduated from a medical school in the U.S./Canada and those who graduated from an

[21] N.C. Gen. State § 90-18(a).
[22] See the Medical Practice Acts of Alaska, Arizona, Hawaii, Missouri, Montana, Oklahoma, Tennessee, Texas, and Wyoming.

international medical school, commonly referred to as an International Medical School Graduate (IMG).

For non-IMGs, a majority of state medical boards (36 in total) require at least one year of certified training after graduating from medical school in order to meet the requirements for licensure. Ten states, including Alaska, Connecticut, Illinois, Kentucky, Michigan, Montana, New Hampshire, New Mexico, Pennsylvania, Rhode Island, and South Dakota, require at least two years of certified training after graduating from a U.S. or Canadian medical school. Only four states (Maine, Nevada, Utah, and Washington) require at least three years of post-graduate training. Maine changed its rules recently and requires all non-IMG who graduated after July 1 of 2004 to complete three years of post-graduate training, while those who graduated before July 1 of 2004 must complete two years of post-graduate training prior to receiving a license to practice medicine in Maine.

Generally, the post-graduate training requirements for IMGs are longer in length than for non-IMGs. However, the length of the post-graduate training requirements for IMGs are much more varied among the states than the requirements for non-IMGs. A slight majority of states (27 in total) require at least three years of post-graduate training, while 20 states require at least two years of post-graduate training for IMGs. Mississippi and Wisconsin are the outlier states that require only one year of post-graduate training for IMG (the same as for non-IMGs) and Georgia requires anywhere between one to three years of post-graduate training.




*e. Number of Permissible Attempts at Licensing Examination*

The United States Medical Licensing Examination (USMLE) is a three-step examination for medical licensure in the United States that is sponsored by the Federation of State Medical

Boards (FSMB) and the National Board of Medical Examiners® (NBME®). Results of the USMLE are reported to each state's medical board for use in granting the initial license to practice medicine. The USMLE provides the medical boards with a common evaluation system for applicants for medical licensure. [23]

The number of permissible attempts at taking the USMLE varies greatly among the states. The number of permissible attempts required by the states can be categorized into the following categories: (1) number of attempts per USMLE step; (2) number of attempts for Step 3 of the USMLE only; (3) number of attempts for all steps of the combined USMLE; and (4) no limit on the number of attempts to take the USMLE.

Under the first category, the number of attempts per USMLE step ranges from 2 attempts per step (Alaska and Idaho) to 6 attempts per step (Arkansas, New Mexico, and North Carolina). For the second category, fifteen states regulate the number of attempts at taking only Step 3 of the USMLE (District of Columbia, Mississippi, Missouri, Montana, Oregon, Pennsylvania, Utah, Vermont, Washington, Alabama, Kansas, Maine, California, New Jersey, and Massachusetts), which range from three attempts to six attempts. Illinois and Nevada are the only two states that regulate the total number of attempts at taking the USMLE, irregardless of the step. Illinois allows 5 total attempts and Nevada allows 9 total attempts. Lastly, twelve states (Arizona, Colorado, Connecticut, Florida, Hawaii, Michigan, New York, Ohio, Tennessee, Virginia, West Virginia, and Wyoming) have no limit on the number of permissible attempts at taking the USMLE.

***f. Time Limits for Completing Licensing Examination Sequence***

Consistent with the standard set forth by the Federation of State Medical Boards, the majority of states (37 states in total) require a physician to complete the USMLE sequence (steps 1 through 3) within seven years. Nonetheless, 17 of those 37 states allow exceptions for physicians pursuing a combined degree such as an M.D./Ph.D. Only five states, including Florida, Kentucky, Louisiana, New Hampshire, New York, and Wyoming, do not place a time limit for completing the licensing examination sequence. A few outlier states, such as Minnesota and North Carolina, require the USMLE step 3 to be passed within a certain number of years of previous USMLE steps.

***g. Licensure Application Methods (i.e. online and paper applications)***

The overwhelming majority of states require applicants to submit paper applications for initial licensure; however, most of these applications are available at the states' Medical Board websites. A few states, including Arkansas, Idaho, Kansas and Oregon require applicants to first submit a pre-application form to request an application for licensure. Only three states, Kentucky, Ohio and New Hampshire, require applicants to submit an online application for licensure via the Common License Application Form ("CLAF"). Pioneered by Ohio, the CLAF is intended to reduce the redundancy of filling out multiple applications when applying for licensure in multiple states. Ohio envisioned that as other Medical Boards joined the CLAF,

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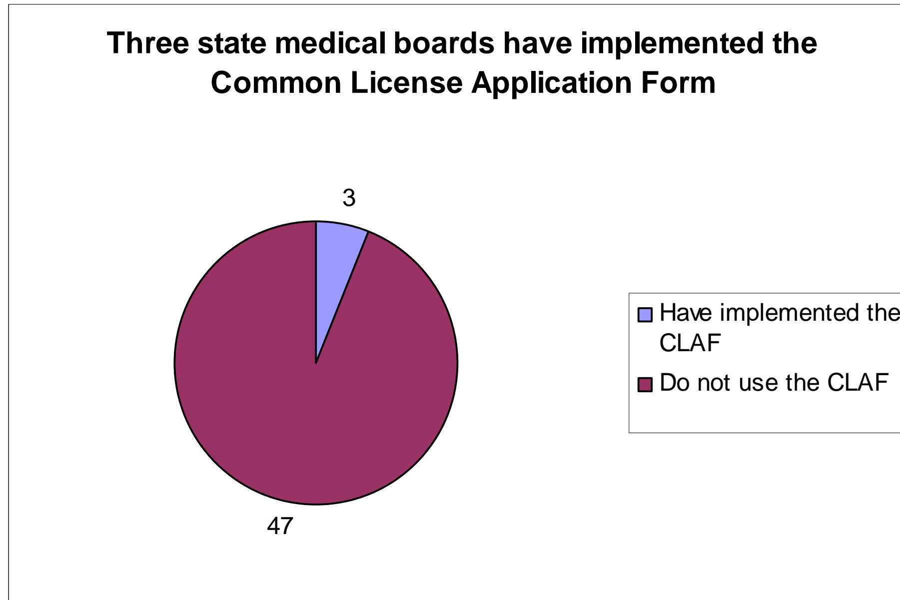
[23] See 2007 USMLE Bulletin, *available at*, http://www.usmle.org/General_Information/bulletin/2007/overview.html.

physicians would be able to apply to multiple states by filling the application out once on the CLAF, and then directing it to other states. Each time a physician applied for licensure in another state, information previously provided to the CLAF would be incorporated into the CLAF used by the state, leaving only the state-specific portion of the application to be completed.




**Board of Osteopathic Medicine:**

Fourteen states, including Arizona, California, Florida, Maine, Michigan, Nevada, New Mexico, Oklahoma, Pennsylvania, Tennessee, Utah, Vermont, Washington, and West Virginia, have separate boards that license the practice of osteopathic medicine. The practice acts promulgated by the Board of Osteopathic Medicine of all these states, except Oklahoma, do not specifically address the practice of telemedicine. Oklahoma requires an osteopathic physician to obtain a full license to specifically provide telemedicine, unless the out-of-state osteopathic physician consults on an irregular basis with an osteopathic physician licensed in Oklahoma.[24]

## VI. Examination of Licensure Laws in the Nursing Profession

### *a. State Licensure Differences for Nurses Seeking to Practice Telehealth*

Most state nurse licensure laws do not specifically address the concept of telehealth practice. When asked, most states choose to interpret their statues as requiring local licensure to practice nursing in their state. But, unlike in the physician area, nurse practice acts have not been marked up to address telehealth practice.

