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State Legal and Regulatory Barriers to Nationwide Telehealth Expansion

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I. Introduction to the Legal Barriers

There has been a notable uptick in health care and technology providers seeking to implement telehealth services across multiple state markets in a legally compliant, but efficient manner. Given the patchwork of evolving state legal requirements, this task is necessarily informed by the modality through which telehealth services will be furnished and the degree to which a state has reformed its statutory framework governing clinical practice beyond those laws that apply to traditional, brick-and-mortar health care services. While telehealth promises to leverage technology to facilitate access to high quality and efficient health care, state laws are inconsistent in how well they accommodate—by design or silence—the rapid pace of technological advancement. Significantly, many state legislative and regulatory bodies with jurisdiction over the practice of medicine, including state medical boards and clinical licensure bodies, have taken a surprisingly conservative approach in permitting health care to move from the physical to the digital.

Despite these challenges, the telehealth industry has been gaining momentum in obtaining state acceptance of telehealth in its various forms. Notably, state legislatures have adopted definitions of "telehealth" or "telemedicine" that presume that telehealth is a valid means of furnishing care, expanded individual provider licensure requirements and adopted telehealth insurance parity laws that mandate coverage for telehealth services. However, these positive trends that indicate acceptance—and perhaps even promotion—of the expansion of telehealth by state legislatures have been practically constrained by two, arguably underappreciated legal barriers to the expansion of telehealth services across multiple state markets in a uniform manner:

1. ***Requirements to Establish a Patient-Provider Relationship:*** Inconsistencies remain between professional boards responsible for licensure and state legislation promoting telehealth in terms of the level of contact—physical, synchronous or asynchronous—that is necessary to establish a provider-patient relationship and prescribe a course of treatment.

2. ***Telehealth Being Viewed as Complementing, Rather than Supplementing Professional Practice:*** State statutory and regulatory schemes often presume that telehealth is complementing traditional, in-person care, rather than (in many ways) supplanting it in its entirety. This disconnect may be the result of the increasingly incorrect assumption that telehealth services will always be ancillary to in-person care, despite signs of patient

preference to the contrary, or it may be due to simple inaction on the part of legislatures and agencies.

Specifically, many state legislatures have taken steps to create a legislative framework that permits or even facilitates the growth of telehealth in their state. However, when telehealth providers attempt to capitalize on these laws, they often find themselves running up against state medical and pharmacy boards that have taken a more cautious approach to permitting the provision of health care services through telehealth modalities. Through strict application of standards of care or prescribing requirements, these boards have succeeded in effectively limiting entry of more novel telehealth providers into state markets. Following the recent, highly public court case (the *Teledoc* case), state medical boards were admonished of the consequences when they explicitly required that, in all cases, an *in-person* (*i.e.*, physical) encounter occur before telehealth services can be furnished.[1] Despite this case, state medical and pharmacy boards have persisted in restricting—either intentionally or inadvertently—different modalities of telehealth, and, therefore, the further proliferation of complete app-based care.

II. Case Study-Based Examination of Requirements for Establishing a Provider-Patient Relationship

A case study regarding self-administered hormonal contraceptives constitutes a particularly salient example of these legal barriers. Specifically, self-administered hormonal contraceptives are, in many ways, exemplary candidates for prescribing through apps and other asynchronous telehealth modalities. As a general matter, contraceptives pose a unique prescribing case that can be differentiated from that of other prescription drugs for two reasons: (1) contraceptives are not prescribed to treat an illness requiring diagnosis; and (2) where most prescription drugs are subject to concerns regarding overprescribing, public health and welfare principles call for maximizing access to and use of contraceptives. CDC guidelines indicate, therefore, that self-administered hormonal contraceptives can be appropriately prescribed based on patient self-reported information.[2] On the other hand, women's health issues also often draw undue political attention and legislative and/or regulatory scrutiny. Accordingly, when considering application of state legal principles to telehealth services, there is a need to contemplate both the nature of the services being offered and the potential "demand" of the patient from the telehealth encounter.

