ASCO Position Statement: Telemedicine Cross-State Licensure
Approved by the Board on May 20, 2021

OVERVIEW

In December 2020, ASCO published *Learning from the COVID-19 Experience to Achieve Affordable and Equitable Care and Clinical Research: The American Society of Clinical Oncology Road to Recovery Report*, which provided recommendations on the immediate and short-term steps that could be taken to protect the safety of patients and health care staff as communities across the country begin gradual easing of pandemic-related restrictions.[1] The report recommended that ASCO develop a public policy position regarding cross-state licensure, coverage, and certification of providers using telemedicine.

ASCO is a national organization representing nearly 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. As the leading professional organization for physicians and oncology professionals caring for people with cancer, ASCO's intent with the release of this statement is to provide a summary of issues our members have raised about telemedicine cross-state licensure and to make the following recommendations:

- **ASCO supports the flexibility CMS has implemented to ensure telemedicine is available to more practitioners and patients during the COVID-19 public health emergency (PHE), and we urge CMS to maintain those expanded telemedicine policies.**

- **All states should participate in the Interstate Medical Licensure Compact (IMLC). In states that do not participate, lawmakers should enact legislation to join. ASCO will work with state medical associations and State Affiliates to support these efforts.**

- **State and federal policies permitting telemedicine to cross state lines should include a provision requiring that the doctor-patient relationship be established prior to provision of any telemedicine service.**

- **Medical liability providers should include telemedicine and data security related risks in their policies. Prior to the delivery of any telemedicine service, physicians should verify that their medical liability insurance includes comprehensive coverage for telemedicine services, including telemedicine**

[1] American Society of Clinical Oncology. *American Society of Clinical Oncology Road to Recovery Report: Learning From the COVID-19 Experience to Improve Clinical Research and Cancer Care*. December 8, 2020. https://ascopubs.org/doi/abs/10.1200/JCO.20.02953

across states in which they practice.

- **The Federal Trade Commission should monitor telehealth practice patterns and prevent unfair methods of competition as well as unfair or deceptive acts or practices.**

BACKGROUND

In March 2020, the entire U.S. health care system was challenged by the rapid and widespread emergence of COVID-19. The COVID-19 pandemic sparked a need for immediate regulatory relief, leading to remarkably swift changes to telemedicine policy across federal and state jurisdictions. Telemedicine, the practice which "encompasses the use of technologies and telecommunication systems to administer healthcare to patients who are geographically separated from providers" has been identified as a key health care delivery strategy which has the potential to increase access to care and reduce cost irrespective of geographic location.[2]

The COVID-19 pandemic has required oncology practices in nearly every community across the United States to adapt and make operational changes to protect the safety of patients and staff while complying with national and state laws and guidelines. During the pandemic, ASCO developed its *ASCO Interim Position Statement: Telemedicine in Cancer Care* to signal its positions on immediate and significant policy issues that emerged during the COVID-19 pandemic and to recommend specific actions for applying telemedicine in cancer care.

Changes to regulatory policies that addressed realities of the COVID-19 public health emergency (PHE) generated an expansion of telemedicine, which helped both to overcome geographic and systemic barriers, and to meet urgent health care needs of patients during the pandemic. The federal government instituted several changes to telemedicine policy, including but not limited to Health Insurance Portability and Accountability Act (HIPAA) flexibility, telehealth waivers from the Centers for Medicare & Medicaid Services (CMS), temporary expansion of telehealth services during the PHE, and flexibility for health care providers to reduce or waive cost-sharing for telehealth visits.[3]

Under its section 1335 waiver authority, CMS now allows Medicare to pay for office, hospital, or other visits furnished via telehealth, including in a patient's place of residence.[4] Prior to the waiver, Medicare could only pay for telehealth services on a limited basis: when the persons receiving the service are in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of

[2] https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0268
[3] Department of Health and Human Services. Telehealth: Delivering Care Safely During COVID-19. https://www.hhs.gov/coronavirus/telehealth/index.html
[4] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers

medical facilities for service.[5] CMS also expanded its telehealth services by temporarily allowing more types of health care practitioners to offer the services via telehealth, including telephonic evaluation and management services, mental health counseling, and preventive health screenings, among others.[6] States followed suit, refining and expanding telehealth reimbursement policies through various changes in Medicaid program policies, including temporarily easing restrictions for state regulated health plans.