To address the needs of nurses to practice in multiple states, in 1996, the National Council of State Boards of Nursing convened a task force to conduct an analysis of potential licensure models that would allow nurses to practice in multiple states, without applying for licenses in all

[24] Okla. Stat. Ann. tit. 59, § 622(B).

those states. One proposed solution was the nurse licensure compact, which is a mutual recognition model in which a state recognizes the licenses of any nurses in any state that has signed onto the compact. This mutual recognition model of nurse licensure allows a nurse to have one license (in the state of residency) and to practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline.

To date, 21 states have adopted and implemented this interstate compact. This includes Arizona, Arkansas, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin. In addition, 2 states have adopted the model and will be implementing the compact within the next two years. These states are Colorado and Rhode Island.

***b. States' Definition of the Practice of Nursing***

Almost all state definitions of the practice of nursing indicate that at a minimum, nursing consists of the maintenance and promotion of health, the prevention of injury, and the care and treatment of illness or injury. Many states explicitly indicate that these activities should be based on a nurse's knowledge of the sciences, particularly the biological sciences. Notably, no states refer to physical presence or contact as a necessary component of nursing in their definitions of the practice of nursing.

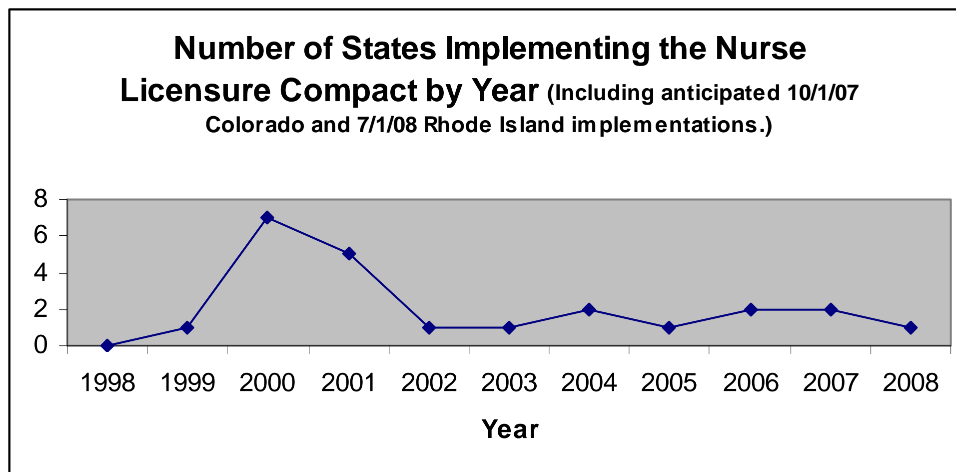
Traditionally, the practice of nursing has been divided into at least two categories: practical/vocational nursing, and registered or professional nursing. Practical nursing requires less education, consists of fewer authorized activities, and requires more supervision than registered or professional nursing. This distinction is manifested in a majority of the states' statutory definitions of the practice of nursing. While some states' laws contain a single definition of nursing that encompasses all varieties of nursing practice, most provide separate definitions for practical nurses and professional or registered nurses, and some provide additional definitions for advanced practice nurses, nurse practitioners, nurse anesthetists, and other areas of specialty.

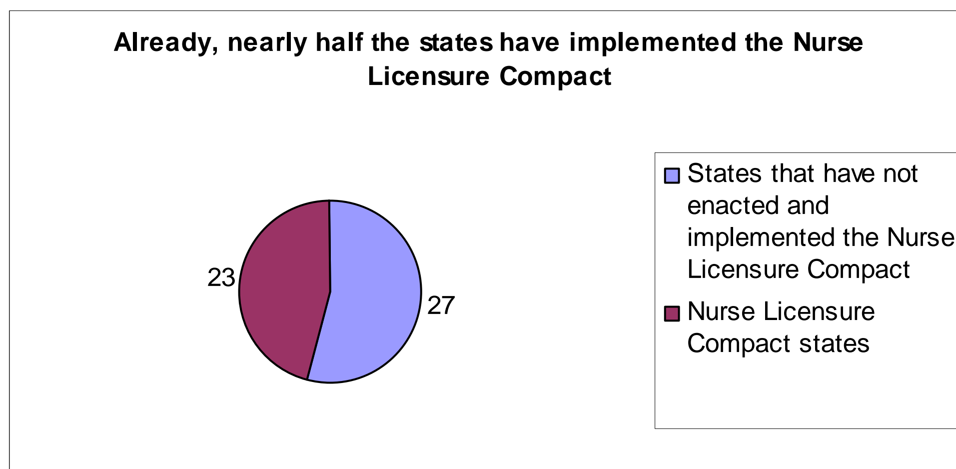
Generally speaking, and in keeping with the more stringent educational and licensing requirements for registered/professional nurses, almost all states that define practical nursing and registered/professional nursing separately provide more expansive definitions of the latter. For example, many states permit registered or professional nurses to make a "nursing diagnosis" of patients, but performing nursing diagnosis is very rarely mentioned in definitions of practical nursing. Similarly, many states permit registered or professional nurses to supervise other health care providers, engage in health teaching, or administer medication as prescribed by a licensed practitioner of medicine, but do not include these activities in their more restrictive definitions of practical nursing. Conversely, many states define practical nursing as a set of activities done under the supervision of a physician, dentist, or other more senior health care provider, but provide no such supervision requirement for professional or registered nurses.

Another way states vary in their definitions of nursing is with respect to compensation. Specifically, some states explicitly define nursing as a set of activities done for compensation, leaving open the question of whether the same activities done for free would be considered

nursing. A related question is whether unlicensed persons, if performing nursing activities without compensation in states that define nursing as activities performed for compensation, could be penalized for the practice of nursing without a license. Similarly, some states include licensure in their definition of nursing: in other words, the definition of nursing includes only those activities done by a licensed nurse. Most states, however, omit both compensation and licensure status from their definitions of the practice of nursing, and address only the activities and authorities which pertain to nurses.

The above encompasses the most common ways the definitions of the practice of nursing vary from state to state. However, it is not an exhaustive catalogue of those differences, and some states have additional provisions in their definitions of the practice of nursing that further differentiate them from other states. For example, a small handful of states explicitly include in their definitions of the practice of nursing the authority to make a pronouncement of death, although typically only in cases where death was both anticipated, and occurred in a facility such as a nursing home or hospice. One state – Louisiana – makes a distinction between registered/professional nursing and practical nursing with respect to compensation: the state considers practical nursing to be activities undertaken for compensation, but registered nursing to be a set of activities that may or may not be compensated.



***c. Potential Liability Issues that May Arise as a Result of Current Licensure Requirements***

All states prohibit the practice of nursing by unlicensed persons, although the penalties for such practice vary widely. In almost all cases, practicing nursing without a license constitutes a misdemeanor for the first offense. The exceptions are Florida, Ohio, and Utah, where the first instance of practicing nursing without a license constitutes a felony. In Texas, the first offense is considered a misdemeanor, while the second offense is treated as a felony.