A. California's "Appropriate Prior Examination" Requirement

California law permits both synchronous and asynchronous telehealth encounters to serve as the basis of establishing a provider-patient relationship.[3] However, California law forbids practitioners from writing prescriptions, unless the provider has performed an "appropriate prior

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[1] Matthew Perlman, *Teledoc Drops Antitrust Suit Against Texas Med Board*, LAW360 (Nov. 30, 2017), *available at* https://www.law360.com/articles/989922/teladoc-drops-antitrust-suit-against-texas-med-board. In the *Teledoc* case, Teledoc, a major telehealth company, argued that the Texas Medical Board's requirement of an in-person examination was an antitrust law violation because it effectively limited the practice of telemedicine to in-state providers, regardless of whether out-of-state providers were appropriately licensed in the State of Texas.

[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, *U.S. Selected Practice Recommendations for Contraceptive Use* (2016), *available at* https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm?s_cid=rr6504a1_w.

[3] CAL. BUS. & PROF. CODE § 2290.5.

examination."[4] In the context of app-based prescribing, the question then becomes whether an "appropriate prior examination" can occur through a telehealth encounter, and, more specifically, through an asynchronous telehealth encounter.

Under California's SB 464, practitioners may write prescriptions for self-administered hormonal contraceptives based on self-reported information obtained through patient surveys.[5] While not entirely explicit, this statute appears to open the door to the inference that an asynchronous telehealth encounter through which certain information was collected could constitute an "appropriate prior examination" for the purposes of contraceptive prescribing. Despite the California legislature's apparent permissiveness towards asynchronous prescribing of contraceptives, a review of California Medical Board disciplinary actions has revealed that the California Medical Board has taken the position that, in order to meet the standard of care, a provider must conduct an initial, medical examination via either in-person or synchronous modality prior to prescribing of *any* drugs, including self-administered hormonal contraceptives.

The result of this apparent disconnect between California statute and state medical board standards is a system in which care that does not result in a prescription (such as preliminary testing) may be performed entirely asynchronously. Any prescribing must be preceded by a synchronous telehealth or in-person encounter, but follow-up care that pertains to the same diagnosis can theoretically be provided asynchronously. As such, a practitioner may prescribe self-administered contraceptives only after performing an in-person or synchronous examination, but may make prescribing decisions with respect to self-administered hormonal contraceptives based off of self-reported information obtained from the patient asynchronously. This complex and inconsistent scheme creates undue burden for both patient and providers that arguably operates in contravention of legislative intent and scientific consensus, and also force the provider to anticipate the treatment demands of the patient in determining how the initial clinical services will be delivered.

B. Strict Interpretation of Standard of Practice Requirements

Utah's telehealth law explicitly provides for the delivery of both synchronous and asynchronous telehealth services.[6] However, the Utah Medical Board has inferred that an asynchronous encounter does not generally adhere to the standards of practice applicable in a traditional health care setting for the establishment of a provider-patient relationship, and that an in-person or synchronous examination must occur to establish a provider-patient relationship before *any* services may be provided.[7] Unlike California, Utah's synchronous encounter

[4] *Id.* §§ 2242, 2242.1(a) 4022.
[5] *Id.* §§ 2242.2.
[6] UTAH CODE ANN. § 26-60-101 *et. seq.*
[7] UTAH ADMIN. CODE r. 156-1-602(6) (proposed July 19, 2018); *Physician Licensing Board Meeting*, Utah Physician Licensing Board (May 17, 2018), https://utah.gov/pmn/sitemap/publicbody/828.html. During the Utah Medical Board's May 17, 2018 meeting, stakeholders from the Utah Medical Association expressed concern that the Telehealth Act does not grant the Division of Occupational and Professional Licensing the statutory authority to promulgate regulations expressly barring the use of asynchronous telehealth to form a provider-patient relationship; however, these same stakeholders noted that the Utah Medical Board could interpret the statutory requirement that telehealth providers "be held to the same standards of practice as those applicable in traditional health care settings" as requiring an initial synchronous encounter in sub-regulatory guidance or enforcement actions. Notably, some

requirement is not limited to care that may result in an order for a prescription drug or diagnostic test.

