February 16, 2022

Mr. John Bremer
Director, State Legislation and Policy
Federation of State Medical Boards
2101 L St NW, Suite 800
Washington, DC 20037

RE: Request for Comments on Draft Report on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

Dear Mr. Bremer,

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide comments on the Federation of State Medical Boards (FSMB) draft document entitled *"Report on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine."* We appreciate the FSMB Workgroup on Telemedicine's efforts to revise and expand the previous 2014 *"Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine"* to reflect the progress made in recent years in this space, especially as a result of the COVID-19 pandemic.

The Alliance is dedicated to improving access to care through the reduction of policy, legal and regulatory barriers to the adoption of telemedicine and remote patient monitoring. Our members are leading health care and technology companies from across the spectrum, representing health systems, health payers, and technology innovators. The Alliance works in partnership with an Advisory Board of more than 40 patient and provider groups, including many types of clinician specialty and patient advocacy groups who wish to better utilize the opportunities created by telehealth.

Below we offer comments we hope the FSMB Workgroup on Telemedicine will consider as it finalizes this document in the coming weeks. We primarily offer recommendations around the provision of audio-only telehealth, reforming licensure laws and regulations, removing restrictive in-person requirements for establishing a provider-patient relationship, and addressing health equity through broadband access and affordability.

I. Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Definitions

The Alliance appreciates the comprehensive set of definitions included in this section of the draft. We recommend an edit to the definition of "telemedicine" as it relates to audio-only telehealth based on feedback from our members on this modality. We appreciate that the definition of "telemedicine" includes audio-only communications, as we believe this is important from an equity perspective to ensure older adults who have complications using technology and individuals residing in rural or underserved communities where broadband access is limited are still able to access virtual care.

Our members are finding that either for patient preference or clinical acuity, telehealth services delivered via telephone can be very sufficient for some visits. While the majority of virtual visits may be delivered

using video for our health system members, telephone remains an important and clinically appropriate access point for many patients. The feedback our members receive from clinicians and patients is that telehealth services don't always *have to* be delivered via video. Regulators should leave the decision on the most appropriate modality for that visit to the provider and the patient. As such, we recommend the following change to this part of the telemedicine definition, to read:

> *Telemedicine may include audio-only communications, but audio-only communications should only be used as a substitute when a patient is unable or does not wish to use live-interactive modalities, when audio-only interactions are considered the standard of care for the corresponding healthcare services being delivered, or when the provider and patient decide this is the most appropriate modality for the respective healthcare visit.*

For further consideration, the CMS Calendar Year 2022 Medicare Physician Fee Schedule proposed rule contained language that our members see as relatively good language that creates flexibility for providers and patients to choose the appropriate modality for a visit: *"We are also proposing to limit payment for audio-only services to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance* ***where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology****."*

Licensure

The Alliance believes that one of the biggest barriers to telehealth becoming a regular patient and provider choice is the administrative burden caused by the variation in licensure requirements from state to state. We generally support licensure requirements that allow for safe and accountable mutual recognition of health professional licensure among states, meaning a health professional licensed and in good standing in one jurisdiction could provide care in other jurisdictions without having to obtain an additional license. This has been successful in practice through compacts like the Nurse Licensure Compact and is widely supported as a best practice for addressing issues related to licensure.

At the outset of the pandemic, governors across the country used emergency authority to waive some aspect(s) of state licensure laws to facilitate patient access to care. Doing so allowed licensed medical professionals more flexibility to treat patients in other states when there were pressing needs or specialized expertise not available where they lived. Our experience during the pandemic has provided an unprecedented opportunity for patients, providers, and policymakers to explore the impact of cross-state care. We have seen it benefit the delivery of health care in many ways, but most notably through new avenues for patient access to care.

Over the last several months, many states have allowed COVID-19 emergency declarations to expire and these licensure flexibilities to expire with it, which has been extremely detrimental and disruptive to necessary and ongoing patient care. Health care providers have had to scramble to notify thousands of out-of-state patients that their telehealth appointments were no longer possible, and that they would have to drive across state borders to keep their appointments.

While challenging for all patients, this reduction in access is particularly troublesome for immunocompromised individuals, individuals who require specialized care, have mobility challenges, or have significant provider shortages and/or geographic distances from the care they need. Many of these

patients relied on telehealth throughout the pandemic to see their specialists who reside in another state, made possible by licensure flexibilities implemented at the start of the pandemic, so as not to risk exposure to the virus and to maintain continuity of care through virtual options. In light of these changes, it is not uncommon for patients to drive just over the state border to take a telehealth appointment from their car in a parking lot.