Cross-State Licensure

Prior to the PHE, the use of telemedicine was limited in scope and stifled in part by ambiguous and continuously changing regulations at the state and federal level. Telemedicine barriers were further compounded by state-based licensure processes for physicians trying to expand telemedicine services across state lines. Despite these barriers, telemedicine was gaining traction in oncology, with providers citing the following factors and benefits as contributing to its uptake: improved documentation, better continuity of care, enhanced communication between provider and patient, greater treatment compliance, and potential availability of data for scientific evaluation.[7] Cancer patients have reported high satisfaction with telemedicine in radiation oncology and in survivorship care planning.[8,9] Nevertheless, adoption remained uneven. As COVID-19 infections increased and a PHE was officially announced, many practices turned to telemedicine for the first time.

The current framework for cross-state licensure, which requires that a physician obtain multiple licenses to practice medicine in multiple states, has been identified by the National Academy of Medicine as a persistent barrier to telemedicine.[10] In the United States, providers must adhere to licensing rules and regulations based on the state in which a patient is located. Each individual state is responsible for regulating the practice of medicine through formal licensing of physicians by state medical boards, and those boards wary widely in their telemedicine license requirements.

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[5] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[6] https://www.cms.gov/newsroom/press-releases/trump-administration-drives-telehealth-services-medicaid-and-medicare

[7] Kessel KA, Vogel MM, Schmidt-Graf F, et al. Mobile apps in oncology: a survey on health care professionals' attitude toward telemedicine, mHealth, and oncological apps. J Med Internet Res. 2016;18:e312. https://www.ncbi.nlm.nih.gov/pubmed/27884810

[8] Hamilton E., Van Veldhuizen E., Brown A., Brennan S., Sabesan S. Telehealth in radiation oncology at the Townsville Cancer Centre: Service evaluation and patient satisfaction. Clin Transl Radiat Oncol. 2019;15:20–25. doi: 10.1016/j.ctro.2018.11.005.

[9] Sprague SL, Holschuch C. Telemedicine Versus Clinic Visit: A Pilot Study of Patient satisfaction and recall of Diet and Exercise Recomendations from Survivorship Care Plans. Clin J Oncol Nurs. 2019 Dec 1;23(6):639-646. https://cjon.ons.org/cjon/23/6/telemedicine-versus-clinic-visit-pilot-studypatient-satisfaction-and-recall-diet-and

[10] Institute of Medicine 2012. The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary. Washington, DC: The National Academies Press. https://doi.org/10.17226/13466.

According to the Federation of State Medical Boards (FSMB), 49 state boards, plus the District of Columbia, Puerto Rico, and the Virgin Islands require physicians practicing telemedicine to be licensed in the state in which the patient is located.[11] Twelve state medical boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to accommodate the practice of telemedicine.[12]

To ease physician burden with obtaining multiple state licensing requirements, many states formed interstate agreements allowing the practice of medicine across state lines. The Interstate Medical Licensure Compact (IMLC), launched in 2017, established a voluntary, expedited pathway to licensure of physicians wishing to practice in multiple states. The IMLC currently includes 29 states, the District of Columbia, and the territory of Guam. In these jurisdictions, physicians are licensed by 43 different medical and osteopathic boards.[13] Although the IMLC was designed to facilitate the growth of telemedicine while preserving state regulation of medical practice, it does not track whether the additional state licenses obtained through the compact were, in fact, pursued for telemedicine purposes.[14]

Provider and Practice Concerns

As previously noted, ASCO developed its *ASCO Interim Position Statement: Telemedicine in Cancer Care* to recommend specific actions for applying telemedicine in cancer care. During that time, cross-state licensure raised questions of appropriate state-based safeguards and unintended consolidation of healthcare providers. ASCO encourages a policy that strikes a balance between expanding telemedicine access in underserved areas and wider populations while maintaining an environment in which local and community practices can continue to thrive. Above all, the goal should be expanding access to care for all patients.

