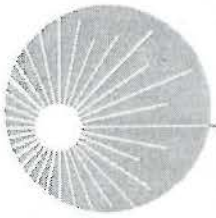
Advancing California's Leadership in Telehealth Policy

A Telehealth Model Statute & Other Policy Recommendations



Center for Connected Health Policy

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Participation in the Work Group and review of this report does not imply endorsement of specific recommendations or the Telehealth Model Statute on the part of any individual or his/her organization.

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About CCHP

Established in 2008 by the California HealthCare Foundation, the Center for Connected Health Policy (CCHP) is a non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system. CCHP conducts objective policy analysis and research, develops non-partisan policy recommendations, and manages innovative telehealth demonstration projects.

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Center for Connected Health Policy

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Executive Summary

In 1996, California passed one of the first telemedicine laws in the country, the Telemedicine Development Act of 1996 (TDA). At its passage, the TDA propelled California into a position of national leadership on telemedicine policy, giving credence to telemedicine as a legitimate means of providing health care services. The original intent of the TDA, as captured in the legislative language below, is as timely today as when it was first written 15 years ago.

> *"The use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care in rural and other medically underserved areas."*[1]

The goals of the TDA—to reduce costs, improve quality, and increase access—are even more urgent today. California faces the 2012 fiscal year with a $25 billion deficit, the latest in a series of fiscally dire budget crises. In addition, California must contend with medical inflation outstripping general inflation,[2] shortages of health care providers, and an unequal distribution of specialists throughout the state.[3] Telehealth technologies can serve as tools to expand the delivery of high-quality, efficient medical care.

The goals of the Telemedicine Development Act—to reduce costs, improve quality, and increase access—are even more urgent today.

This report puts forth a Model Statute, developed by the Center for Connected Health Policy (CCHP). CCHP convened a diverse group of 25 prominent health care professionals to serve on its Telehealth Model Statute Work Group. Over a year's time, Work Group members studied and debated current California policies, available research, and experience from the field, and helped hone recommendations for the Model Statute.

The Model Statute represents a platform for the ideal California telehealth policy environment, and sets aside constraining fiscal, economic, and political considerations. It should be acknowledged that there was not unanimous consensus among the Work Group members on all of the recommendations presented in this report. While this report reflects the Work Group's deliberations, CCHP assumes full responsibility for its content. Work Group members participated as individuals; neither they nor their respective organizations were asked to endorse the policy proposals presented here.

The proposed Model Statute is a revision to California's visionary TDA, which focused on expanding coverage of interactive telemedicine services by private and public insurers. In 1996, policy makers feared patient resistance to telemedicine, on the one hand, and overuse of services on the other. These concerns led to TDA provisions, and subsequent regulations, that have become barriers to the use of telehealth. CCHP's assessment of current telehealth practice, research findings, and other states' policies, found high patient satisfaction with telehealth, and no indication of over-utilization of telehealth services. CCHP concluded that existing policy barriers to the spread of telehealth need to be eliminated.

The Model Statute proposes changes to existing law and key policy areas, where CCHP believes the state has the most leverage to promote telehealth use to the greatest benefit. The statutory changes included in the report update the TDA, by broadening the type of technologies covered, encouraging more consistent payment policies, reducing administrative burdens on providers, and incorporating telehealth into aspects of state workforce laws. There are other policy recommendations made in the report that do not require changes in law, but would aid the state in the quest to expand adoption of telehealth technologies. CCHP encourages policy makers interested in sponsoring legislation to adopt all or portions of the recommendations contained in the Model Statute.

Summary List of Telehealth Model Statute Recommendations

Redefine Telemedicine as Telehealth and Remove Existing Restrictions

1A. Update the term "telemedicine" used in current law to "telehealth" to reflect changes in technologies, settings, and applications, for medical and other purposes.

1B. Include the asynchronous application of technologies in the definition of telehealth and remove the 2013 sunset date for Medi-Cal reimbursement of teledermatology, teleophthalmalogy, and teleoptometry services.

1C. Remove restrictions in the current telemedicine definition that prohibit telehealth-delivered services provided via email and telephone.