We must take advantage of this unprecedented experience to reform state licensure laws to ensure improved access to and continuity of care for patients. While we acknowledge that our views on ways to reform licensure laws differ from those of FSMB, we appreciate that FSMB is willing to consider instances where exceptions may be made to permit the practice of medicine across state lines without the need for licensure in a jurisdiction where the patient is located. Below, we offer comments on the recommendations made in the draft, as well as suggestions for additional exceptions to consider for inclusion in the final draft of this document.

Consultations and Screenings

We applaud the inclusion of physician-to-physician consultations and prospective patient screening for complex referrals as exceptions to licensure in this draft document. Especially for patients with rare diseases, chronic conditions, or other diseases, being able to meet with a specialty provider through telehealth for an assessment or consultation to establish if the provider can meet their needs or is the right fit is critically important and would help reduce the burden many patients face in finding the appropriate provider for their condition, including travel, time and financial barriers. We hope this section remains in the final document.

Limited Follow-Up Care

We appreciate the inclusion of follow-up care as an exception to licensure in certain instances. This is critical for continuity of care, particularly for patients in need of post-operative care or ongoing specialty care. While we generally agree with the recommendations included in this section around exceptions for episodic follow-up care and follow-up care after travel for surgical or medical treatment, we recommend an expansion of this section to acknowledge the need for continuity of care for certain populations.

We encourage you to expand the categories of patients included in the *"Episodic Follow-Up Care"* section beyond patients travelling to other states for a limited time, as there are other groups of patients with ongoing medical needs that could benefit from continued access to their out-of-state providers through telehealth. The inclusion of a flexibility for those traveling for vacation, business or education is a critical next step. In the instance of students, there was a great need for students to be able to access their mental health providers in the state where they attended university when COVID-19 shut down campuses and forced students to return home. COVID-19 licensure flexibilities allowed students to continue their care with their existing provider, especially in a time when access to mental health providers was extremely limited (and continues to be). However, the uncertainty of when these flexibilities would expire was in many instances detrimental to continued care.

We would encourage FSMB to consider additional populations that could benefit from this continued care, including the elderly and those in need of specialty care who cannot access it where they reside. Parents with children with diseases like epilepsy, pediatric cancer, autism, rare diseases, and others often have to drive across states to get needed specialty care. Being able to have ongoing follow-up care via telehealth

with their specialty providers would be critical to ensure these patients continue to access needed care from their providers of choice, while reducing travel burden and other common barriers to access. Elderly patients with mobility issues have to find ways to be seen by specialists if they do not have access to them where they reside. Telehealth has been critical for continuity of care for this population throughout the pandemic, and could continue to be beneficial both for elderly patients with mobility challenges and for the "snow bird" population who travel to warmer climate states during the winter and wish to maintain access to their providers in their main state of residence.

Additional Category for Inclusion
We encourage FSMB to consider the inclusion of an additional category in this section to address state licensing limitations in clinical trials. State licensing limitations effectively prohibit clinicians working on clinical trials from recruiting patients from outside the state where the clinician is licensed, thereby diminishing the impact of recent initiatives at the federal and state level to modernize and decentralize clinical trials. This is especially important for rare diseases affecting fewer than 200,000 people in the United States, for which utilizing clinical trials across state lines, enabled by telehealth, may significantly increase the likelihood of a successful and diverse clinical trial.

When focusing on addressing inequities in the health care system and ensuring that telehealth does not exacerbate existing inequities in access to care, it is critical to account for logistical and other participant-related factors that could limit participation in clinical trials. Travel time, lost wages, and childcare/eldercare are all considerations that go into participation in clinical trials by patients, and obviating these needs through use of digital technologies will increase the pool of potential participants. State regulators have a role in breaking down additional barriers in using digital technology, and ensuring clinicians can recruit clinical trial participants across state lines can help improve recruitment, retention, and participation in clinical trials.

Standard of Care
We appreciate FSMB's inclusion of the section entitled "*Establishment of a Physician-Patient Relationship,"* particularly the assertion in this section that a physician-patient relationship may be established using telemedicine technologies without the requirement of a prior in-person meeting. The Alliance and its members strongly believe that an in-person requirement is not necessary or appropriate for a telehealth service. Requiring an in-person visit constrains telehealth from helping individuals with access challenges, including those that are homebound, have transportation challenges, live in underserved areas, or face other barriers in accessing care. It does not constrain those using telehealth for convenience. This creates a perversion in the health care payment system by reducing access for those who need it most, while allowing access for others. An in-person requirement creates an access barrier between patients and their clinicians, and will lead to harm for the most vulnerable and access-constrained patients. We appreciate you addressing this concern in the draft report, and encourage this assertion to be maintained moving forward.

II. Equity of Healthcare Access

The Alliance believes telehealth has the potential to broaden access to care and improve patient engagement, and we agree it demands thoughtful consideration to ensure all Americans are provided

equal and equitable access. We applaud the FSMB for including a section in this draft directly addressing equity in health care access via telehealth. We specifically want to comment on the inclusion of broadband as a means to addressing equity in health care delivery via telemedicine.

