The State of Telehealth
Implications for interstate licensing.

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Covid is causing seismic shifts in the practice of medicine.

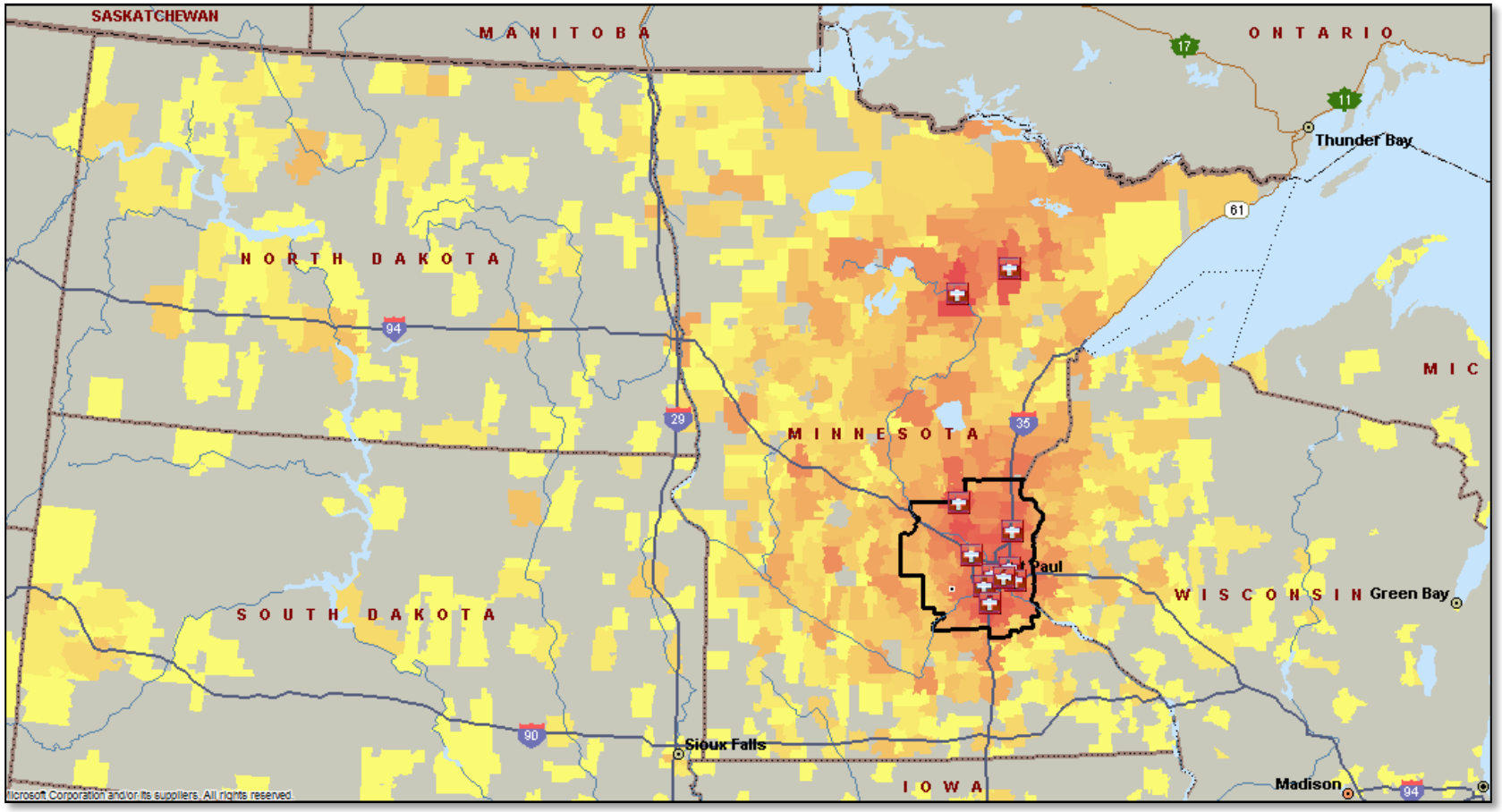
- In the name of safety, technology is upending the typical Doctor patient interaction

- *Many upsides* – convenience, visits available to more visitors (e.g. family)time efficiency, cost.

