REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Telehealth Licensure
(Reference Committee J)

EXECUTIVE SUMMARY

Telehealth falls within the Council on Medical Service's purview and has been the subject of several reports, including Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, which established American Medical Association (AMA) policy supporting an exception for out-of-state physicians providing continuity of care to existing patients (Policy D-480.960), and Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, which established AMA policy encouraging participation in the Interstate Medical Licensure Compact (ILMC) and supporting state efforts to expand licensure recognition across state lines (Policy D-480.964).

The Council monitors telehealth policy issues and self-initiated this updated report to assess the need for new AMA policy supporting licensure exceptions that permit physicians to provide medical care to out-of-state patients using telehealth. Existing AMA policy supports exceptions allowing interstate telehealth for continuity of care purposes, physician-to-physician consultations, and in the event of urgent or emergent circumstances. Additional AMA policy supports streamlining licensure processes and reducing licensure costs, as well as state efforts to expand licensure recognition across state lines.

Consistent with previous work on this topic, the Council adopted a balanced approach to policy development that seeks solutions for physicians and patients as well as appropriate guardrails that ensure high quality patient care. The Council continues to believe that there must be clear lines of accountability in licensure policies to protect patients, and that licensure of physicians and other health professionals should remain within the purview of each state, which is the prevailing standard. At the same time, AMA policy needs to keep pace with telehealth innovations, including those that lessen geographic barriers to care by enabling patients to access medical services not available close to home. After reviewing the literature and updated telehealth policies from the Federation of State Medical Boards, the Uniform Law Commission, and across states, the Council found that additional licensure exceptions are warranted for physicians using telehealth to prospectively screen patients for complex referrals, and physicians working on and recruiting patients for clinical trials. As with any exception, a physician must have a medical license in good standing in order to qualify. Accordingly, the Council recommends amending Policy H-480.969[1] to support exemptions from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition; physicians screening out-of-state patients for acceptance into a clinical trial; and physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, as long as certain conditions are met.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-25

Subject: Telehealth Licensure

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

Telehealth falls within the Council on Medical Service's purview and has been the subject of several reports, including two addressing state licensure requirements and exceptions allowing physicians to provide telehealth across state lines:

- Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, was written during the COVID-19 pandemic, when telehealth use increased dramatically. This report established American Medical Association (AMA) policy supporting an exception for out-of-state physicians providing continuity of care to an existing patient, provided that a previous in-person visit has occurred and the telehealth services are incident to an ongoing care plan or one that is being modified (Policy D-480.960). Prior to this policy being adopted, the AMA had supported narrow exceptions to state licensure requirements for physician-to-physician consultations and in the event of an urgent or emergent circumstance (Policy H-480.969).
- Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, was written prior to the pandemic at a time when fewer physicians were practicing interstate telehealth. This report established new AMA policy encouraging participation in the Interstate Medical Licensure Compact (ILMC) and supporting state efforts to expand licensure recognition across state lines (Policy D-480.964).

This report was self-initiated by the Council to assess the need for additional AMA policy on licensure exceptions that permit physicians to use telehealth to provide care to patients in other states without seeking licensure in the state where the patient is located. As such, this report provides updates on interstate telehealth, including state policies and updated model policies; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

As highlighted in Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, the use of telehealth by physicians and other health providers rapidly expanded during the COVID-19 pandemic, enabling physicians to provide uninterrupted continuity of care while protecting patients and physicians from exposure to the virus. Whereas telehealth encounters made up a small percentage of total care visits before the pandemic, they increased by 2,000 percent during the first six months of the public health emergency.[1] Of note, telehealth use continues at significantly higher rates than pre-pandemic, as data from the AMA's Physician Practice Benchmark Surveys (nationally representative surveys of non-federal physicians providing at least 20 hours of patient care per week) demonstrates. According to data from Benchmark Surveys fielded between 2018 and 2024, only about one-quarter of physicians were in a practice that used any form of telehealth

in 2018, a figure that rose to 79 percent in 2020 before decreasing to 71 percent in 2024.[2] To support this transformation, telehealth became a core element of the AMA Recovery Plan for America's Physicians post pandemic.