2A. Specify that any service otherwise covered under standard contract terms (e.g., covered benefit, medically necessary) must be covered, whether provided in-person or via telehealth.

2B. Eliminate the current Medi-Cal requirement to document a barrier to an in-person visit for coverage of services provided using telehealth.

3. Require private health care payers and Medi-Cal to cover encounters between licensed health practitioners and enrollees irrespective of the setting of the enrollee and provider(s).

4. Remove the requirement necessitating an additional informed consent waiver be obtained prior to any telehealth service being rendered.

Incorporate Telehealth into State Workforce Law

5. Require the Office of Statewide Health Planning and Development (OSHPD) to develop and implement a plan to provide greater visibility for the State Health Workforce Pilot Project (HWPP), and require that OSHPD prioritize HWPP projects that utilize telehealth.

6. Require OSHPD to receive assurances that each program receiving Song-Brown funds includes training on uses of telehealth to expand access to, and increase the efficiency of, needed care; and train prospective health professionals in the use of telehealth technologies, to the greatest extent possible.

7. Require OSHPD to incorporate mechanisms into loan repayment programs that assure that telehealth technologies are being used to expand access to health care to underserved Californians. Certification criteria for approved sites and selection criteria for applicants should reflect the state's desire to maximize the use of telehealth technologies to the benefit of Californians with difficulty obtaining health care.

Other Statutory Recommendations

8. Require telehealth equipment and software vendors who seek to contract with the State of California to show that their products comply with current telehealth industry interoperability standards.

9. Require CalPERS to include telehealth services information in health benefits collateral materials for all beneficiaries.

Other Policy Recommendations

1. Require the state Legislative Analyst's Office to conduct a study to identify the most promising practices using telehealth-delivered care that could benefit Medi-Cal and other state-financed health programs.

2. Require state activities related to Health Information Technology/Health Information Exchange (HIT/HIE) to explicitly include telehealth advocate representation.

3. Require practitioners providing volunteer health services via telehealth to be included in any legislation that allows for malpractice coverage to volunteers providing health services.

4. Require malpractice insurance vendors and professional societies to educate practitioners regarding their options for malpractice coverage for telehealth services.

I. Introduction

In 1996, California passed one of the first telemedicine laws in the country, the Telemedicine Development Act of 1996 (TDA). At its passage, the TDA propelled California into a position of national leadership on telemedicine policy, giving credence to telemedicine as a legitimate means of providing health care services.[4] The original intent in the TDA, as captured in its legislative language below, is as timely today as when it was first written 15 years ago.

> *"The use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care in rural and other medically underserved areas."*[5]

The goals of the TDA—to reduce costs, improve quality, and increase access—are even more urgent today. California faces the 2012 fiscal year with a $25 billion deficit, the latest in a series of fiscally dire budget crises. In addition, California must contend with medical inflation outstripping general inflation,[6] shortages of health care providers, and an unequal distribution of specialists.[7] Telehealth technologies can serve as tools to expand the delivery of high-quality, efficient care.

"The use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care in rural and other medically underserved areas."

Telemedicine Development Act of 1996

Fortunately, thanks to a combination of state, federal, foundation and other investments, California has developed a great deal of capacity to expand telehealth use. For example, the Federal Communications Commission committed $22 million to The California Telehealth Network, which is connecting more than 800 California health care providers in underserved areas to a state and nationwide broadband network dedicated to health care. Also, the five University of California campuses and 40 safety net clinics are participating in a demonstration project to provide specialty care in six key medical specialties, via telehealth technologies, to safety net patients. Telehealth technologies improve access, quality of care, and cost savings in a variety of care settings, to a broad spectrum of patient populations. Examples include:

- Live, two-way interactive videoconferencing that connects the patient, primary care provider and specialist for specialty care collaboration;
- Tele-ICUs, which link provider teams and patients at multiple remote sites through video conferencing to bring timely, highly specialized care to the patient, and support to local clinicians;
- Monitoring systems that help persons with chronic conditions in their home, school, or work place;
- Digital images and structured patient interviews that can be uploaded and transferred to distant medical specialists for consultation;
- Patients and caregivers meeting online with trained facilitators to share solutions for better health and care management;
- A virtual dental home project in California that connects dentists in dental offices and clinics with allied dental personnel working in schools, head start centers, group homes, nursing homes, and community centers, for low-income and underserved populations.