Fines and jail time for practicing without a license vary greatly by state, with fines ranging from $25 to $10,000 and potential jail time ranging from ten days to five years. In most states, fines and other penalties increase for additional offenses following the first instance of practicing without a license. And in almost all cases, each day on which violations occur is counted as a separate offense.

***d. Post Graduate Training Requirements for Licensure***

Unlike physicians, practical nurses and registered nurses are almost never required to complete post-graduate training similar to residencies or internships prior to becoming fully licensed. In all states but one, completing a licensed nursing education program and passing the nursing board examinations are sufficient demonstrations of nursing expertise to become licensed (although additional requirements not directly related to expertise such as background checks are also necessary steps).

The one exception to this rule is Kentucky, which requires aspiring nurses who have graduated from a nursing program and passed the examination to complete a 120 hour "clinical internship" consisting of supervised, on-the-job training before becoming fully licensed. The nurse is given a six-month provisional license during the clinical internship, and the internship must be completed within that six-month timeframe. The Joint Commission recommended in 2003 that the establishment of structured, standardized nursing residency programs similar to the medical student residency would improve the quality of care and ease the transition from nursing schools to practice. However, the states have undertaken few steps in this direction.

***e. Number of Permissible Attempts at Licensure Examination***

States nurse licensure boards vary in their approach to setting limits on the number of times a prospective nurse may attempt to pass the NCLEX nurse licensure examination. Most states place no limitation whatsoever on the absolute number of times an applicant may attempt the licensing examination, although they do impose a penalty for failure insofar as there is a fee for reapplication for examination. However, it should be noted that because some states require prospective nurses to pass their examinations within a certain time frame (as addressed below), and because all states have required waiting periods between examination attempts, there is a de facto maximum number of attempts in some states that do not explicitly enumerate maximum attempts. However, these de facto maximums – usually based on the NCLEX-standard 45-day waiting period between examinations and therefore permitting eight attempts per year, but occasionally mandating longer waiting periods – are higher than the absolute maximums set by

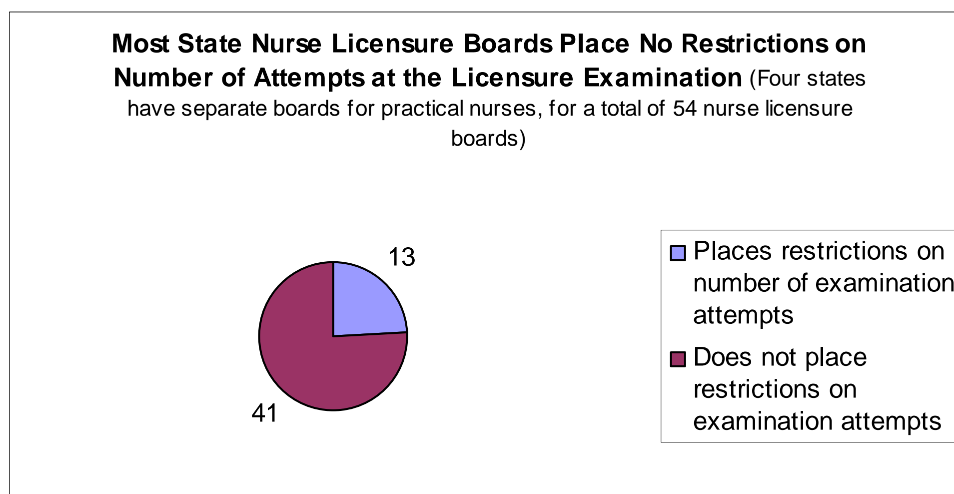
states explicitly, which in no case exceed ten (the maximum set by the Wyoming Board of Nursing), and average 6.25.

Among states that do set explicit limits on the number of times an applicant may attempt the licensure examination, there are two categories of limit, which are not mutually exclusive and in many cases are used in concert by nurse licensure boards. The first is a simple maximum number of attempts at the licensure exam. For example, Louisiana requires applicants taking the RN NCLEX to pass the examination within four attempts.[25]

The second type of limit on examination attempts is more complicated, and entails the establishment of additional application or educational requirements that are triggered when prospective nurses fail to pass the licensure examination. Under this category of restriction, after failing the examination a specific number of times, (including, potentially, after a single attempt), an applicant might be required to submit to the board a plan of study indicating the applicant's plans for improving his or her performance, formally petition the board for permission to retake the examination, complete a refresher course, or some combination thereof.

Michigan presents a useful example of how these various limitations can be used in combination. The Michigan Board of Nursing allows unlimited attempts within 12 months of the first failed attempt, within the limits of the 45-day NCLEX waiting period. If the applicant has failed to pass the examination after this 12 month period, he or she must complete a board-approved nursing education program, after which a maximum of three attempts at the examination are permitted. However, no more than six lifetime attempts are permitted.

As noted, although some states impose both categories of limitations on reexamination, the latter is more common. Very few states mandate a lifetime maximum number of attempts. Instead, maximum number of attempts generally refers to the maximum number permitted before the applicant is required to return to a school of nursing and complete a second course of study.



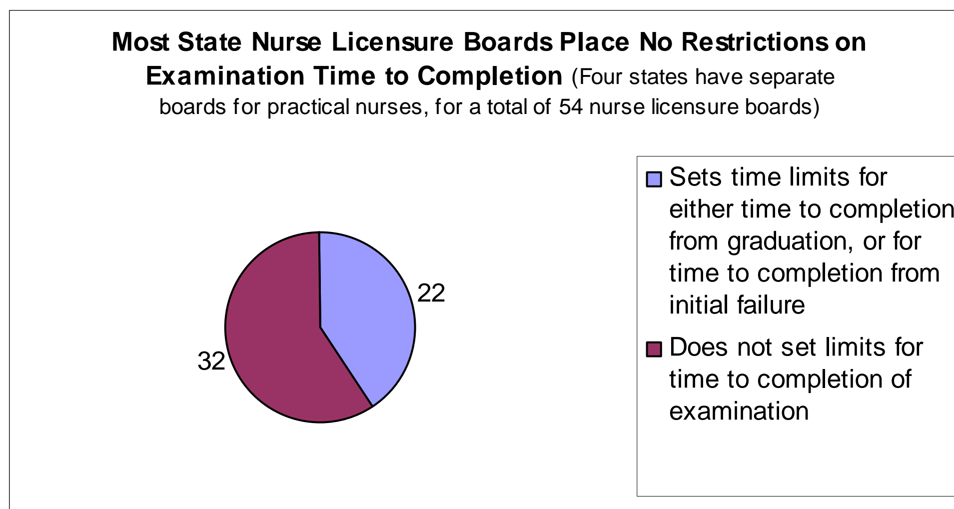

[25] Notably, New Hampshire regulations state that "An applicant who has failed 3 times and has completed remediation, may retake the examination only one additional time, for a life-time total of 5 attempts to pass." This appears to be a mathematical error, and it is unclear what maximum is currently mandated under New Hampshire's rules.

### *f. Time Limits for Completing Examination Sequence*

Unlike prospective physicians, prospective nurses do not face a segmented battery of licensure examinations. Instead, the NCLEX nursing licensure examination is taken in a single session. Consequently, state nurse licensure boards do not establish time limit for completing the licensing examination sequence in the sense of a maximum amount of time that can elapse between the beginning and end of the examination process, as physician licensure boards often do.