The increased availability of telehealth has mitigated some of the barriers patients face in accessing essential health care services, especially in rural and underserved areas where physician specialists may not be available close to home and patients must travel long distances for in-person care. The expanded telehealth landscape has also produced innovative hybrid models of care delivery utilizing in-person, telehealth, and remote monitoring services so that patients can obtain the optimal mix of care modalities. Such models reduce fragmentation of care and fortify physician-patient relationships because patients receive telehealth services from their regular physicians, as opposed to payer-facilitated telehealth programs or corporate telehealth-only entities. Rapid growth in the use of telehealth, including by large telehealth-only companies, has challenged policymakers and regulators to facilitate the expanded and appropriate use of telehealth technologies while ensuring care coordination and quality.

INTERSTATE TELEHEALTH

As explained in Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, and Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, medical licensure is granted to physicians by state medical boards, a structure that dates to the 1800s and is embedded in state authority granted by the 10th amendment. The prevailing standard of care in this country affirms that the practice of medicine occurs where the patient is located and, therefore, that physicians are generally required to be licensed in the state where the patient is located. This standard also applies to telehealth, which is considered to be provided at the location of the patient and, therefore, typically requires licensure in the patient's state. This standard enables states to make sure that all types of health care providers adhere to that state's laws and regulations (e.g., licensing requirements and scope of practice parameters) and that the public is protected from the unprofessional and improper practice of medicine. Alternatives to state-based licensure raise accountability and enforcement concerns as states do not have interstate policing authority and cannot investigate crimes that happen in another state.

When the public health emergency was declared in March 2020, the rapid proliferation of federal and state temporary waivers of telehealth coverage and payment regulations facilitated a large-scale expansion of telehealth that helped meet the high demand for virtual care. Most states also waived certain licensure requirements, enabling physicians and other health providers to work across state lines without having to be fully licensed to treat patients in those states. Some states issued broad reciprocity waivers while others required registration with, or approval by, the state medical board in order to practice in that state. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to existing patients in that state, or by physicians in contiguous states who had established relationships with state residents.

During the pandemic, people living near state borders, patients in need of specialized care in another state, and more mobile patients such as college students were more likely to receive interstate telehealth visits.[3] Additionally, individuals were able to participate remotely in clinical trials overseen by the Food and Drug Administration.[4] Most temporary COVID-19-related licensure flexibilities have since been lifted; however, many stakeholders—including the AMA—support continued flexibility to provide cross-state telehealth in reasonable circumstances that would be beneficial to patients and physician-patient relationships.

Interstate Medical Licensure Compact

Relatedly, the AMA has long recognized the costs and burdens associated with obtaining physician licenses to practice medicine (or telehealth) in multiple states and has supported solutions that streamline licensure processes while preserving state oversight of the care of patients within their borders. The Interstate Medical Licensure Compact (IMLC) is considered one such solution because it provides an expedited pathway to licensure for qualifying physicians seeking to practice in multiple states. The mission of the Compact is to increase access to health care, particularly for patients in underserved or rural areas, by making it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of telehealth.[5] Because the IMLC adopts the prevailing standard that the practice of medicine occurs where the patient is located at the time of the visit, physicians practicing under a license facilitated by the Compact must comply with the statutes, rules, and regulations of each state wherein they choose to practice. Of note, the reach of the IMLC has grown significantly since the Council began studying telehealth policy and, at the time this report was written, 42 states—plus the District of Columbia (DC) and Guam—were member jurisdictions.[6] Since operations began in April 2017, over 150,000 licenses have been issued through the IMLC process, helping over 42,000 physicians.[7]

Federal/National Initiatives

Although physician licensure is regulated by states, a handful of federal initiatives have facilitated cross-state telehealth in certain circumstances. Physicians and other professionals employed by the U.S. Department of Veterans Affairs, Indian Health Service, and Department of Defense are generally permitted to practice medicine—including via telehealth—outside of the state where they are licensed. Of note, these health systems are federally funded and regulated and serve limited patient populations. Health care teams (including physicians) mobilized by the National Disaster Medical System, which is a partnership of the U.S. Departments of Health and Human Services, Homeland Security, Defense, and Veterans Affairs, essentially become federal employees while responding to disasters and emergencies, and physicians are thus able to temporarily practice in another state as part of that team without seeking a new license.