POLICY RECOMMENDATIONS

The future of federal and state telemedicine policy remains uncertain. Most of the regulatory flexibilities and telemedicine policies implemented under the PHE are currently structured as temporary. As the world's leading professional organization for physicians and oncology professionals that care for people with cancer, ASCO offers the following recommendations to stakeholders and policymakers:

- **ASCO supports the flexibility CMS has implemented to ensure telemedicine is available to more practitioners and patients during the COVID-19 public health emergency (PHE), and we urge CMS to maintain those expanded telemedicine policies.**

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[11] Federation of State Medical Boards. Understanding Medical Regulation in the United States. https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf.
[12] Ibid
[13] Interstate Medical Licensure Compact. About the Compact. https://www.imlcc.org/a-faster-pathway-to-physician-licensure/
[14] American Medical Association. Interstate medical licensure by the numbers. October 11, 2019. https://www.ama-assn.org/practice-management/digital/interstate-medical-licensure-numbers

In response to the PHE, the Centers for Medicare and Medicaid Services (CMS) relaxed originating site requirements on a temporary and emergency basis under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act, which was signed into law on March 6, 2020. Under its waiver authority, Medicare can now pay for office, hospital, and other visits furnished via telehealth across the country including in the patient's home. During the PHE, telemedicine delivered through cross-state licensure has demonstrated the ability to address patient access in several ways. Patients in rural areas without a local specialist have utilized telemedicine to access providers in contiguous states, while limiting inter-state travel. Additionally, patients who have temporarily or permanently relocated out-of-state have been able to maintain a relationship with their preferred providers through telemedicine follow-ups. While CMS has the authority to make certain permanent modifications such as with telehealth reimbursement, ASCO is aware that other modifications such as changes to originating site and geographic requirements require congressional action.

- **All states should participate in the Interstate Medical Licensure Compact (IMLC). In states that do not participate, lawmakers should enact legislation to join. ASCO will work with state medical associations and State Affiliates to support these efforts.**

While not every state participates in a licensure compact, these programs have been effective in reducing the burden placed on providers to become licensed in multiple states. ASCO encourages states to join the IMLC as an opportunity to streamline the process for physicians to apply for licensure in other member states, recognizing the practice of medicine remains subject to state licensure laws. Supporting the Compact would not undermine state jurisdiction over medical practice.

The American Medical Association (AMA) opposes carve-outs for primary care physicians, who work in medical homes/primary care practices, to provide telehealth services for patients when the patient travels to any of the fifty states.[15] In its report, the AMA notes the increasing challenge for physician practices to compete with large commercial entities but highlights the potential for unintended consequences of creating an exception for primary care physicians. The AMA believes such a carve-out would be disruptive to existing state laws and regulations and could result in national oversight of telemedicine that would be subject to influence by a variety of stakeholders. Although federal oversight of telemedicine may ease tensions between larger providers contracting with payers to provide telemedicine, it could usurp the states' authority to regulate the practice of

[15] https://www.ama-assn.org/system/files/2019-12/i19-cms-report1-patient-relations-telemedicine.pdf

medicine. Further, treating physicians who are not licensed by specific states may not receive local public health department notifications or alerts, critical during times of local outbreaks. Although ASCO does not support a national system for telehealth licensure that usurps state medical board authority, ASCO is committed to working with stakeholders to promote increased research focus among cross-state licensure in telemedicine and encourages more studies to determine the feasibility of a national telehealth program and its impact on provider networks.

