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Cross-State Practice of Telehealth and the VA’s Proposed Rule

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In a proposed rule issued by the Department of Veterans Affairs (VA proposed rule) in early October, the VA would permit VA health care providers licensed in any state to provide telehealth services to VA beneficiaries regardless of where the health care provider or beneficiary is physically located.[1] In doing so, the VA makes clear that it intends to exercise its federal preemption rights with respect to any conflicting state licensure laws. More recently, on November 7, the U.S. House of Representatives unanimously passed legislation that would accomplish the same thing.[2]

The VA already preempts state licensure regarding in-person care furnished to VA beneficiaries at a VA facility provided the health care provider is licensed in at least one state. In other words, the health care provider need not be licensed in the state where services are provided. This proposal would apply that same policy to telehealth services. Although the proposed rule can be viewed as simply an extension of existing VA licensure policies, it raises issues that are part of the ongoing national debate on how to reconcile the proliferation of technologies that permit across border practice with the traditional role of the states as guardians of public safety.

The VA has been a leader in the use of telehealth services to broaden access to health care, especially in rural areas, and currently is the largest provider of telehealth services in the country. In 2014, the VA reported 2.1 million telehealth encounters, 45% of which involved veterans living in rural areas.[3] In 2016, the VA reports that almost 12% of veterans (over 702,000) who received clinical services from the VA received a portion of that care through telehealth.[4]

The VA proposed rule is limited to VA-employed physicians and would not apply to contracted health care providers such as community-based physicians furnishing services under the Veterans Choice program. The reluctance to apply federal preemption more broadly is understandable given that regulating health care professionals historically has been one of the states' "police powers" under the Tenth Amendment to the U. S. Constitution. In exercising their authority over the health care professions, most states require physicians to have a full medical license *in the state where the patient is physically located* with some narrow exceptions for physician-to-physician consultations. The consultation generally must be "episodic" or "infrequent" and the out-of-state physician usually is not permitted to consult directly with the patient, but instead provides consultation and support to the in-state doctor.[5]

Federal health programs for the most part generally defer to state law with respect to licensure. Medicare defines "physician" as a doctor of medicine or osteopathy "legally authorized to practice medicine and surgery by the State in which he performs such function or action."[6] Under TriCare, physicians must be "currently licensed to render professional health care services in each state in which the individual renders services" to Tricare beneficiaries to be an authorized provider.[7]

To address challenges of telemedicine, the Federation of State Medical Boards (FSMB) developed the Interstate Medical Licensure Compact (IMLC) that allows for expedited licensing for telemedicine.[8] Under the IMLC, physicians can practice medicine across state lines within the Compact states if they meet certain eligibility requirements. The IMLC was launched in 2014 and 22 states have signed on to the Compact.[9]

However the IMLC still requires that physicians be licensed in the state where the patient resides and, although it streamlines the process, it still poses administrative burdens and licensure fees. The

National Council of State Boards of Nursing (NCSBN) approved a Nurse Licensure Compact (NLC) that takes a different approach: nurses licensed in a Compact state may practice in any other Compact state without obtaining separate licensure in that state.[10] Twenty-six states have adopted the NLC. A separate Compact for Advanced Practice Registered Nurses (APRN) has been approved and will be implemented when enacted by ten states. Like the NLC, that Compact also would create license reciprocity so that an APRN need only be licensed in one state.[11] Also under development is the Psychology Interjurisdictional Compact (PSYPACT), which would allow psychologists to provide telepsychology services without obtaining additional licensure.[12] The PSYPACT has been enacted in three jurisdictions and is under consideration in several more states.

Two bills pending in the current Congress essentially would duplicate what the VA has proposed with respect to multistate licensure for telehealth purposes. The Care Veterans Deserve Act[13] and the Veterans E-Health and Telemedicine Support Act (VETS Act)[14] would make statutory the provisions in the VA proposed rule, allowing VA health care professionals to practice in any state using telehealth, regardless of the patient or health professional's location. The House passed the VETS Act on November 7. In the 114th Congress, the Health Equity and Accountability Act of 2016[15] would have required the Department of Health and Human Services to take action to "encourage and facilitate" adoption of telehealth practice across state lines for Medicare beneficiaries but was not specific as to what that action should be. Many other bills are pending in Congress that include telehealth provisions, but they generally focus on expansion of Medicare coverage and do not contain provisions that would facilitate multistate licensure.

Although proposals to bypass state medical licensure generally elicit vigorous opposition from states and physician organizations, the American Medical Association (AMA) has expressed strong support for the VA's proposed rule, stating that the VA's "unique federally controlled healthcare system [has] essential safeguards to help ensure that both in-person and virtual beneficiary care meet and exceed the standard of care.[16] However, the AMA's support is conditioned on the fact that the VA proposal does not extent to contracted physicians.

In contrast, the AMA and other physician organizations opposed a provision in the 2017 National Defense Appropriations Act (NDAA) that would have deemed TriCare providers to be furnishing telehealth services in the state where the provider was located rather than where the patient was.[17] More than 47 state medical boards joined in an AMA letter to the Senate and House Armed Services Committees, stating that adopting the provision would result in "fundamentally subverting and undermining existing state-based patient safety protections . . ."[18] They asserted that state boards would not be able to protect patients in their states from out-of-state providers and that state boards where the practitioner was licensed would have no authority to investigate matters that took place in another state. The provision ultimately was removed from the NDAA.