The Uniform Telehealth Act, proposed by the Uniform Law Commission in 2022, authorizes the establishment of a state registration system for practitioners licensed in other states that allows registrants to provide telehealth services in states adopting the Act. The model bill, enacted by Washington State and DC, also permits out-of-state practitioners to provide telehealth care: 1) in consultation with other practitioners licensed in the state; 2) to provide specialty assessments, diagnoses, and/or recommendations for treatment to a patient located in the state; and 3) to existing patients with whom a practitioner has an established practitioner-patient relationship. The Uniform Emergency Volunteer Health Practitioners Act allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the DC that have enacted the model Act.

State Exceptions to Licensure Requirements

Because the standards and scope of telehealth services should be consistent with related in-person care (consistent with Policy H-480.946), state licensure requirements vary by but still generally adhere to the prevailing standards, with some exceptions. In an attempt to address some of the challenges to practicing telehealth across state lines, states have adopted a variety of measures, including limited licensure exceptions for certain types of care, alternative licensure/registration processes for interstate telehealth, and cross-state licensing that allows physicians to practice in

contiguous states. An example of the latter is the agreement between DC, Maryland, and Virginia medical boards that facilitated expedited licensure reciprocity for physicians practicing in the area.[8]

According to the Federation of State Medical Boards (FSMB), all state medical boards require that physicians engaging in telehealth be licensed in the state where the patient is located or registered in the state if the state maintains a special registry for interstate telehealth. Licensure exceptions and/or consultation exceptions for telehealth services rendered across state lines are in place in 40 states plus DC and Guam.[9] To qualify for an exception, physicians must have an existing license to practice medicine in good standing. State-based licensure exceptions can be useful to physicians because they permit limited interstate telehealth work without requiring lengthy applications or licensure fees. Some of the more common state licensure exceptions include:

- *Exceptions allowing episodic and follow-up care* via interstate telehealth, which are available in 14 states and DC.[10] For example, Alaska permits physicians licensed in other states to provide telehealth services for ongoing treatment or follow-up care, as long as there is an established physician-patient relationship and the physician has previously conducted an in-person visit with the patient.[11] Ohio's licensure exception allows an out-of-state physician or surgeon, who treated the patient out of state, to provide follow-up services within one year.[12]
- *Exceptions allowing a limited number of telehealth encounters* from out-of-state physicians. For example, Alabama permits services provided on an irregular or infrequent basis, defined as occurring less than 10 days in a calendar year or involving fewer than 10 patients in a calendar year.[13] Minnesota similarly permits the practice of interstate telehealth as long as services are provided on an irregular (less than once a month) or infrequent (fewer than 10 patients per year) basis.[14]
- *Exceptions allowing licensed out-of-state physicians to consult* with in-state licensed physicians, provide second opinions, or provide care in an emergency or disaster, which are permitted in more than 30 states.
- *Exceptions allowing certain mental or behavioral health providers licensed or registered in another state to provide telehealth services* to in-state residents, such as those in place in Colorado and Utah.
- Some states have *universal licensure recognition laws* which allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.

According to FSMB, eight states either allow interstate telehealth if physicians register with the state medical board and pay associated fees, or have a waiver in place that allows the practice.[15] Most of these states impose additional requirements, including Florida which requires out-of-state physicians to designate a duly appointed registered agent in the state. Some states also limit the types of services that can be provided by registered out-of-state providers, such as for mental and behavioral health (e.g., Utah) or consultation services (Maine). Many states with registration processes in place prohibit out-of-state physicians who register with the state medical board from opening offices in the state.[16]

Another approach taken by eight states involves the issuance of a telehealth-specific license or certification.[17] Tennessee's telehealth certification is limited to osteopathic practice. As previously noted, DC, Maryland, and Virginia have entered into a regional compact recognizing licensure reciprocity across these jurisdictions. Pennsylvania also issues extraterritorial licenses that allow physicians in adjoining states, whose practices extend into Pennsylvania, to practice in the state provided other requirements are met and the adjoining state maintains similar privileges.[18]

Of note, most telehealth registration processes and telehealth-only licenses require out-of-state physicians to submit paperwork and fees before they are able to practice interstate telehealth, even on a limited basis. Depending on the time and money required, these processes may or may not be worth pursuing. Although the fees for telehealth registrations and licenses vary by state, most cost less than the IMLC, which requires an initial $700 fee plus the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.[19] If a physician wishes to practice in multiple states, any such fees may be beyond the budgets of many physician practices—particularly independent practices.