Many of these projects and initiatives have struggled to survive beyond their initial demonstration phase. Reasons include the uncertainty of payment for services, difficulties in developing and sustaining provider networks, the challenge of integrating technology among providers, and lack of training resources.

To help state policy makers assess California's current telehealth policy environment, and identify specific opportunities for change, the Center for Connected Health Policy (CCHP) launched an effort in 2009 to identify policy barriers to telehealth adoption in California. CCHP's work builds on previous efforts by the California Telemedicine and eHealth Center.

CCHP's efforts included:

- Analyzing current California telehealth laws;
- Conducting a scan of state and national literature on telehealth policy;
- Holding key informant interviews of practitioners, industry experts, and other telehealth professionals;
- Reviewing telehealth laws in select leading states.

CCHP's research pointed to the pressing need to review and update the TDA, and to consider new statutes and regulatory changes to encourage more robust adoption of telehealth technologies in California.

In the years since its passage, the TDA has kept pace somewhat with other states—many of which modeled their telehealth laws after it. However, in certain key areas, the California statute has become outdated. Moreover, some components of California law may actually hinder the uptake of telehealth in both the public and commercial sectors, blunting its effectiveness and reach.

Additionally, the March 2010 passage of the federal Patient Protection and Affordable Care Act (ACA) established mechanisms that will put coverage within reach of approximately 94 percent of all Californians. It is estimated that approximately 2 million or more enrollees will be added to the state Medi-Cal program.[8] The need for providing care for so many, in a time of limited resources, was also a consideration for CCHP in its efforts.

Telehealth Model Statute Work Group

These findings prompted CCHP to initiate a process to create a Telehealth Model Statute. In this effort, model legislative language, and the rationale behind it, was developed for state policy makers, in an effort to remove barriers to the use of telehealth as an integral part of the health care system. In addition, CCHP identified policies that would be most likely to promote greater use of telehealth technologies, to maximize their benefit to Californians.

In early 2010, CCHP convened a diverse group of 25 prominent health care and policy professionals to participate in a Telehealth Model Statute Work Group (see Acknowledgements, for a full list of Work Group members).

The Work Group's vision for the Model Statute was two-fold: that it support the integration of telehealth as a tool into health care delivery systems; and that it help reshape California's health care delivery system into a "safe, timely, efficient, equitable, effective, and patient-centered system."[9]

To help state policy makers assess California's current telehealth policy environment, and identify specific opportunities for change, CCHP launched an effort in 2009 to identify policy barriers to telehealth adoption in California.

Work Group members identified three overarching policy goals to support their vision, and to help guide discussions:[10]

1. To create **parity** of telehealth among health care delivery modes;
2. To actively **promote** telehealth as a tool to advance stakeholders' goals regarding health status and health system improvement;
3. To create **opportunities and flexibility** for telehealth to be used in new models of care and in system improvements.

Work Group members analyzed and debated a set of wide-ranging proposals for the Model Statute. CCHP staff and consultants developed recommendations based on Work Group discussions. It should be acknowledged that there was not unanimous consensus among Work Group members on all of the recommendations presented in this report. While

this report reflects the Work Group's deliberations, CCHP assumes responsibility for its content. Work Group members participated as individuals; neither they nor their respective organizations were asked to endorse the policy proposals presented here.

This Model Statute reflects the findings from CCHP research and the best thinking of policy experts and practitioners. It represents a statutory framework for an ideal California telehealth policy environment, and sets aside constraining fiscal, economic, and political considerations. Policy makers interested in sponsoring legislation may wish to adopt all or portions of the recommendations contained in the Model Statute.

This report contains 13 policy recommendations, nine for inclusion in a Telehealth Model Statute, and four others that CCHP found to be worthy of inclusion, but not appropriate for a Model Statute. Each policy recommendation includes a supporting rationale, for a full understanding of the thinking behind the recommendation. Where applicable, Medicare policy is noted, as are approaches taken in other states.