As highlighted by the COVID-19 pandemic, access and affordability of broadband is an important aspect to accessing health care services, including telehealth services. Broadband is essential to expanding access to telehealth. Without it, we will never reach populations who need access to behavioral health, primary care, specialty consults and more. States must pursue policies to expand broadband access alongside changing coverage policy for telehealth.

The inequities in broadband access across geography, race, and income are clear. According to a 2021 Pew Research Center survey, home broadband use varies significantly across demographic groups, including race and income levels. Nearly all Americans with annual household incomes above $75,000 reported having a broadband connection at home, compared to just half of households making less than $30,000 a year. Similar stark contrasts can be seen between races and geography, with 80 percent of White people having access, compared to just 70 percent and 65 percent of Black and Hispanic people, respectively. Additionally, more than 35 million rural Americans lack access to broadband.

In January 2021, the Federal Communications Commission (FCC) released their fourteenth annual Broadband Deployment Report finding progress in closing the digital divide. For example, the gap between urban and rural Americans with access to high-speed broadband service has been nearly halved, falling from 30 percentage points at the end of 2016 to just 16 points at the end of 2019. Despite significant progress being made, tens of millions of Americans do not have access to broadband. Estimates range from roughly 14.5 million to 42 million Americans in total, with the lowest coverage levels experienced in Tribal and rural areas.

Below we provide recommendations we encourage FSMB to add to this section of the draft report for states to consider in pursuing broadband policies:

- States should invest in efforts and pursue policies that support broadband affordability for patients and providers. For digital health technologies to truly transform the way Americans obtain and receive access to health care services, we must address affordability and usability of the technology supporting that access. Despite advancements in telehealth usage throughout the pandemic, many households lack the ability to benefit from these digital services. This is partly due to the United States having one of the highest broadband prices among OECD countries.

- States should continue to address anticompetitive behaviors in all industries, and explore solutions that support patients. According to a 2020 Institute for Local Self-Reliance report which analyzed data from the FCC, more than 20 million Americans live in broadband monopolies, whereby they have access to only one broadband provider. Another roughly 100 million Americans live in areas with access to only two broadband service providers. A lack of affordable broadband is a significant barrier to not only virtual health care access, but also other important social determinants of health such as education and employment opportunities. States must ensure that access to these services take precedent over corporate interests.

- States should invest in efforts that support the deployment of broadband for all Americans, including those living in rural areas, on Tribal lands, and to our nation's health care providers and centers. This includes maintaining access to audio-only services for patients who, in the interim,

continue to lack broadband access and/or affordability. The Alliance believes that audio-only telehealth has been a critical tool for many clinicians and patients during COVID-19, especially when considering providing equitable access to care for patients facing broadband, affordability and other barriers. While we believe that audio-video communication is the preferred modality for most telehealth, we strongly support continued flexibility for audio-only – when clinically appropriate and when meeting the need or request of the patient.

  - To support this recommendation, a recent report by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) found disparities among subgroups in use of audio versus video telemedicine, with the highest share of visits that utilized video services occurring among young adults age 18 to 24 (72.5 percent), those earning at least $100,000 (68.8 percent), those with private insurance (65.9 percent), and White individuals (61.9 percent). Video telehealth rates were lowest among those without a high school diploma (38.1 percent), adult ages 65 and older (43.5 percent), and Latino (50.7 percent), Asian (51.3 percent) and Black individuals (53.6 percent).

- States should consider addressing licensure issues that impede access to care to address gaps in the delivery system and provide high-value care directly to consumers in rural or underserved areas. State lines often create artificial barriers to the delivery of care – complicating access for patients and creating additional burden on clinicians. These lines sometimes split major urban areas and hamper the ability of telemedicine providers to fill in gaps in the delivery system and provide high-value care directly to consumers in rural or underserved areas, who may not have access to health care providers where they reside. Current efforts to expand interstate licensure have been insufficient to meet the needs of patients and the clinicians seeking to better serve them. As our entire ecosystem works to address inequities, we urge states to consider addressing antiquated licensure laws that impede access to care, and the value of cross-state care in providing greater access to health care and specialty medicine, addressing provider shortages in rural and medically underserved communities, improving follow-up and continuity of care, and providing patients with more choice in the providers they wish to see.

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The Alliance greatly appreciates FSMB's leadership on this report. We look forward to working with you to inform the final document to ensure the value of telehealth is fully realized in the practice of medicine. If you have any questions or would like to hear from Alliance member experts on these topics, please do not hesitate to contact me at krista.drobac@connectwithcare.org.

Sincerely,

Krista Drobac

Krista Drobac
Executive Director
Alliance for Connected Care