Importantly, compliance with state licensure and medical practice requirements does not guarantee that insurers will cover a telehealth visit with a patient in another state. Although Medicare generally requires out-of-state providers to comply with state laws, other payer policies vary and therefore it is important that physicians review specific payer policies before providing telehealth services to patients in another state. Liability concerns are also integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) MODEL POLICY

Around the time Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, was being written, FSMB—the national organization representing and supporting state medical and osteopathic boards—convened a special workgroup charged with updating its model policy in light of the proliferation of telehealth during the pandemic. Representatives from several state medical boards, the American Telemedicine Association, and the AMA participated in the FSMB workgroup, during which the AMA was able to facilitate the inclusion of language consistent with AMA telemedicine/telehealth policy. In April 2022, the FSMB House of Delegates adopted the workgroup's final report which, consistent with AMA policy, affirms that:

- A physician must be licensed, or appropriately authorized, by the medical board of the state where the patient is located.
- The practice of medicine occurs where the patient is located at the time the telehealth technologies are used.
- Physicians who diagnose, treat, or prescribe using online service sites are engaged in the practice of medicine and must possess appropriate licensure in all jurisdictions where their patients receive care.[20]

FSMB's updated model policy permits the practice of interstate telehealth, without the need for licensure in the state where the patient is located, for the following:

- *Physician-to-physician consultations*, which permit physicians licensed in another state to consult with licensed practitioners responsible for diagnosing and treating a patient in the patient's state. Policy H-480.969 similarly supports an exception for physician-to-physician consultations.
- *Prospective patient screening for complex referrals*, which exempts physicians providing specialty assessments or consultations, such as at centers for excellence, from obtaining licenses in the state where the patient is located in order to screen a patient for acceptance of

a referral. FSMB policy specifies that, "If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located." Policy H-480.969 supports an exception for physician-to-physician consultations but does not specifically address prospective patient screening for complex referrals.

- *Episodic follow-up care for established patients*, which permits physicians to provide care while an established patient is temporarily out of the state as long as the physician has sufficient clinical information to provide care that meets the accepted standard of care. Policies D-480.960 and H-480.969 similarly support a continuity of care exception.
- *Follow-up after travel for surgical/medical treatment*, which allows follow-up care via telehealth for patients with rare or severe diagnoses or treatments who have traveled to a medical center in another state to get specialty care and need follow-up care after returning home. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary." Policies D-480.960 and H-480.969 support continuity of care exceptions that are inclusive of follow-up care.
- *Clinical trials*, so that physicians working on clinical trials enabled by telehealth are not precluded from including patients residing in states where the physician is not licensed. FSMB policy stipulates that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical conditions make that necessary." A licensure exception for clinical trials work is not addressed in AMA policy.

A comparison of telehealth licensure exceptions in FSMB policy and AMA policy can be found in Appendix A of this report. Of note, FSMB's model policy includes two exceptions that are not specifically addressed in AMA policy—for clinical trials work, and for prospective patient screening for complex referrals. A clinical trials exception alleviates state licensing barriers that prevent physicians from recruiting patients from outside of the state, potentially increasing trial participation and accessibility.

An exception allowing prospective patient screening for complex referrals recognizes the geographic barriers many patients face in seeking specialty assessments that are not available close to home. Although this exception is limited to screenings for referral, the National Organization for Rare Disorders advocates for a broader expansion of interstate telehealth pathways for rare disease patients, acknowledging that for many rare diseases there are only a handful of specialists nationwide.[21,22]

Preliminary discussions among physicians and other stakeholders, including the AMA, have also begun to explore the potential for a national registry that would allow out-of-state physicians to use telehealth to treat patients enrolled in clinical trials, patients being screened for complex referrals, and new patients with rare and/or life-threatening conditions without obtaining a license in the patient's state. This concept is in the early stages of development and, therefore, its feasibility is unclear.