Utah's Medical Board and legislature appear to align on the prescribing of contraceptives. Utah law permits asynchronous prescribing of self-administered hormonal contraceptives through an "online branching questionnaire" that has been approved by the Board of Pharmacy.[8] In order to prescribe via online branching questionnaire, the telehealth provider, the pharmacy that receives the prescription and the technological intermediary that facilitates the provider-patient interaction must all meet a host of requirements, including specific licensure requirements.[9] Accordingly, despite similar Medical Board concerns, the practical experience in California and Utah is entirely different. While Utah's Medical Board has taken a more cautious approach to telehealth generally than in California, it has accepted the contraceptive services "use case" as not requiring a synchronous patient encounter. Conversely, California is generally more lenient in the provision of telehealth services, which is dependent on the clinical result of the encounter, but has taken a stricter position on contraceptive treatment. Taken together, a telehealth provider is left to grapple with subtle, yet significant differences in the provision of services over telehealth modalities, which is not easily discernable from the applicable statutory framework.

III. Case Study Examination of Telehealth as Being Able to Supplant In-Person Care

State legislative efforts to facilitate the expansion of telehealth often overlook the extent to which state statutes and regulations presume that health care will occur during an in-person visit. Effective promotion of telehealth will, in many cases, require an overhaul of a host of statutes and regulations that govern the practice of medicine because telehealth services will do more than supplement the in-office provision of care. Specifically, state telehealth laws or guidance present three barriers under this rubric: (1) requirements that providers deliver telehealth services at the "same standard" as would apply to such services when performed in person, without clarification regarding whether precise equivalency between in-person and remote services is required or even feasible; (2) requirements, without contemplation of the type of patient information reasonably available to a remote provider, that a telehealth provider review a patient's medical records before delivering telehealth services or issuing a prescription; and (3) requiremenents—due to the prohibition on the corporate practice of medicine—to furnish professional services through a particular practice or entity structure that is not nationally scalable, but complies with specific state laws or guidance.

A. Application of a Common Standard of Care

Utah's telehealth law provides, for example, that "a provider offering telehealth services shall . . . be held to the same standards of practice as those applicable in traditional health care

members of the Utah Medical Board voiced that they could not think of *any* instance in which the standard of care in a traditional health care setting would allow a provider-patient to be formed through an asynchronous encounter. Thus, although the proposed regulations, as currently drafted, do not expressly bar the use of asynchronous telehealth to form a provider-patient relationship, the Utah Medical Board's prior discussions indicate that it will never view asynchronous telehealth as establishing a provider-patient relationship except in limited circumstances.

[8] UTAH CODE ANN. § 58-32-101 *et seq.*; UTAH ADMIN. CODE r. 156-83-306.

[9] UTAH CODE ANN. § 58-32-101 *et seq.*

settings."[10] Despite this edict, telehealth services are more commonly understood to be a unique modality that will never be a perfect analog for brick-and-mortar services. It may provide some advantages over in-person care (*e.g.*, ease of access, facilitation of patient monitoring), and it may fall short of in-person care in other ways. Providers who wish to engage in telehealth in Utah, therefore, are left to wonder what it means for health care to be the same but different: how much and in what ways can telehealth care differ from in-person care before it is deemed to not meet the same standard of practice? Furthermore, telehealth platforms must endeavor to build in features that mimic important aspects of in-person care, while not rending the platform so cumbersome as to lose telehealth's advantages.