However, state nurse licensure boards do set examination completion time limits in two different respects: limits on the amount of time that can elapse between graduation and successful examination, and limits on the amount of time that can elapse between failure of an examination and successful reexamination. Most states do not impose either type of restriction, but some impose one, or both. The most common approach by states to setting time limits for completion of examination – after the approach of setting no limit at all – is to require prospective nurses to pass the nurse licensure examination within a certain time period following graduation.

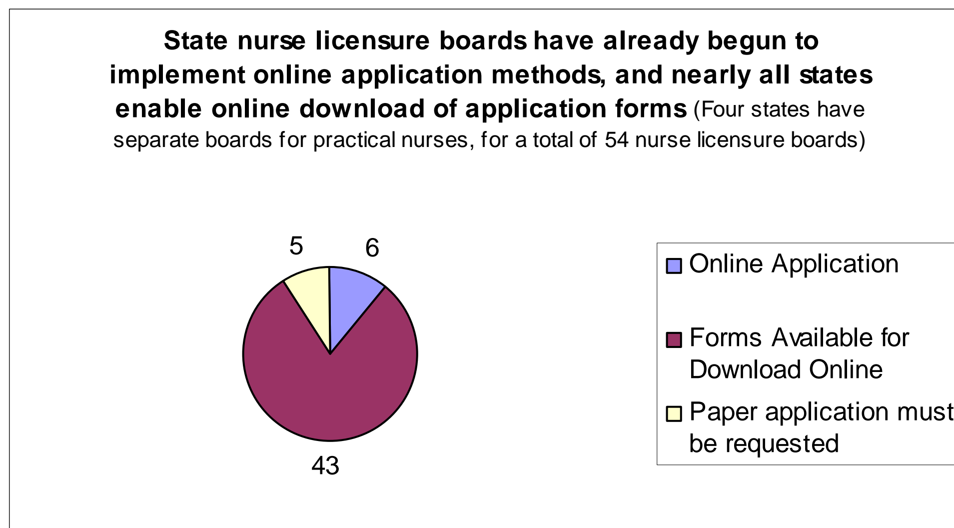
As is the case with many of the maximum attempts at examination limits set by states, however, the time limits for completion set by states are not usually absolute lifetime limits, but rather limits whose violation requires additional education or administrative efforts on the part of the applicant. For example, the Alaska Board of Nursing requires applicants who fail the nurse licensure examination to pass it within two years of that initial failure. However, if the prospective nurse fails to do so, he or she has the option to complete a remedial course, after which additional attempts at examination are permitted. Another example is Delaware, which requires prospective nurses to take the licensing examination within 90 days following graduation. However, if the applicant fails to meet this deadline, he or she can petition the board for an extension.



### *g. Licensure Application Methods (i.e. online and paper applications)*

Very few state nurse licensure boards have taken full advantage of the internet to facilitate the licensure of new nurses, although many states provide for online license renewal, as well as online verification of licensure status. This reliance on conventional, paper-based application processes appears to be the result of two related factors. First, some aspects of most states' nurse applications are difficult to replicate electronically, particularly fingerprint cards for criminal background checks, and documents that must be notarized. Second, and in contrast to physician licensure boards, there has been no centralized effort to create a standardized online nurse licensure application that can be used by many nurse licensure boards.

Nearly all state nurse licensure boards provide electronic versions of their applications on their websites, but these must be printed out and mailed in hard copy form. However, some states do not provide their application documents in electronic format on their websites, and instead require prospective licensees to contact the board and request that an application packet be mailed to them. As noted, a small number of states have developed online application systems, an encouraging development with the potential to create efficiencies and savings for both applicants and licensure boards. For the meantime, however, it appears that the resources of the nursing board community are largely dedicated to advancing the nurse licensure compact, and that in the consequent absence of a standardized online application process similar to the Common Licensure Application for physicians, nurse license boards will continue to implement online application in a piecemeal fashion.




## VII. Examination of Licensure Laws in the Pharmacist Profession

### *a. Oversight of the Practice of Pharmacy*

Every state has established a State Board of Pharmacy to regulate the practice of pharmacy in that particular state. The State Board of Pharmacy regulates the practice of the pharmacists and the operation of pharmacies both retail and wholesale. In addition, the State Boards of Pharmacy also have oversight of prescription drugs and controlled substances such as narcotics. These

three areas are interconnected by the nature of the practice of pharmacy. The Pharmacy Boards of all fifty (50) states, in addition to certain international Pharmacy Boards, belong to the National Association of Boards of Pharmacy ("NABP"). The NABP provides a unifying force among the various pharmacy boards, which has led to standardization of many aspects of the licensure process and regulation of the practice of pharmacy.

***b. State's Definition of Practice of Pharmacy***

The practice of pharmacy by a pharmacist encompasses two general responsibilities: (i) the implementation of medical orders and (ii) patient counseling. The implementation of medical orders incorporates multiple duties such as interpreting the prescriber's order, compounding and dispensing the medication or device, and confirming the safety of dispensing such drug in light of the patient's medical history. Patient counseling normally involves discussing with the patient the prescribed drug's dosage, potential side effects and interactions with other medications. The pharmacist may also discuss and recommend over the counter medications. In addition to these patient care activities, the practice of pharmacy also involves overseeing the operation of a pharmacy through supervision of pharmacy technicians and interns and ensuring the safety and purity of the drug supply. Finally, the pharmacist must always practice within the parameters of Federal and State laws regulating both pharmacies and drugs and comply with registration and reporting requirements.

***c. Examinations***

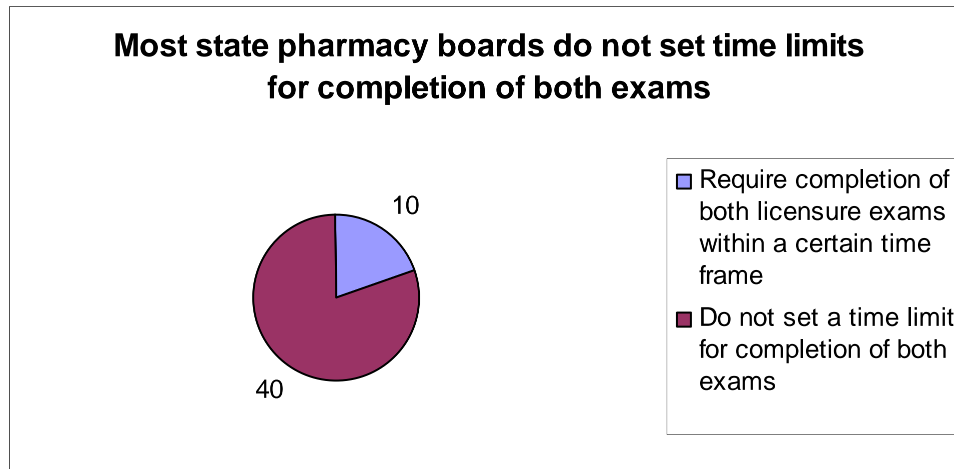
Similar to nursing licensure, all candidates for pharmacist licensure in any State must take a national exam, known as the North American Pharmacist Licensure Examination ("NAPLEX"). The NAPLEX consists of 185 multiple-choice test questions. The majority of states have stated within their practice acts and attendant regulations that a score of seventy-five is required pass the NAPLEX.