AMA POLICY

The AMA has numerous telemedicine/telehealth policies as well as model state legislation. Policy D-480.960 was established by Council on Medical Service Report 8-Jun-21, Licensure and Telehealth, along with a follow-up Board of Trustees Management Report. This policy directs the AMA to work with FSMB, state medical associations, and other stakeholders to encourage states to

allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

a. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action;
b. There is a pre-existing and ongoing physician-patient relationship;
c. The physician has had an in-person visit(s) with the patient;
d. The telehealth services are incident to an existing care plan or one that is being modified;
e. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements; and
f. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

A key safeguard included in Policy H-480.946, which was established through Council on Medical Service Report 7-A-14, Coverage and Payment for Telemedicine, stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. Additional longstanding AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods (Policy H-480.969). This policy also delineates exemptions from such licensure requirements for physician-to-physician consultations and in the event of emergent or urgent circumstances, and also allowances—by exemption or other means—for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan (the latter clause was added via Council on Medical Service Report 8-Jun-21, Licensure and Telehealth).

Policy D-275.994 supports the IMLC. Under Policy D-480.964, which was established via Council on Medical Service Report 1-I-19, Established Patient Relationships and Telemedicine, the AMA will work with state medical associations to encourage states to consider joining the IMLC; advocate for reduced application and licensure fees processed through the IMLC; work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services; and support state efforts to expand physician licensure recognition across state lines in accordance with the standards outlined in Policy H-480.946.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 states that our AMA will work with FSMB, and state and territorial licensing boards, to develop licensure guidelines for telemedicine/telehealth practiced across state boundaries. Policy D-480.969 states that our AMA will work with FSMB to draft model state legislation to ensure telemedicine/telehealth is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policies H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-480.963 directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

Policy H-130.941 supports the Uniform Emergency Volunteer Health Practitioners Act. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through

telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. Clinical trials are addressed by numerous policies, including Policies H-460.911, H-460.912, and H-460.965, and Code of Medical Ethics Opinion 7.1.4. The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937.

DISCUSSION

Previous House of Delegates discussions of Council on Medical Service reports on this topic were robust and reflective of the range of physician opinions about appropriate licensure flexibilities that allow telehealth services to be provided across state lines. Consistent with previous work, the Council adopted a balanced approach to policy development that seeks solutions for physicians and patients as well as appropriate guardrails that ensure high quality patient care. The Council continues to believe that there must be clear lines of accountability in licensure to protect patients, and that licensure of physicians and other health professionals should remain within the purview of each state. At the same time, we recognize that AMA policy must keep pace with telehealth innovations that mitigate geographic barriers and enable patients to access medical care that is not available close to home. In developing this report, the Council found that previous calls for national telehealth licensure, which AMA policy opposes (Policy D-480.999), have lessened somewhat, in part because of ongoing concerns about safety and the preservation of states' rights but also in response to increasingly divergent state policies on reproductive health, gender-affirming care, and other health policy issues.[23]

AMA policy already supports streamlining licensure processes and reducing associated costs for physicians; use of the IMLC; state efforts to expand licensure recognition across state lines; interstate telehealth allowances for continuity of care purposes; and additional exemptions for physician-to-physician consultations and in the event of urgent or emergent circumstances. We continue to believe that exceptions allowing cross-state telehealth in common-sense circumstances remain an important pathway for patients and physicians. After reviewing the literature and updated model policies released since the Council's 2021 report, we believe that exceptions are warranted for both physicians using telehealth to prospectively screen patients for complex referrals, and physicians working on and recruiting patients for clinical trials. As with any exception, a physician must have a medical license in good standing in order to qualify. Accordingly, we recommend amending Policy H-480.969[1] to support an exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition. We believe this exemption will alleviate some of the obstacles patients face when seeking specialty assessments for complex and/or rare conditions. If, after the telehealth assessment, the physician agrees to diagnose or treat the out-of-state patient, the patient will need to travel to the physician for treatment. After establishing a treatment plan, incident care that is needed between in-person visits and is appropriate for telehealth may be provided under a continuity of care exception.