As the fight over the NDAA provision illustrates, preemption of state law for VA-employed physicians treating VA beneficiaries via telehealth is viewed by at least some medical boards and the physician community as an acceptable override of state authority, while efforts to apply that policy to physicians outside the closed VA system appear to be viewed as an unacceptable incursion into state sovereignty that jeopardizes patient safety.

Despite states' asserted interest in protecting the public, the Federal Trade Commission (FTC) has challenged state laws regulating health care professionals as anti-competitive, stating that "the practice of telemedicine has crystallized tensions between the states' role in ensuring patients have access to quality care and the anticompetitive effects of protecting in-state physicians from out-of-state competition."[19] The FTC has been especially critical of states that attempt to impose stricter standards on the practice of telemedicine than apply to traditional practice.[20]

Some telehealth advocates have suggested the need for a federal law that would preempt state licensure laws when telehealth services are provided to beneficiaries of federal health programs

including Medicare, TriCare, and the VA. Others have argued more broadly that telehealth service should be deemed to take place where the physician is located.[21]

Such a proposal would certainly face constitutional challenges under the Tenth Amendment as well as Executive Order 13132, which sets out principles of federalism that must be followed when executive branch agencies adopt policies that restrict state authority.[22] Under E.O. 13132, national action limiting state policymaking discretion should be supported by constitutional and statutory authority and be appropriate "in light of the presence of a problem of national significance." When determining whether to establish uniform national standards, federal agencies must consider alternatives and regulatory preemption of state law must be the minimum level necessary to achieve statutory objectives.

In the proposed rule, the VA justifies the need for federal preemption because of state laws restricting the practice of telehealth and the need for the VA to better serve its beneficiaries, especially in the behavioral health area. The agency asserts that it has been restricted from expanding critical telehealth services because VA physicians are concerned about running afoul of state licensure laws. It also states that, although there is no specific statutory authority given to the VA for preemption of state licensing laws, it can be inferred from legislation requiring the VA to incorporate telehealth into its national health care system, especially for provision of remote mental health and traumatic brain injury assessments.[23]

It is difficult to make the case for similar federal preemption under the Medicare program, given its current limited coverage of telemedicine. Unlike the VA proposal, the implications for extending preemption to any provider that sees Medicare patients would be much more far-reaching and controversial. However, it is clear that use of telemedicine technologies is growing rapidly and has a critical role to play in treatment of mental and behavioral health issues. With the country's seemingly out of control opioid crisis, and the potential cost savings and increased access when patients can receive services in their homes, it is not hard to imagine a future in which providers, payers, and patients will demand that state obstacles to multistate licensure be removed, whether through federal preemption or individual state action.

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[1] 82 Fed. Reg. 45756 (Oct. 2, 2017).
[2] H.R. 2123
[3] *Id.* at 45758.
[4] *Id.*
[5] *See, e.g.*, Ariz. Rev. Stat. Ann. § 32-1421; Mo. Rev. Stat. § 191.1145(4); 5 R.I. Gen. Laws § 5-37-16.2(a)(3).
[6] Section 1861(r) of the Social Security Act.
[7] 32 C.F.R. § 199.6(c)(2)(i).
[8] *Interstate Medical Licensure Compact*, http://www.imlcc.org/.
[9] The IMLC is live in 17 of the member states. Washington, South Dakota, Tennessee, Pennsylvania, and Maine have adopted the Compact but with delayed implementation.
[10] The NCSBN recently revised the NLC to create the new Enhanced NLC (eNLC). *Enhanced Nurse Licensure Compact (eNLC) Implementation*, https://www.ncsbn.org/enhanced-nlc-

implementation.htm.
[11] *Advanced Practice Registered Nurses Compact*, https://www.ncsbn.org/aprn-compact.htm.
[12] *Psychology Interjurisdictional Compact*, http://www.asppb.net/news/news.asp?id=217917.
[13] H.R. 1152, 115th Cong. (2017).
[14] H.R. 2123/S. 925, 115th Cong. (2017).
[15] H.R. 5475, 114th Cong. (2016).
[16] Jack Resneck Jr., MD, *AMA Statement on VA Telehealth Proposed Rule*, (Sept. 29, 2017), https://www.ama-assn.org/ama-statement-va-telehealth-proposed-rule.
[17] NDAA Section 705(d); S. 2943, 114th Cong.
[18] Letter from AMA and 47 State Medical Societies to Senate and House Armed Services Committees (Sept. 12, 2016), http://ims.informz.net/IMS/data/images/Documents/NDAA%20State%20Ltr_09-16.pdf.
[19] Letter from Federal Trade Commission to Rep. Steve Thompson, Alaska State Legislature (Mar. 25, 2016) (citing FTC & U.S. Dept. of Justice, Improving Health Care: a Dose of Competition (2004)), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alaska-state-legislature-regarding-telehealth-provisions-senate-bill-74-which/160328alaskatelehealthcomment.pdf.
[20] *Id. See also* FTC investigation into Texas telemedicine policy, *available at* https://www.ftc.gov/news-events/press-releases/2017/06/federal-trade-commission-closes-investigation-texas-medical-board.
[21] *See, e.g.,* Charles G. Kels & Lori H. Kels, *Portability of Licensure and the National's Health*, 178 Mil. Med. 279 (2013).
[22] 64 Fed. Reg. 43255 (Aug. 10, 1999).
[23] 82 Fed. Reg. at 45757.

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