As mentioned above, the practice if pharmacy, which includes the individual pharmacists, the settings in which they practice and the actual drugs that are dispensed is highly regulated by both the federal and individual state governments. Consequently, pharmacists must also have a good working knowledge of the legal parameters of the practice of pharmacy. In addition to the NAPLEX, all pharmacists must take an examination regarding the laws of pharmacy. In forty-three (43) states, the test that is administered is the Multistate Pharmacy Jurisprudence Examination ("MPJE"), which may be customized to a particular state's laws. In most states, a passing grade on the MPJE is a seventy-five (75). Seven (7) jurisdictions, including Arkansas, California, Oklahoma, Puerto Rico, South Dakota, Mississippi and Virginia, also require pharmacist licensure candidates to pass a jurisprudence examination, but do not use the MJPE.

The NAPLEX and the MPJE are administered independent of each other. Most states simply require a passing grade on both exams and allow a candidate to retake the exam until the candidate has achieved a passing score. The State of Louisiana requires that a candidate wait a certain number of days before they are allowed to retake either examination. Ten states[26] require that the candidate successfully complete both exams within a certain time frame such as one year

[26] Colorado, Delaware, Florida, Iowa, Kentucky, Maryland, Massachusetts, Oregon, South Dakota and Vermont.

or two years. Finally, certain states[27] require a candidate who has failed the NAPLEX or MPJE multiple times to have remedial education or clinical experience and/or approval from the state pharmacy board to retake the examination after failing repeatedly.




***d. Practical Clinical Experience***

All states require a candidate for pharmacist licensure by examination to have completed a course of clinical practical experiences in the form of an internship. In general, the internship hours are fulfilled while completing the necessary coursework in an academic pharmacist program. The majority of states that indicate the required number of internship hours within the State laws require fifteen hundred (1500) clinical hours. Hawaii, Oregon and Wyoming require two thousand (2000) hours, while Florida requires two thousand and eighty (2080) internship hours. Pharmacy interns are also subject to regulation by the state pharmacy board.

***e. Reciprocity- License Transfer***

All states, except for California, have established a regulatory process for licensure of those pharmacists licensed in other states. California does not specifically address reciprocity or licensure by endorsement; however, that does not mean that a licensed pharmacist seeking licensure in California would necessarily find it more difficult to obtain the California license. NABP has established the Electronic Licensure Transfer Program ("ELTP"), which facilitates the transfer of a pharmacist license. In addition, the licensure standards for all states are uniform, thus if an individual qualifies for licensure in one state, they most likely qualify in any other jurisdiction. The clinical internship requirement generally does not apply to licensure by reciprocity because the pharmacist has (i) already met those requirements in another state and (ii) has been practicing as a pharmacist, thus has clinical experience. In order to ensure that the licensed pharmacist has the requisite clinical experience, a few states will require the pharmacist to have practiced recently or have been licensed for a set amount of time in order to qualify for licensure by endorsement. The pharmacist applying for licensure by endorsement may also be required to take a state-specific jurisprudence examination. Despite this examination

[27] California, Delaware, Illinois, Michigan, Minnesota, Mississippi, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Virginia, and Wisconsin.

requirement, the standardized testing and similar state requirements for licensure may make obtaining a license by reciprocity relatively straightforward.

***f. Potential Limitations for the Practice of Telepharmacy***

Except for direct patient counseling regarding medications, the majority of a pharmacist's practice must occur in a pharmacy *e.g.* interpretation of the medical order and preparing and/or supervising the preparation of the prescription. In addition to the proscription of practicing without a license, it is also considered unethical and illegal in most states to aid or abet the practice of pharmacy without a license, which can occur if the pharmacist does not adequately supervise the pharmacy technician's preparation of the prescription. Consequently, there are limitations to how removed a pharmacist can be from the actual site of drug dispensation.

The increased accessibility of certain technological advances, such as scanning documents, e-mail, and video and audio links have made it possible for a pharmacist to practice remotely from the site of actual drug dispensation. North Dakota, Texas, Utah and Wyoming have all enacted laws regulating the practice of telepharmacy, while Idaho has instituted a test pilot program for telepharmacy. Montana and Vermont have certain definitions or provisions within their codes that contemplate the practice of telepharmacy, but do not provide significant regulation of the practice. Texas, Utah and Wyoming have limited the site of the telepharmacy to either remote locations or certain types of health care facilities. These limitations suggest that the state boards of pharmacy recognize the need for telepharmacy availability in particular situations, but due to the practical limitations of the practice of pharmacy want to restrict its application to those situations in which it is the only reasonable method to provide pharmacy services.

Various components of the practice of telepharmacy are already being regulated in most states, such as the electronic transmission of prescriptions and the operation of out-of-state pharmacies within another state's jurisdiction. Therefore, while portions of the practice of pharmacy can be achieved through means associated with telepharmacy, there are limitations in practicing what is traditionally thought of as pharmacy services via telepharmacy.

## PART B

## I. OPTIONS FOR REDUCING LICENSURE AS A BARRIER TO THE PRACTICE OF TELEHEALTH

In this section, we will suggest several different types of approaches enabling the practice of telehealth. These vary from simple steps we can take to encourage the practice of telehealth, to much more comprehensive approaches. We will highlight the benefits and drawbacks of each option.

As we consider these options, we want to point out that the purpose of licensing health care professionals is public protection. Licensure of health care professionals is generally a state function. State legislatures enact laws about licensure and give authority to state licensing boards to implement these laws and govern the health care professionals.

There are many approaches to reducing licensure as a barrier to telehealth. Mutual recognition, reciprocity, the special purpose license, simplified application and open consultation are all options for enhancing the ability of health care professionals to practice across the country.

***a. National Licensure***

As mentioned above, licensure is typically a state function: both the authority to grant a license and enforce discipline regarding that license lie with individual states.

Some advocate a national licensure model operated by the federal government. Uniform national standards for licensure would eliminate the barrier to the practice of telehealth. If a health care professional has a national license, it would be valid in any state. Thus, a health care professional could practice telehealth anywhere without the burden of applying for individual state licenses anywhere he or she sees patients. Proponents argue that it is logical for the federal government to promote a national standard for those health professions where the qualifications to practice have already become uniform in virtually all states and where interstate practice is becoming increasingly prevalent.

There is precedent for the federal government to establish national standards when it comes to health and safety. For example, Congress passed the Mammography Quality Standards Act (MQSA) of 1992, which allows the Food and Drug Administration to establish national standards for mammography facilities and associated staff. It is also important to consider that the practice of telehealth does involve interstate commerce; and, the federal government has the authority to act in situations of interstate commerce.

In addition, there has been some Congressional involvement in addressing state licensure as a barrier to telehealth. Specifically, in 2002, the United States House Commerce Committee inserted language in the Health Care Safety Net Legislation that expressed Congressional interest in collaboration among regulatory boards to facilitate elimination of barriers to telehealth practice. (Health Care Safety Net Amendments of 2002, Pub. L. No. 107-251, 116 Stat. 1621.). This legislation was ultimately signed into law by the President. Congress has also called on the Administration to take action to reduce state licensure barriers to telehealth. Language to this effect has been included in many pieces of legislation considered by Congress. For example, in S. 1605, the Craig Thomas Rural Hospital and Provider Equity Act of 2007, there is language instructing "the Department of Health and Human Services to facilitate the adoption of provisions allowing for multistate practitioner practice across State lines." This federal legislative action demonstrates that Congress is becoming increasingly concerned over the restrictive nature of certain state licensure requirements and their negative impact on the delivery of telehealth services.