- *Worrisome downsides* – loss of person to person contact, billing reductions, less satisfaction for physicians, burnout, isolation.

Masonic Cancer Center Catchment

Just over 95% of the cancer patients treated by the combined health system in 2019 lived in the State of Minnesota. In addition, nearly 82% were from the 12 County Primary Service Area (PSA), while 13% were from Greater Minnesota, 3% from Wisconsin, 1% from North Dakota and less than 1% from South Dakota.



2019 Patient Origin

95% - Minnesota
82% - 12 Cty PSA
13% - Greater MN
3% - Wisconsin
1% - North Dakota
>1% - South Dakota

Source: Strata Decision Support, 2019; UMP BI – CSC, 2019 – Unique MRNs by Zip Code

Step 1: The Emergency

- Waivers by State medical boards to allow practice via telehealth regardless of where patient and physician are

U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19

(Out-of-state physicians; preexisting provider-patient relationships; audio-only requirements; etc.)

Last Updated: January 15, 2021

States with Waivers: 41 + GU + CNMI + PR
States with Waivers, not allowing new applications: 2
States without Waivers: 7 + DC + USVI

Step 2: The Retraction

- Even though COVID continues, states pulled back the waiver
  - Protecting their membership?
  - Legitimate medical concerns
  - Input from State Medical Societies?

Step 3: Confusion

- Patients have grown accustomed to it
- Still concerned about travel and crowds

Four paths to reform

- 1. Keep licensing by state, but make it easier to obtain out of state licenses.
- 2. Encourage Reciprocity between states
- 3. License based on the Physicians location, not the patients location
- 4. Federal License to Practice medicine

Mahrotra, Nimgaonkar, Richman. NEJM 2021

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Interstate Medical Licensure Compact

- streamlined licensure process

- agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify.

- Operational since 2017
- Federation of State Medical Boards, Attorneys

Interstate Medical Licensure Compact

mission of the Compact

- increase access to health care – particularly for patients in underserved or rural areas. The Compact makes it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of new medical technologies, such as telemedicine. While making it easier for physicians to obtain licenses to practice in multiple states, the Compact also strengthens public protection by enhancing the ability of states to share investigative and disciplinary information.