The Council also recommends amending Policy H-480.969[1] to support an exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial, as long as the trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy. Further, the Council recommends supporting an exemption for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that: 1) the trial meets certain standards; 2) assessments are not intended to replace care for the

patient outside of the context of the trial; and 3) physicians identify a physician in the patient's state in case in-person care is needed. With recommended guardrails in place, we believe these exemptions will improve the accessibility of clinical trials and increase participation. Lastly, we recommend reaffirmation of Policies D-480.960, which supports a licensure exceptions for continuity of care purposes, and D-480.964, which supports the IMLC and expanded licensure recognition across state lines.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our AMA amend Policy H-480.969[1] by addition to read:

(1) It is the policy of our American Medical Association (AMA) that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

a. Exemption from such a licensure requirement for physician-to-physician consultations.

b. Exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient.

c. Allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.

d. Exemption from licensure requirements for physicians assessing or screening out-of-state patients for acceptance of a referral to a center for excellence or to a physician with specific expertise in the patient's condition, as selected by the referring physician and patient.

e. Exemption from licensure requirements for physicians screening out-of-state patients for acceptance into a clinical trial that meets relevant federal, state, and ethical standards as well as those outlined in AMA policy.

f. Exemption from licensure requirements for physicians conducting assessments of out-of-state patients that are required as part of a clinical trial, provided that:

1. The trial meets relevant federal, state, and ethical standards as well as those outlined in AMA policy;
2. The assessments are not intended to establish or replace care for the patient outside of the context of the trial; and
3. Physicians planning to use telehealth identify a physician licensed in the patient's state to address in-person care needs that may arise from the clinical trial.

~~d~~g. Application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current HOD Policy)

2. That our AMA reaffirm Policy D-480.960, which encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to existing patients if there is a pre-existing and ongoing physician-patient relationship and a previous in-person visit, and the care is incident to an existing care plan or one that is being modified. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-480.964, which encourages states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining the Compact; advocates for reduced application and state licensure(s) fees processed through the IMLC; supports state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in AMA policy; and encourages states to pass legislation enhancing patient access to and proper regulation of telehealth services. (Reaffirm HOD Policy)

Fiscal Note: Minimal

REFERENCES

[1] Federation of State Medical Boards. The Appropriate Use of Telemedicine Technologies in the Practice of Medicine. Report of the FSMB Workgroup on Telemedicine Adopted by the FSMB House of Delegates, April 2022 Available at: https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf
[2] Carol Kane. Preliminary analysis of 2018 - 2024 AMA Physician Practice Benchmark Survey data. Unpublished as of September 1, 2025.
[3] Jolin JR, Richman B, Mehrotra A, and Shachar C. Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives. *The Milbank Quarterly*, Vol. 102, No. 4, 2024. Available at: https://pubmed.ncbi.nlm.nih.gov/39158210/
[4] Jolin JR, Richman B, Mehrotra A, and Shachar C. Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives. *The Milbank Quarterly*, Vol. 102, No. 4, 2024. Available at: https://pubmed.ncbi.nlm.nih.gov/39158210/
[5] Interstate Medical Licensure Compact. Webpage accessed May 2025. Available at: https://imlcc.com/a-faster-pathway-to-physician-licensure/#WhoDevelopedTheCompact
[6] Interstate Medical Licensure Compact. Information Release: IMLCC Data Study Year 8. July 3, 2025. Available at: https://imlcc.com/wp-content/uploads/2025/07/IMLCC__Year8_DataStudy-7-3-2025-FINAL.pdf
[7] *Ibid*.
[8] Federation of State Medical Boards. Comparison of States with Permanent Interstate Telemedicine. Accessed May 2025 from the FSMB Web site. Available at: https://www.fsmb.org/siteassets/advocacy/key-issues/comparison-of-states-with-permanent-interstate-telemedicine.pdf
[9] *Ibid*.
[10] Federation of State Medical Boards. States with Episodic and/or Follow-Up Care Licensure Exceptions. Webpage accessed July 17, 2025. Available at: https://www.fsmb.org/siteassets/advocacy/policies/states-with-episodic-follow-up-care.pdf
[11] Laws of Alaska: Enrolled House Bill 265 (2022). Available at: https://www.akleg.gov/PDF/32/Bills/HB0265Z.PDF
[12] Federation of State Medical Boards. Comparison of States with Permanent Interstate Telemedicine. Accessed May 2025 from the FSMB Web site. Available at: https://www.fsmb.org/siteassets/advocacy/key-issues/comparison-of-states-with-permanent-interstate-telemedicine.pdf
[13] 2024 Alabama Code, Section 34-24-702 Licensure Requirements Available at: https://law.justia.com/codes/alabama/title-34/chapter-24/article-12/section-34-24-702/