However, there are many issues raised by opponents of potential federal licensure of health care professionals. The main concern is the long history of state regulation of health care professionals. States have traditionally had the role of licensing health care professionals. State regulatory boards have the unique responsibility of monitoring and disciplining health care professionals. First, states will be reluctant to give up this authority. They will argue that it is best to have local standards and local enforcement for local health care professionals and

consumer advocates will likely argue this same point. Also, states often depend on the funds raised by licensure application fees.

Second, there would be significant administrative challenges if the federal government were to implement a national license for health care professionals. This would require a new federal regulatory structure to oversee the issuance and renewal of licenses for several million health care professionals. This would take several years and federal revenue stream to implement.

Third, there would be significant administrative challenges if the federal government were to enforce standards and ensure that unsafe practitioners were removed from practice in a timely manner. There would be difficulty in deciding which areas of the country to enforce the standards, as there would not be the resources or time to adequately enforce the rules in every single neighborhood, town, and city. In other enforcement actions taken by the federal government, there usually is a long lag time between when the offender violates the law and the federal government is able to punish the offender and prevent future offenses.

***b. Limited License or Special Purpose License***

A limited license or special purpose license allows health care professionals to receive a limited license to practice within a state. The limited license has some restrictions placed on the ability of the health care professionals to practice within a state; it is not a full and unrestricted license.

***Example: Physician Limited License***

State medical boards generally take the position that the practice of medicine occurs in the state where the patient is located. Medical boards want control over any physician treating patients in their state, even if that physician never enters their state while treating patients and is already licensed by another state.

There are two common scenarios that occur for physicians who practice medicine across state lines without being physically located in the state where the patient encounter occurs: 1. the physicians are either required to have a full and unrestricted license in that state or 2. the physicians are unregulated. The Federation of State Medical Boards (FSMB) believes that there need to be more options than the two scenarios described above. Thus, in 2000, the FSMB established a committee to evaluate the issues involving telemedicine and make recommendations to state medical boards regarding potential regulation of physicians who practice across state lines. The Committee recommended that state medical boards offer a process for physicians who meet certain qualifications to have an expedited endorsement process to get a special purpose license solely to practice across state lines, without the intention of physically practicing in the state, without having to apply for a full and unrestricted license. Endorsement is a process in which a state issues a license to practice to a physician who already holds a valid and unrestricted license in another jurisdiction.

The FSMB developed a model legislative act for states to adopt in order to implement the recommendations of this Committee. The model will encourage the practice of telemedicine, while continuing to protect patients by giving states regulatory control over the physicians practicing within their states. The model act establishes an abbreviated licensure process for

physicians not physically practicing within a state's jurisdiction, but providing services to patients within that jurisdiction. Specifically, the state uses an expedited endorsement process to grant special purpose licenses to physicians who already have a license in another state. The special purpose licenses only allow for the practice of telehealth, when the physician is practicing across state lines and is not physically located in the state.

So far, a total of 9 states have adopted plans similar to the FSMB model. These include Alabama, Minnesota, Montana, Nevada, New Mexico, Ohio, Oregon, Tennessee, and Texas.

The model act has had limited success in its adoption by different states, thus it has not had a great impact on physicians' ability to get licenses. However, the concept of a model act to grant special purpose licenses to physicians has many advantages. It reduces the administrative complexities of applying for a license by allowing an expedited endorsement process. It grants physicians a special purpose license by which they can engage in telemedicine. It does not impact an individual state medical board's ability to enforce its regulations and discipline physicians, as the states will maintain regulatory control over the physicians practicing within their borders. It is an efficient process as it follows an expedited endorsement process, thus reducing the wait time for physicians to receive the special purpose license. Furthermore, the state medical board will still maintain its ability to raise revenue from granting licenses. The model act does not prohibit this.

***c. Mutual Recognition and State Compacts***

Another approach is for states to enter into interstate compacts to grant licenses to health care professionals within the states that have signed onto the compact. This approach is generally considered a mutual recognition model that is then implemented by an interstate compact. An interstate compact is an agreement between two or more states that is entered into for the purpose of addressing a problem that crosses state lines. Modification of the compact is only possible with the unanimous consent of all party states. Once enacted, it takes precedence over prior statutory provisions.

Under a mutual recognition model, practice across state lines is allowed, whether physical or electronic, unless the health care professional is under disciplinary action or a monitoring agreement that restricts practice across state lines. In order to implement a mutual recognition model, each state must adopt and implement the interstate compact.

There are several advantages to interstate compacts. First, as long as a health care professional is licensed within one of the compact states, he or she is able to practice in any state that has signed onto the state compact. This eliminates the administrative burden for health care professionals created by requiring them to apply for licenses in each state in which they would like to practice telehealth. It is efficient for both the health care professional, as well as the licensing boards. In addition, it eliminates the financial burden for the health care professionals to apply for licenses in multiple states. Second, each state licensing board has the jurisdiction to discipline the health care professional who is practicing in its state. This is extremely important as state licensing boards fear the national licensure model because they do not want to lose the ability to enforce the laws in their local jurisdictions. In addition, uniform standards are not required. Thus, individual states are able to maintain their specific state rules and maintain the individual state

standards as they relate to the practice of health care. A state is not losing any of its identity or regulatory control when entering an interstate compact, and benefits because it is reducing the administrative burden on both health care professionals and its state board.

One concern would be that the state boards will not be able to raise revenue from granting licenses. State boards will recognize licenses of health care professionals who have a license in a state that is part of the compact. Thus, the state boards will limit their ability to fund their activities by granting licenses. Another concern would be that health care professionals within a state may not want the additional competition from those who are licensed outside their state, but are able to practice due to the interstate compact. This concern is mitigated by the fact that one of the main purposes of this model is to encourage the practice telehealth. Those who practice telehealth remain in their home state and practice health care from their home state.

***Example: Nurse Licensure Compact***

The nursing community is using a mutual recognition model through the creation of the nurse licensure compact: a state compact that recognizes that licenses of any nurses in any state that has signed onto the Compact. The National Council of State Boards of Nursing recommended this solution after convening a task force in 1996 to conduct analysis of potential licensure models. This mutual recognition model of nurse licensure allows a nurse to have one license (in the state of residency) and to practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline.

To date, 21 states have adopted and implemented this interstate compact. This includes Arizona, Arkansas, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin. In addition, 2 states have adopted the model and will be implementing the compact within the next two years. These states are Colorado and Rhode Island. In addition, there is a central licensee information system called NURSYS in which all states participating in the interstate compact can access.

Although the nurse licensure compact supersedes state provisions that are in direct conflict, all provisions that are not addressed by the compact, or are not in direct conflict, continue to be in full force and operation. Since the nurse is not required to obtain a new license for temporary practice in a party state, the nurse can begin practice when needed.