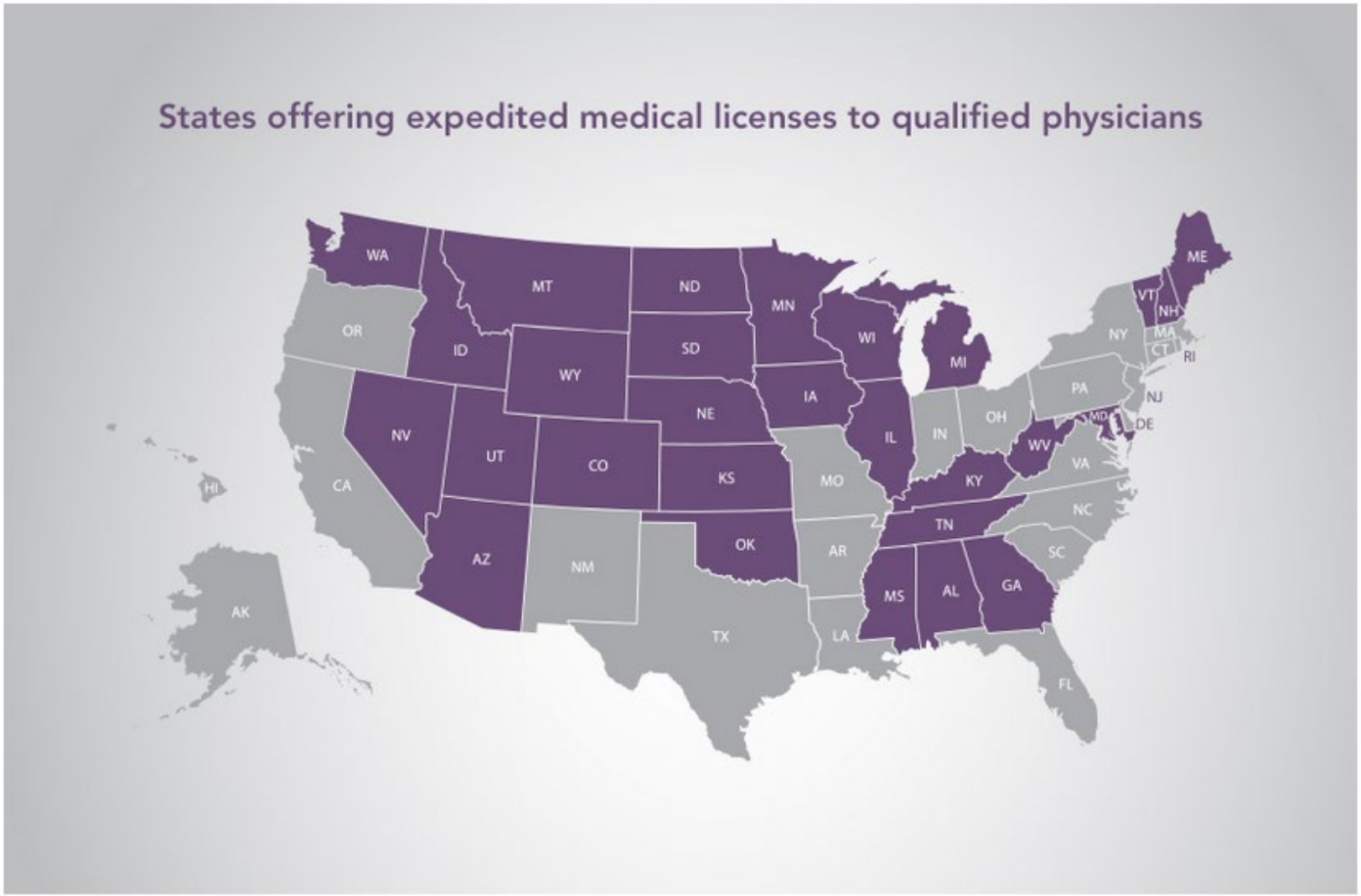
Interstate Medical Licensure Compact

Eligibility

- The first requirement for physicians to participate in the Compact is to hold a full, unrestricted medical license in a Compact member-state that can serve as a declared State of Principal License (SPL). In order to designate a state as an SPL, physicians must ensure that at least ONE of the following apply:
- The physician’s primary residence is in the SPL
- At least 25% of the physician’s practice of medicine occurs in the SPL
- The physician is employed to practice medicine by a person, business or organization located in the SPL
- The physician uses the SPL as his or her state of residence for U.S. Federal Income Tax purposes.

Interstate Medical Licensure Compact States List [and Guide for 2021]