The report and its recommendations are organized as follows:

- Section II presents the revisions to the TDA, focusing primarily on financial incentives and informed consent;
- Section III incorporates telehealth into state workforce law;
- Section IV contains two additional statutory recommendations to promote interoperability of technology and consumer education;
- Section V contains the four recommendations not included in the Model Statute. These issues can be addressed in other legislation, regulations, or practice;
- A set of three Appendices, which includes The Work Group's Charter, suggested legal language for the Telehealth Model Statute, and a glossary of terms in the report.

II. Redefine Telemedicine as Telehealth and Remove Existing Restrictions

This section includes recommendations that update the TDA by redefining "telemedicine" as "telehealth," and removes other restrictions to its use in existing state law. California law and Medi-Cal regulations contain barriers to the state garnering the fullest possible benefit from telehealth. While these restrictions served a purpose in 1996, when use of telemedicine was relatively new, they have become outdated and cumbersome. Fifteen years later, telemedicine use has not resulted in increased health care expenditures, and consumers have been as satisfied or more satisfied with technology-supported services, when compared with usual care. In fact, recent studies have found that new telehealth applications such as remote patient monitoring have reduced overall costs, and improved health outcomes for target populations.[11]

Model Statute Definition of Telehealth

Telehealth is a mode of delivering health care services and public health that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients, at a distance from health providers. Telehealth allows services to be accessed when providers and patients are in different physical locations, facilitates patient self-management and caregiver support for patients, and includes synchronous and asynchronous interactions.

Another concern at the time of the TDA's passage was that local delivery systems and economics would be harmed by telemedicine.[12] That did not occur. In fact, local communities benefited from telehealth because patients did not have to travel for specialty services. Rather, such services could be received using telehealth, allowing primary care and other services to be maintained in their respective communities.[13] Additionally, local providers gained support and learned new skills from distant clinicians, which would then benefit future local patients.[14]

CCHP recommends that the state set policy, through statute, that allows greater flexibility to integrate new technologies into health care delivery and payment mechanisms. Health care providers working within their scope of practice should have the ability to choose the most appropriate method of delivering health services to their patients. Telehealth is simply another option of treatment that should be available for the practitioner to use. Removal of barriers in existing law and regulation and easing payment restrictions will encourage the greater use of these modalities, resulting in more efficient and effective use of all services, whether provided in-person or virtually.

Recommendation 1A

Update the term "telemedicine" used in current law to "telehealth," to reflect changes in technologies, settings, and applications, for medical and other purposes.

Rationale

Under current law, "'*telemedicine' means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes 'telemedicine' . . . 'interactive' means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.*"[15]

This definition restricts the statute to medical care and education using interactive technologies. It does not fully

reflect advances in technologies that allow for their use outside of traditional clinical settings. Telehealth is valuable for public health surveillance and delivery, patient and caregiver education/support, and other non-medical uses. The proposed Model Statute definition of telehealth is meant to accommodate changes in technology, health services, and payments. It is intended to be broad and encompassing, and emphasizes that telehealth is a **means of delivery** or set of tools. Coverage or reimbursement is tied to specific services, and telehealth should be viewed as one option for delivering services. Further, services delivered via telehealth should be broadly viewed to include the full range of health-related services, for example, dental and behavioral health.

The proposed telehealth definition allows for new models of care, and new varieties of interaction between clinicians and patients. Telehealth facilitates collaborative care management when patients, providers, and other caregivers are in different locations. This definition also allows for health care services to take place outside traditional provider schedules. With store and forward technologies, for example, a primary care provider (PCP) sends digital images and other medical information electronically to a specialist. The specialist reviews the information and sends the PCP an initial consult (also electronically) without having to set up an appointment with the PCP or the patient.

Recommendation 1B

Include the asynchronous application of technologies in the definition of telehealth and remove the 2013 sunset date for Medi-Cal reimbursement of teledermatology, teleophthalmalogy, and teleoptometry services.

Rationale

Current California law creates confusion among payers and providers, because of its imprecise language and differing coverage requirements across payers. This is particularly true in the legal treatment of store and forward, or asynchronous, applications.