In California, a review of disciplinary actions taken against telehealth providers demonstrates both how medical record review and standard of care equivalency requirements that are not explicitly stated in statutes or regulations may, nonetheless, be a source of risk for telehealth providers. Disciplinary proceedings have resulted in telehealth providers being sanctioned for failure to meet the standard of care when providing telehealth services and, in some cases, going beyond the recognized standard of care. For instance, the California Medical Board expressed concern that a provider had not sufficiently verified the identity of patients before writing prescriptions. While not required by statute or regulation, the California Medical Board appeared to take the position that the provider should have required proof of identity, heightened controls to reduce the risk of patients coming back multiple times under new identities, and verification that prescriptions were being delivered to home addresses. Additionally, the California Medical Board has expressed that a provider should have engaged in confirmatory testing prior to prescribing antibiotics for urinary tract infections, expressing concern that patient self-reporting was insufficient for diagnosis in the telehealth context, when such self-reporting would be considered sufficient for diagnoses in a brick-and-mortar setting.

B. Review of Available Medical Records and Patient Information

New Jersey recently also enacted a telehealth law.[11] While this law is, in many ways, intended to facilitate the expansion of telehealth in New Jersey, lack of clarity surrounding provisions that appear to be drafted under the assumption that telehealth services will be ancillary to an in-person relationship create risk for providers. Specifically, the law requires that the telehealth provider "[review] the patient's medical record" to determine whether telehealth services could meet the standard of care for that patient.[12] The law does not clarify what the "medical record" consists of, nor does it describe the type or depth of review contemplated. A provider who sees a patient in a brick-and-mortar facility is not subject to this requirement that they review the patient's medical records before engaging with the patient. Furthermore, providers whose sole or primary interaction with a patient is via telehealth modalities will have access to different information about that patient's medical history than a provider at a brick-and-mortar facility. Because New Jersey's law provides little insight into what is expected of telehealth providers to meet the medical records review requirements, it creates risk for telehealth providers who elect to offer treatment without a prior patient relationship.

[10] *Id.* § 26-60-103(1)(a)(2).
[11] N.J. S.B. S291 (2017).
[12] *Id.* §2(c).

C. Corporate Practice of Medicine

Many states also have what are referred to as "corporate practice of medicine laws." While these laws vary quite a bit from state to state, as a general matter, corporate practice of medicine laws prohibit or limit the ability of corporations to offer or control health care services. Many telehealth providers mistakenly believe that, to provide telehealth services across state lines, they simply need to make sure that they are appropriately licensed in the state in which patients are located. These providers overlook the fact that state corporate practice of medicine laws often presume that care is fixed in place and provided by a local professional practice entity (*e.g.*, a professional corporation or professional limited liability company) that meets state corporate practice of medicine requirements. In such cases, the very corporate structure under which the telehealth provider operates in one state may disqualify it from entering a new state.

New York, for instance, has a particularly strict corporate practice of medicine law, which extends to services rendered by all licensed health care practitioners, not just physicians, and is accompanied by a prohibition on the splitting of fees for health care services between licensed professionals and non-licensed individuals or corporations.[13] Telehealth providers who wish to provide services across state lines in New York may find that they need to form a New York professional practice entity, under the control of a health care professional licensed in the State of New York. Accordingly, New York's corporate practice of medicine laws pose a structural hurdle to out-of-state telehealth providers who seek to deliver care into that state.

IV. Conclusion

As technology has advanced and consensus has grown regarding the potential of technology to improve the efficiency and quality of health care services, state legislatures have passed laws aimed at facilitating the delivery of health care services. While these state laws are an important first step in the acceptance and expansion of telehealth, telehealth providers still encounter barriers to entering new state markets, as state medical and pharmacy boards have been seemingly reluctant to accept that telehealth may meet standards of care. Furthermore, the complex web of state laws that govern the provision of health care services may presume that care is delivered in person, leaving providers to undertake risk in the face of a lack of legal clarity, and sometimes effectively barring the provision of certain telehealth services altogether. Accordingly, failure of the state medical boards and legislatures to take a thoughtful and coordinated approach to governing the provision of telehealth services results in the partial or total loss of some of the biggest benefits that telehealth has to offer.

[13] *Corporate Practice of the Professions*, Report to the New York State Board of Regents (Sept., 1998), *available at* http://www.op.nysed.gov/corp/corppractice.htm.