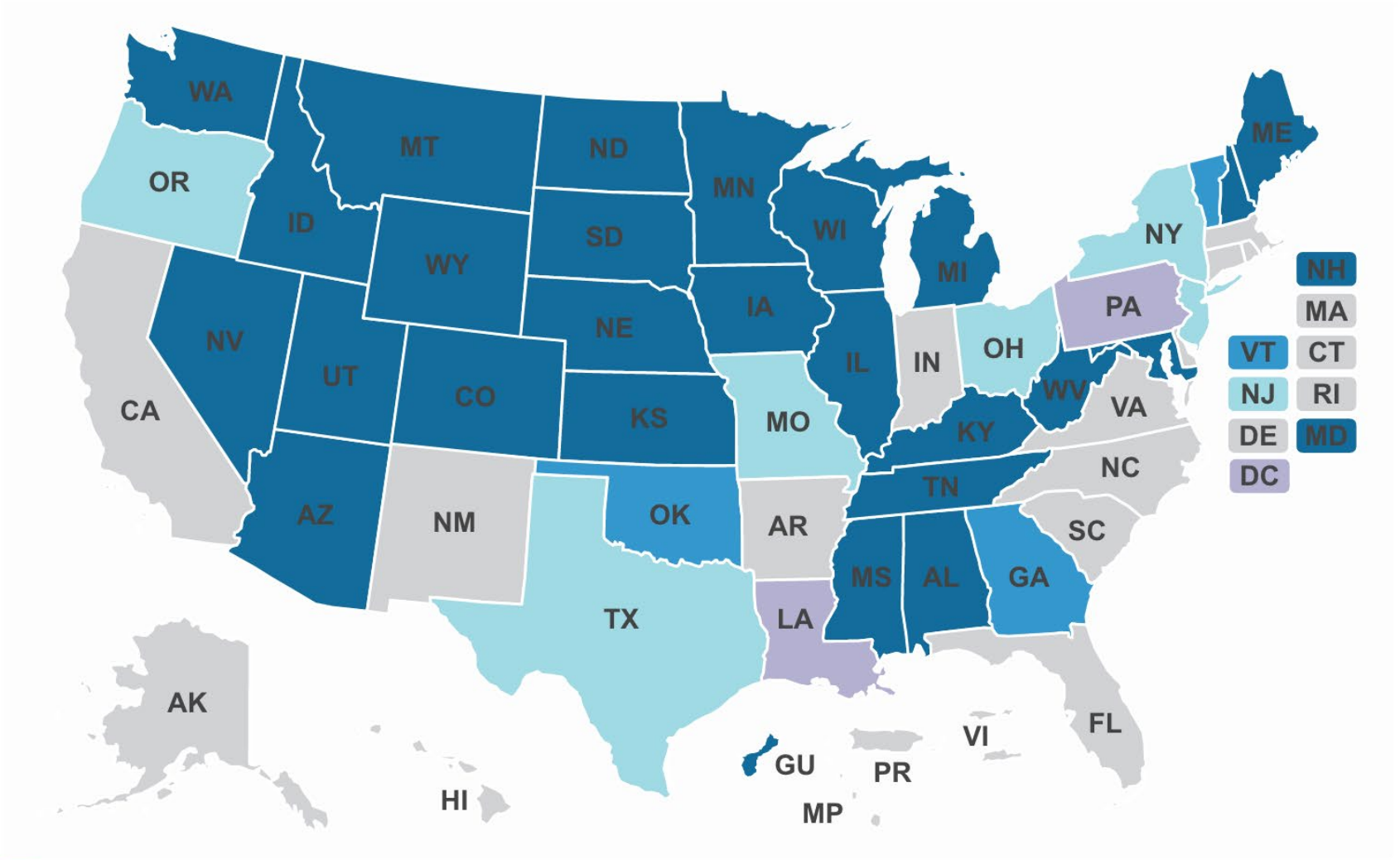
December 11, 2020 2 Min Read



Last updated Dec. 11, 2020 to include Louisiana and Ohio as future compact states.

The Compact 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. Other states are currently in the process of introducing legislation to adopt the Compact.

Participating States



= Compact Legislation Introduced
= IMLC Member State serving as SPL processing applications and issuing licenses*
= IMLC Member State non-SPL issuing licenses*
= IMLC Passed; Implementation In Process or Delayed*

* Questions regarding the current status and extent of these states' and boards' participation in the

From: **The Interstate Medical Licensure Compact Commission: Growth, Success, and the Future**

Journal of Medical Regulation. 2020;106(3):22-26. doi:10.30770/2572-1852-106.3.22