- **State and federal policies permitting telemedicine to cross state lines should include a provision requiring that the doctor-patient relationship be established prior to provision of any telemedicine service.**

While there are many issues related to telehealth, this statement is intended to address those related to care delivery with patients and not other uses of telemedicine such as second opinions. Many issues are evolving as people gain experiences through the COVID-19 pandemic and ASCO will revisit as appropriate.

Effective communication is a central function in building a doctor-patient relationship that has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for better identification of patients' needs, perceptions, and expectations.[16] Effective doctor-patient communication has been shown to influence a wide array of outcomes including: emotional health, symptoms resolution, function, pain control, and physiologic measures such as blood pressure levels.[17] For these reasons, an established doctor-patient relationship is important for the ongoing health care management of patients with the shared goal of high-quality care. An established doctor-patient relationship also aids in reducing fragmentation of care while improving patient safety and quality of care.

The AMA has outlined that a valid doctor-patient relationship should ideally be established before the provision of telemedicine services, through one of the following:

(1) a face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or

(2) a consultation with another physician who has an ongoing doctor-patient relationship with the patient. The physician who has established a valid doctor-patient relationship must agree to supervise the patient's care; or

(3) Meeting standards of establishing a doctor-patient relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by

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[16] Ha JF, Longnecker N. Doctor-patient communication: a review. Ochsner J. 2010;10(1):38-43.
[17] Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995 May 1;152(9):1423-33. PMID: 7728691; PMCID: PMC1337906.

major medical specialty societies.[18]

- **Medical liability providers should include telemedicine and data security related risks in their policies. Prior to the delivery of any telemedicine service, physicians should verify that their medical liability insurance includes comprehensive coverage for telemedicine services, including telemedicine across states in which they practice.**

Consistent with the recommendations in our previously issued *ASCO Interim Position Statement: Telemedicine in Cancer Care*, medical liability policies should provide comprehensive coverage for telehealth, and providers should ensure they are covered across all states in which they practice. According to the Center for Connected Health Policy, some but not all malpractice insurance will cover telemedicine services.[19] Providers should ascertain that they are adequately covered as malpractice insurance carriers may not extend their coverage to other states. Providers should also carefully review any definition of doctor-patient relationship required by their medical malpractice insurance prior to the provision of telemedicine services.

- **The Federal Trade Commission should monitor telehealth practice patterns and prevent unfair methods of competition as well as unfair or deceptive acts or practices.**

The Federal Trade Commission (FTC) protects consumers by stopping unfair, deceptive, or fraudulent practices in the marketplace. In previous administrations, the FTC has taken an interest in how states are regulating telehealth by issuing various comment letters to federal and state agencies.[20] We urge the FTC to continue its monitoring of telehealth in order to protect consumers and promote healthy competition.

CONCLUSION

The COVID-19 pandemic led to dramatic and swift upheaval in our health care system for patients and health care providers alike. As telemedicine continues its rapid expansion across the United States, there is a strong likelihood that its benefits will motivate continued growth beyond the public health emergency. ASCO remains committed to the principles and recommendations previously conveyed in its policy statements addressing telemedicine. As we learn more about how the expanded use

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[18] American Medical Association. Report on the Council on Medical Service. Established Patient Relationships and Telemedicine (Resolution 215-I-18). https://www.ama-assn.org/system/files/2019-12/i19-cms-report1-patient-relations-telemedicine.pdf

[19] The Center for Connected Health Policy. Malpractice. https://www.cchpca.org/telehealth-policy/malpractice

[20] The Center for Connected Health Policy. The Federal Trade Commission and Professional Licensure Boards. https://www.cchpca.org/telehealth-policy/federal-trade-commission-and-professional-licensure-boards

of telemedicine has impacted care, ASCO will continue to follow developments very closely and will analyze how new information can be applied to policy development with the goal of improving patient access to high-quality cancer care.

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