[14] 2024 Minnesota Statutes. 147.032 Interstate Practice of Telehealth. Available at: https://www.revisor.mn.gov/statutes/cite/147.032
[15] Federation of State Medical Boards. Comparison of States with Permanent Interstate Telemedicine. Accessed May 2025 from the FSMB Web site. Available at: https://www.fsmb.org/siteassets/advocacy/key-issues/comparison-of-states-with-permanent-interstate-telemedicine.pdf
[16] *Ibid*.
[17] *Ibid*.
[18] *Ibid*.
[19] Interstate Medical Licensure Compact. What does it cost? Webpage accessed July 17, 2025. Available at: https://imlcc.com/what-does-it-cost/
[20] Federation of State Medical Boards. The Appropriate Use of Telemedicine Technologies in the Practice of Medicine. Report of the FSMB Workgroup on Telemedicine Adopted by the FSMB House of Delegates, April 2022 Available at: https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf
[21] National Organization of Rare Disorders. Letter to Chair and Vice Chair of Colorado Senate Subcommittee on Health and Human Services. February 21, 2024. Available at: https://rarediseases.org/wp-content/uploads/2024/02/CO-SB24-141-Support.pdf
[22] National Organization of Rare Disorders. Letter to Chair and Vice Chair of Hawaii House Committee on Finance. March 30, 2023. Available at: https://rarediseases.org/wp-content/uploads/2023/03/Hawai%CA%BBi-SB-674-NORD-Testimony-033023.pdf
[23] Jolin JR, Richman B, Mehrotra A, and Shachar C. Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives. *The Milbank Quarterly*, Vol. 102, No. 4, 2024. Available at: https://pubmed.ncbi.nlm.nih.gov/39158210/

APPENDIX A

Telehealth Licensure Exceptions in Federation of State Medical Boards Policy and AMA Policy

Exceptions in FSMB Policy	Relevant AMA Policy
Physician-to-physician consultation, which permits a consulting physician licensed in another state to consult with a licensed practitioner who remains responsible for diagnosing and treating the patient in the patient's state.	**Policy H-480.969** supports exemption of licensure requirements for physician-to-physician consultations.
Prospective patient screening for complex referrals, which exempts physicians providing specialty assessments or consultations, such as at centers for excellence. FSMB policy specifies that, "If the out-of-state physician agrees to diagnosis, counsel, or treat the patient directly, the patient must travel to the state where the physician is licensed, or the physician must obtain a license to practice medicine in the state where the patient is located."	**Policy H-480.969** supports exemption of physician-to-physician consultations but does not specifically address prospective patient screening for complex referrals.
Episodic follow-up care for established patients, which permits physicians to provide care while an established patient is temporarily out of the state as long as the physician has sufficient clinical information to provide care that meets the accepted standard of care. FSMB policy specifies that, "If the patient is presenting with new medical conditions, the physician may consider directing the patient to receive local care," and "physicians providing care under this exception should also be prepared to make referrals to a hospital or to a local specialist who can step in and assist …"	**Policy D-480.960** encourages states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if: a. The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action. b. There is a pre-existing and ongoing physician-patient relationship. c. The physician has had an in-person visit(s) with the patient. d. The telehealth services are incident to an existing care plan or one that is being modified. e. The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements. f. Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. **Policy H-480.969** supports allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.

Follow-up after travel for surgical/medical treatment, which allows follow-up care via telehealth for patients with rare or severe diagnoses or treatments who have traveled to a medical center in another state to get specialty care and need follow-up care after returning home. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical condition make that necessary."	**Policies D-480.960 and H-480.969** support continuity of care exceptions but do not specifically address follow-up care after patients have traveled to another state for surgical or medical treatment.
Exceptions for clinical trials, which maintains that physicians working on clinical trials enabled by telehealth should not be precluded from including patients residing in states where the physician is not licensed. FSMB policy states that, "Physicians providing out-of-state care under this exception should ensure that their patients have backup plans to receive care locally if changes in their medical conditions make that necessary."	Not addressed in AMA policy.