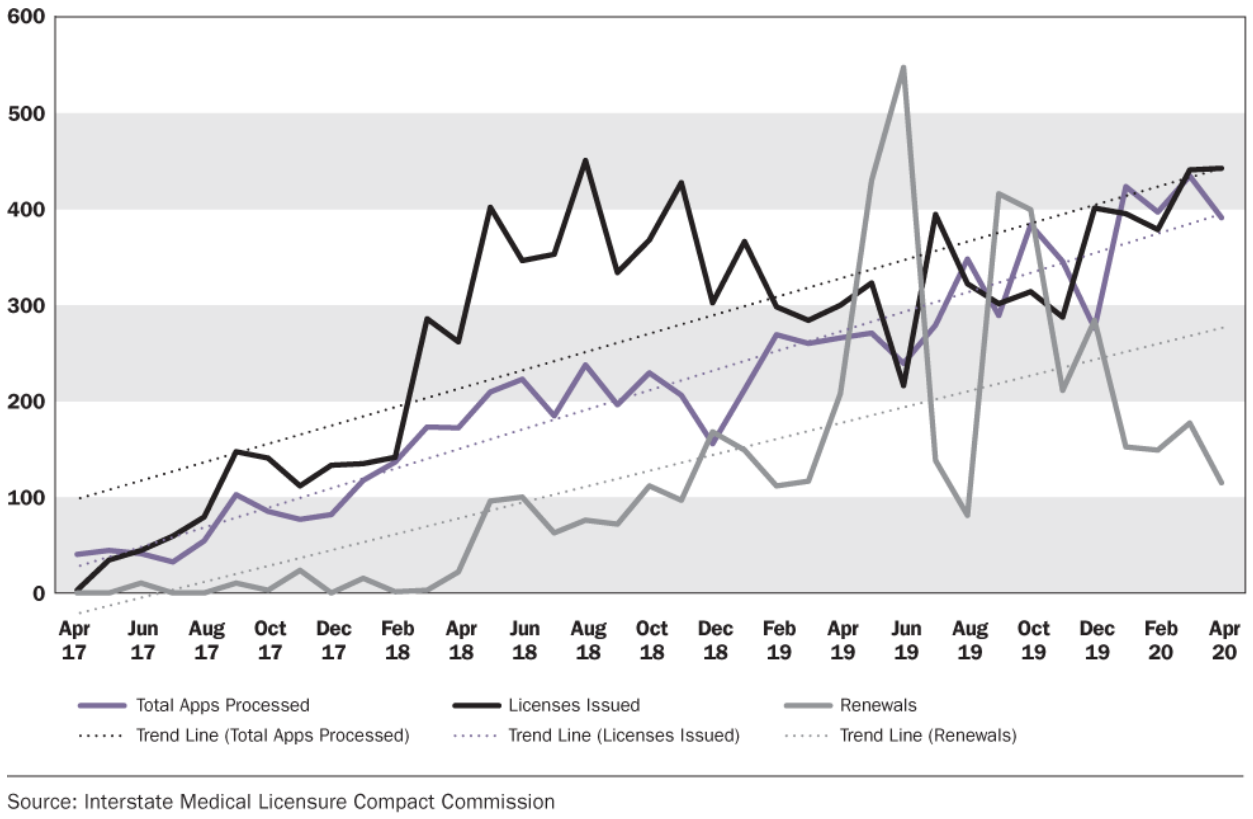


Figure Legend:

IMLCC Applications, Licensing and Renewals 2017–2020 (IMLCC Processing Data)

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Reciprocity for Federal Care

- VA – reciprocity exists
- Tricare – reciprocity exists
- Medicare - No reciprocity

Physicians could use telemedicine for medicare patients in any state

May drive adoption by the private sector

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Where is medicine practiced? Where the doctor is or where the patient is?

- If the doctor is the one needing the license, shouldn’t the license be attached to where the doctor is?

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Federal License

- Logical given federal payment for much of health care
- Impractical for regulation, discipline
- Unwanted competition from out of state providers?
  - Wisconsin- Minnesota example.

AACI Position: Discussion topics

- In what way are Cancer Centers unique in this regard?
- Does AACI want to have a statement / position on this?
- Can major referral centers for cancer. (e.g. MD Anderson, MSKCC, Mayo etc) leverage this to take primary care of patients from multiple states.
- How does this affect Catchment Area and CCSG?


Masonic Cancer Center
University of Minnesota
Comprehensive Cancer Center designated by the National Cancer Institute
Advancing Knowledge, Enhancing Care