The Business and Professions Code is unclear as to the meaning of *"near real time (asynchronous) two-way transfer of medical data and information,"*[16] and thus is subject to different interpretations. As evidence began to show improved patient access to specialists utilizing store and forward technologies, the Welfare and Institutions Code was amended to allow Medi-Cal reimbursement for teleophthalmology and teledermatology.[17]

In 2009, the definition of teleophthalmology and teledermatology store and forward services was expanded to include optometrists trained to diagnose and treat eye diseases.[18]

However, reimbursements for these services have a sunset date of Jan. 1, 2013. The original sunset date has been extended twice, with AB 354 (Cogdill) in 2005, and AB 2120 (Galgiani) in 2008.[19] Both the extension and expansion are recognition of the merits of these services and therefore should be permanently codified.

Store and Forward (Asynchronous) Technologies

These technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos.

Data is collected, or stored, at one site, by an originating provider. The data is then sent electronically, or forwarded, to a specialist, who evaluates the data, and provides an assessment and/or treatment recommendations to the originating provider, without the need for the patient to be present.

Under the Welfare and Institutions Code, telemedicine reimbursement is *"subject to reimbursement policies developed by the Medi-Cal program."*[20] Medi-Cal currently limits what is reimbursable for store and forward to specific specialties.[21] These restrictions have had an impact on other payers in California. Several private payers now follow the same coverage rules as Medi-Cal.[22] However, many additional specialties lend themselves favorably to this technology. For example, CCHP's Specialty Care Safety Net Initiative includes 40 California safety net clinics, which receive asynchronous services from University of California providers in dermatology, endocrinology, hepatology, orthopedics, and

psychiatry. Failing to cover store and forward technologies restricts consumers' timely access to necessary care.

Store and forward applications allow more flexibility in data assembly and review than interactive sessions with patients. Many providers report that this flexibility is more convenient for patients, as well as providers, and may be more cost effective than other telehealth technologies, or in-person visits.[23] Expanding the use of store and forward services could increase access to specialists and alternative therapies for rural and underserved populations, and allow providers to more easily seek input on complex cases from specialists. Including asynchronous applications of technologies in the legal definition of telehealth recognizes technological advances that allow important diagnosis and treatment recommendation to be made without the patient being present.

Medicare and Other States' Policies

Medicare allows payment for services provided through store and forward in demonstration programs in Hawaii and Alaska.[24] Additionally, Medicare allows payment for some services provided through store and forward technologies, but does not explicitly identify them as "telehealth." For example, the largest single specialty providing remote services is radiology. The use of telecommunications in delivering pathology, cardiology, physician team consultations, and other services in a manner similar to store and forward, is also reimbursed by Medicare.[25]

Medicaid programs in Arizona, Georgia, Wisconsin and Minnesota all cover the use of store and forward technologies, regardless of the service provided. Arizona and Georgia reimburse for store and forward use in all specialties.[26, 27] Wisconsin requires providers to submit a state plan for telehealth, and become certified to provide the service, while Minnesota treats store and forward consults the same as video conferencing, but limits coverage to no more than three consults per enrollee per week.[28]

Recommendation 1C

Remove restrictions in the current telemedicine definition that prohibit telehealth-delivered services provided via email and telephone.

Rationale

The TDA excluded the use of the telephone or email from the definition of "telemedicine."[29, 30, 31] At the time, reasons behind this policy varied. Some feared rampant fraud and abuse; others thought it too cumbersome to define what would constitute a reimbursable service. Medi-Cal and some private payers do not include telephone and email services. However, there are a growing number of private payers that do reimburse for such services.

Both patients and providers benefit from reduced travel and wait times, and communication does not have to be limited to time-certain appointments. Surveys have shown that patients have an increased desire to be able to communicate with their providers through email, and the positive impacts this would have on patient outcomes, patient-provider relationships, and efficiency.[32]

With advancements in smart-phone technologies, where video consultations could take place via a phone call, providers need the flexibility to utilize these technologies and be compensated for them.