***d. Common Licensure Application and Electronic Application***

A common licensure application allows a health care professional to use one form to apply for licenses in multiple states. It reduces the administrative burden on the applicant to fill out numerous applications with the same information. The applicant is able to send the same form to apply for licenses in multiple states. Individual states must agree to accept a common licensure application.

An electronic application allows a health care professional to fill out a form electronically so that the information can be used repeatedly. It reduces the administrative burden on the applicant to fill out numerous applications with the same information, by instead allowing an applicant to fill

out one form electronically in which the information can be applied to various individual state licensure applications.

Often a common licensure application is performed through an electronic platform so that it is both an electronic application and a common licensure application.

This is an advantageous concept. Most importantly, it reduces the administrative burden on the applicant by reducing the need for the applicant to fill out the same information numerous times. It may add an additional burden to state boards as they decide to switch over to this type of application, but that additional burden should be temporary as the new application is implemented. It could increase the number of health care professionals available to practice telehealth as there would be less time and administrative burdens presenting obstacles to becoming licensed in multiple states. This concept would not impact regulatory enforcement and discipline by state boards, nor would it interfere with their ability to raise funds via licensure applications. It would merely make the application process less burdensome on the applicant.

One concern would be that health care professionals within a state may not want to decrease the administrative burden for health care professionals outside of their state to apply to work within their state. This concern is minimal as the health care professional must still apply and pay for a license, they simply have less paperwork burden.

***Example: Physician Electronic Common License Application***

The physician community has recently created an online Common License Application Form (CLAF) for physicians to use in the licensure application process. The Federation of State Medical Boards (FSMB) states that the "CLAF has been developed to: 1) reduce the number of incomplete applications received by state medical boards, 2) allow for the collection of uniform information, and 3) add convenience for physicians applying for licensure in multiple states."

The CLAF was developed by a workgroup of state medical board representatives. In addition, the FSMB and the National Board of Medical Examiners are working together on a pilot program, "Trusted Agent pilot program," to look at the feasibility of building a Web-based system that will allow physicians to fill out and submit state licensing applications online, as well as obtain confidential credentialing data from primary sources in a secure environment.

Ohio was the first state to integrate the online form into its licensure application process. Since its integration in December 2006, more than 1,300 physicians have used the online application form. In addition, two other states are using the online application form. The New Hampshire Board of Medicine started using the form in April 2007 and the Kentucky Board of Medical Licensure started using the form in June 2007.

***e. Deemed Status***

The term deemed status refers to the fact that a licensure applicant has complied with the standards and rules necessary to qualify for a license. A state board may "deem" that an applicant has met the standards and rules necessary to receive a license. This often applies in the situation where an applicant is already a license holder in another state. A second state would

use the fact that an applicant meets the standards and conditions for licensure in one state to "deem" the applicant as meeting the basic standards and conditions for licensure in the second state. This concept often applies to reciprocal agreements between states. This option reduces the administrative burden for state boards to verify that applicants meet the standards and conditions. A state board must first establish a reciprocal agreement with another state and analyze the other state's requirements before it is willing to deem that an applicant from another state actually meets its own standards. But once this research has been done and the decision to have a reciprocal agreement is made, it greatly reduces the burden for the state boards. In addition, it also reduces the administrative burden for the applicants as it takes less time for them to receive a license from the state board. This option does not impact an individual state medical board's ability to enforce its regulations and discipline health care professionals; individual states maintain regulatory control. State boards also maintain their ability to raise revenue from granting licenses. This would be a promising option during an emergency situation, in which one state needs more licensed health care professionals immediately due to a natural disaster or medical crisis. That state could quickly set up reciprocal agreements with other states in order to expedite the process and have health care professionals from other states assist during an emergency.

***f. Additional Options***

***1. Additional Options -- Consent to Receive Out of State Care***

States do not have the authority to limit the right of a patient to physically travel to another state to receive care from a physician who is not licensed in the patient's home state. Home state regulators simply do not have jurisdiction over these interactions, since both the patient and the provider are located out of the state at the time of the interaction. It is assumed that when a patient physically travels to another state that the patient is prepared to assume the risk that the standards regulating health professionals may not be the same as in the patient's home state.

Modern communications technologies have eliminated in some cases the necessity for a physical trip. However, a patient may inappropriately assume that a physician or other provider practicing electronically is approved and regulated by the patient's home state. An alternative approach to addressing this issue would be to require health professionals practicing electronically to clearly state the locations where they are licensed and require the patients to affirmatively acknowledge that they are aware that the provider is not located or licensed in their home state and may not meet the same standards as set forth by their home state for the practice of the particular health profession.

An even more aggressive option would require the patient to receive permission from a locally licensed physician prior to receiving direct care from an out-of-state physician. This would allow the local physician to advise the patient regarding the appropriateness of the care and the risks associated with utilizing a physician who is not subject to the same controls and regulations as the locally licensed physician.

*2. Additional Options -- Defining an Appropriate Examination*

Many states have adopted requirements that a physician must conduct an in-person physical examination of a patient before they are permitted to write a prescription for the patient. These requirements apply even if the physician is licensed in the same location as the patient. They were adopted by many states in response to abuses by rogue Internet sites where patients would receive prescriptions to various medications (Viagra, weight loss drugs, and even pain medications) based solely on written on-line questionnaires.

The blanket requirement for an in-person examination in all cases for writing prescriptions will significantly impede certain well-respected applications of telemedicine. The development of more refined options would seem to be appropriate given the competing needs to protect the public, and provide the public access to necessary health care services.

***Example: The FSMB policy on physical examinations***

This issue was considered in April of 2002 by the Federation of State Medical Boards (FSMB). The FSMB developed the following guidance for state medical societies:

> A documented patient evaluation, including history and physical evaluation adequate to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided, must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. FSMB - Model Guidelines for the Appropriate Use of the Internet in Medical Practice (April 2002).

This guideline provides greater flexibility in determining the nature of the appropriate patient evaluation and permits the evaluation to be performed by another provider. This is consistent with the way health care services are provided in a physical environment. Often the treating physician is not the same provider as the one who performs the patient evaluation. The scope and nature of the patient evaluation may vary significantly based on the condition of the patient and reason why they are seeking medical assistance. For example, dermatologists will often prescribe medications for a patient without conducting a full physical examination. Psychiatrists typically do not conduct a full physical examination prior to treating or prescribing for their patients. The FSMB policy takes into account these variations in practice but requires that physicians obtain an appropriate evaluation prior to treatment or prescribing.

*3. Additional Options -- An Open Consultation Policy*

Another option would be an open consultation policy. This scenario would enable health care professionals to consult with other health care professionals in other states for their expertise and specialized knowledge. A health care professional in one state may want to reach out to the nation's experts on a specific patient they are treating. Examples of when a consultation could occur include: imaging interpretations, laboratory services, cross-specialty and subspecialty reviews, communications between primary care physician and the specialist who treated the patient in another state, and second opinions on the interpretation of biopsies, images, tests or

exams. This option would not involve the expert health care professional actually meeting or speaking with the patient, but it would involve the expert assessing the patient's medical records and offering expert advice for diagnosis and treatment. Under this option, the expert would not be required to obtain a license to practice in the state where the patient is located. Administrative challenges for the consulting physician are eliminated. This option could be used in an emergency situation, or in an everyday situation.