This recommendation supports removing these restrictions for the purposes of:

- Keeping pace with rapid technological advancements;
- Reducing bias among providers to use certain technologies because they are reimbursed and others are not;
- Providing flexibility when equipment fails.

In expanding the legal definition of telemedicine to telehealth, policy shifts from a limiting, narrow focus on interactive video consultations to services provided remotely by various telecommunications technologies. The proposed legal changes aim to focus payers' coverage decisions on the service delivered, not on the tools used to deliver that service. Payers may of course prescribe parameters, for example, regarding what constitutes a phone or e-mail visit.

Recommendation 2A

Specify that any service otherwise covered under standard contract terms (e.g., covered benefit, medically necessary) must be covered, whether provided in person or via telehealth.

Recommendation 2B

Eliminate the current Medi-Cal requirement to document a barrier to an in-person visit for coverage of services provided using telehealth.

Rationale

Similar to the preceding recommendations, the central policy premise behind these recommendations is that providers working within their scope of practice should have the ability to choose the most appropriate method of delivering health services to their patients. These two proposed changes in California law are intended to make clear that telehealth is a mode of care delivery, and as such, should be treated similarly to other proven modalities. The proposed Model Statute provisions provide a framework for telehealth payment policy that is broad enough to encompass new technologies as they develop, and avoids placing telehealth at a disadvantage by imposing administrative documentation requirements. The first provision is more direct than the current statute, which prohibits payers from requiring in-person contact in the provision of a health care service.[33] Current statute wording, *"appropriately provided though telemedicine,"* which can be used by payers to limit coverage,[34,35] is eliminated. Replacing the current TDA coverage requirements with a more direct, comprehensive provision will reduce confusion and uncertainty for both providers and consumers over coverage and payment for telehealth services. Although coverage for specific services may vary by payer, a clearer and more consistent policy context concerning the delivery of those services through telehealth should lead to increased provider and consumer adoption of these tools.

The second proposed provision recommends removal of a Medi-Cal regulation that requires providers to justify the use of telehealth-delivered services. Under this regulation, providers must complete a separate form explaining why the patient cannot receive services in person, thus necessitating the use of telehealth tools.[36] While Medi-Cal could eliminate this regulatory requirement, it has not done so, and CCHP recommends it for inclusion in statute to ensure its removal.

The regulation is administratively burdensome and, at least initially, led to significant payment delays, as telehealth claims were "flagged" for separate review. This discouraged use of telehealth services. Some claimants may not have submitted billing claims at all for telehealth services, given the associated costs of doing so. This defeats a key purpose of the required documentation, as Medi-Cal could be hindered in tracking and assessing use of telehealth services. According to Medi-Cal staff, it appears that Medi-Cal telehealth documented claims to date are likely underestimated.[37]

Other States' Policies

This recommendation is similar to a statute in the State of Maine, which reads, *"A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health services provided through in-person consultation."*[38] The state of New Hampshire modeled the language used in its telehealth coverage bill after the Maine law.[39]

Recommendation 3

Require private health care payers and Medi-Cal to cover encounters between licensed health practitioners and enrollees irrespective of the setting of the enrollee and provider(s).

Rationale

Payer limits on the setting where services delivered by telehealth must occur (provider offices, clinics, etc.) greatly curtail the use of technology. Inconsistent payer restrictions

on care settings for telehealth have led to confusion among providers regarding coverage. As long as quality standards for a service are met, the physical location of the patient and provider should not matter.

This provision gives discretion to the provider, who as the licensed health care professional, is ultimately responsible for the care of the patient. It is intended to acknowledge:

- The great advantage of telehealth to be able to take services to where the patient is located;
- The importance of telehealth delivery in urban as well as rural settings.

The TDA does not place limits on originating sites, except that they be licensed: *"Facilities located in this state including, **but not limited to** clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law."* (Emphasis added.)[40] Also, the TDA does not mention specifically that services should be limited to rural areas.

Telehealth Site Definitions

Distant or hub site(s) refers to the location(s) of the provider delivering a medical service using telehealth.

Originating or spoke site refers to the location of the patient or referring PCP.