***Example: California Physician Consultation Policy***

The California Business and Professional Code contains the following policy on consultations between physicians.

> Section 2060. Nothing in this chapter applies to any practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state, or when [engaged in professional education through lectures, etc.], if he or she is, at the time of the consultation, lecture, or demonstration a licensed physician and surgeon or a licensed doctor of podiatric medicine in the state or country in which he or she resides. This practitioner shall not open an office, appoint a place to meet patients, receive calls from patients within the limits of this state, give orders, or have ultimate authority over the care or primary diagnosis of a patient who is located within this state.[28]

This policy illustrates an open consultation policy that is not limited by frequency or compensation. Physicians are able to consult with the necessary experts to diagnose and treat their patients, provided that the local physician maintains responsibility for the patient and is the sole provider having direct contact with the patient.

## II. RECOMMENDED SOLUTIONS

We recommend the following set of combined options as potential solutions to reduce the barriers associated with the state-based licensure system while still providing protection to patients.

### *1. Simplify the Application Process*

A common application should be available both on paper and in an electronic format, and should be used to apply for a health profession license in any state in America. In addition, a common credentialing process should have a standard system to review and verify credentials that would be considered an official validation by all state boards. These two concepts would dramatically reduce the administrative burden on health care professionals who would otherwise be required to provide the same information numerous times in different formats for different applications. This would eliminate the need for health care professionals to attend many in-person interviews

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[28] Cal. Bus. & Prof. Code § 2060.

to verify their credentials. This concept would not impact regulatory enforcement and discipline by state boards, nor would it interfere with their ability to raise funds via licensure applications. It would merely make the application process less burdensome on the applicant.

The online Common License Application Form (CLAF) used by the physician community is an example of a simplified application process. The CLAF is the result of a work group spearheaded by the FSMB. Ohio was the first state to integrate the online form into its licensure application process. Since its integration in December 2006, more than 1,300 physicians have used the online application form. In addition, two other states are using the online application form. The New Hampshire Board of Medicine started using the form in April 2007 and the Kentucky Board of Medical Licensure started using the form in June 2007.

In order to implement a simplified application process, it would be best to consult, as the physicians did, with the state boards across the country which will be processing the applications. Then a taskforce should be formed that will recommend the necessary elements to be included in a common application. Next, there would need to be an education effort at the state level to encourage state boards to use the application. Then state boards would need to decide if they would like to offer an electronic version, in addition to a standard paper version. This would require each state board to assess its technical capabilities for accepting an electronic application. In order to be useful, it is ideal to have as many states participate as possible. In addition, in the physician field, it would be best to work with the FSMB on their CLAF as there is no need to duplicate an existing endeavor.

***2. Recognition of Licensure Actions by Other States***

This can be done in several different ways. One option is for states to use the process of endorsement to expedite the licensure process if a health care professional is already licensed in another state. In addition, states should be strongly encouraged to enter into reciprocal agreements and interstate compacts. These agreements and compacts would state that if a health care professional is licensed in a participating state, then other participating states must consider him or her as being licensed in their own state. This model has several advantages. It eliminates the administrative burden for health care professionals to apply for licenses in each state in which they would like to practice telehealth. It is efficient for both the health care professional as well as the licensing boards, as the boards do not need to process the applications of these health care professionals. In addition, it eliminates the financial burden for the health care professionals to apply for licenses in multiple states.

Using reciprocal agreements and interstate compacts enables each state licensing board to maintain authority to enforce and discipline health care professional who are practicing in its state. States will be more likely to enter into agreements and compacts when they can maintain their specific state rules and maintain the individual state standards as they relate to the practice of health care. A state will not lose its regulatory control, nor its unique identity as it applies to standards and rules related to health care. And states will reduce the administrative burden on the state boards as the boards will not need to process as many applications.

The nurse licensure compact is an example of a successful interstate compact. As discussed above, 21 states have adopted and implemented the interstate nurse licensure compact. Two

more states have adopted the compact and will implement it in the next two years. The nurse licensure compact is a result of a task force in 1996 where the National Council of State Boards of Nursing met to discuss methods to reduce licensure as a barrier to the practice of nursing. The task force recommended this mutual recognition model of nurse licensure which allows a nurse to have one license (in the state of residency) and to practice in other states, as long as that individual acknowledges that he or she is subject to each state's practice laws and discipline. The compact allows a state to maintain its unique provisions that are not in direct conflict or are not addressed by the compact. The adoption of the nurse licensure compact by additional states would address many of the licensure-related barriers associated with interstate nursing related issues.

In order to implement a reciprocal agreement or interstate compact model for other professional groups, it would be best to first convene a task force among the members of the specific health care professional community to discuss the various elements and provisions that should be included in the compact. Next, there would need to be an education effort at the state level to encourage state legislatures to adopt the compact. The education outreach should be directed at the state board, the health care professionals that the board governs, as well as state legislatures and their staff. Next, states must adopt and implement the interstate compact. In order to be successful, it is best to have a large group of states participate.

***3. States Should Adopt Free and Open Consultation Policies***

Health care professionals should be permitted to consult with health care professionals in other states with no limitations on the number of consultations or types of specialists that can be consulted. There are many benefits to this concept. The local health care professional maintains responsibility for the patient; all care is coordinated through the local professional who seeks advice from experts and specialists who can best help to treat the patient. The local health care professional is governed by local laws. Thus, states maintain their enforcement and discipline authority. The patient receives the best possible care when his or her provider can consult with experts and specialists. These experts and specialists do not need to get licensed in every state where they consult, as the local health care professional maintains responsibility for the patient. Furthermore, this concept does not limit a state board's authority to regulate the traditional physician to patient relationship.

***4. Consent to Receive Out of State Care***

A major concern in the practice of telehealth is that the patients are not aware that the health care professionals they visit electronically may not be licensed in their home states and thus not subject to their home state standards. To address this concern, health care professionals should clearly state the locations where they are licensed and require patients to give consent that they are aware the provider is neither licensed, nor located in their home state and thus may not meet the standards of the home states. This would address the concern that patients be informed, and allow patients to travel electronically to see the most appropriate health care professionals, in the same manner that they can physically travel to other states to see the most appropriate health care professionals.

### *5. States Should Adopt Requirements that Define an Appropriate Examination*

Health care professionals should not always be required to conduct a complete in-person physical examination of the patient before they are permitted to write a prescription for a patient. The scope and nature of an appropriate evaluation should be able to vary based on the condition of the patient and the reason they are seeking medical assistance. Thus, states should follow the Federation of State Medical Boards guidance on appropriate examinations. States should adopt more flexible guidelines that define different standards of "appropriate examination" based upon the scope and nature of the patient's condition and the health care professionals' standard of care as it relates to their specific practice. States can still focus on preventing abuse by rogue internet health care professionals, but provide greater flexibility of examination standards when appropriate.

## *Conclusion*

By analyzing state licensure laws and regulations, we have provided an in-depth discussion of how these laws can be a barrier to the practice of telehealth within the physician, nursing and pharmacist professions. We have provided many examples of the barriers and administrative hurdles created by our current licensure system. In the solutions section, we set forth five concrete solutions that can address the various reasons that state licensure is a barrier to telehealth. These five solutions should be a starting point for addressing the current licensure system and paving the way for advances in the use of telehealth.

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