Despite the flexibility in state law, some private payers in California use the same originating site restrictions for payment as Medicare,[41] limiting coverage to areas outside Metropolitan Statistical Areas (MSAs) and requiring services to be provided in a limited set of facilities. The Medicare facilities are:

- Practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural health clinics
- Federally Qualified Health Centers (FQHCs)
- Skilled Nursing Facilities (SNFs)
- Hospital-based renal dialysis centers
- Community mental health centers[42]

Medi-Cal does not restrict payment to originating sites based on geography or urban/rural designations, but has a more limited site list than Medicare. The Medi-Cal handbook lists as originating sites:

- Physician or practitioner offices
- Critical Access Hospitals (CAHs)
- Rural health clinics
- FQHCs[43]

In addition to allowing for a more expanded list of licensed sites, this provision would allow providers and patients to deliver and receive care from other locations, such as the home. Unlike some commercial payers, Medi-Cal prohibits providers from rendering telehealth services from their homes.[44] This has resulted in some Medi-Cal providers, notably those offering store and forward services, refusing to provide telehealth services to Medi-Cal beneficiaries.[45] This provision will ensure that Medi-Cal patients have access to telehealth services that is comparable to commercial plan enrollees.

Other States' Policies

Two other states have taken similar approaches to the proposed Model Statute provision. Oregon offers a list of originating sites, but eligible sites are not limited to what is listed. New Mexico offers a list of originating sites that is more extensive than Medi-Cal, but not as broad as Oregon.

Oregon's 2009 telemedicine law defines "originating site" as the physical location of the patient receiving a telemedical health service, **including but not limited to:**

- Hospital
- Rural health clinic
- FQHC
- Physician office
- Community mental health center
- SNF
- Renal dialysis center
- Sites where public health services are provided

The law further states that a plan may not distinguish between originating sites that are rural and urban in providing coverage.[46]

In addition to those sites allowed in the Medi-Cal program, New Mexico's Medicaid program authorizes the following originating sites:

- All hospitals
- Community mental health centers
- School-based centers
- Indian health and tribal 638 facilities
- Ambulatory surgical or treatment centers
- Residential treatment centers
- Home health agencies
- Diagnostic lab or imaging centers
- Rehabilitation or other therapeutic health settings
- Eligible recipients' residences[47]

Several other states, including Minnesota and Kansas, provide Medicaid coverage for telehealth services in the home, or "telehome" care.[48] Again, if the focus is on the service provided, the location of the provider or patient should not matter.

Recommendation 4

Remove the requirement necessitating an additional informed consent waiver be obtained prior to any telehealth service being rendered.

Rationale

Current California law requires a provider to obtain a signed patient consent form prior to any delivery of telemedicine health care services, regardless of the service being rendered.[49] This separate informed consent is solely applied to services provided using telemedicine, and is not related to any privacy, security or health services informed consent law on the state or federal level. Medicare does not impose this requirement.

Written when the TDA was first placed into law, this restriction was a precaution to appease lawmakers wary of telemedicine's safety. Today, with nearly two decades of experience in a variety of telehealth technologies, the additional patient consent requirement is redundant, inefficient, and burdensome. If an informed consent requirement does not exist for in-person services, it should not be required for telehealth services. Informed consent would still be required when providing services via telehealth if that same service requires informed consent when delivered in person.

III. Incorporate Telehealth into State Workforce Law

State workforce policies are important levers for increasing telehealth use in California. Professional licensure and scope-of-practice laws define what services health care professionals can provide. How California trains its health care workforce in its universities, and community-training programs shapes how care is provided, both now and in the future. While the TDA did not specifically address these issues, clarifications and modifications to existing workforce laws would enable the state to more fully realize the promise of telehealth technologies.

The Work Group considered statutory provisions to change state-based professional licensure, scope of practice, training, and loan repayment programs. The Work Group deferred discussions of licensure issues related to telehealth to the Federation of State Medical Boards. The Federation is exploring approaches to facilitating telehealth-delivered services across states. This section outlines recommendations for policy changes governing pilot programs to test scope-of-practice changes, a state-funded training program, and state-administered loan repayment programs. These programs are administered by the Office of Statewide Health Planning and Development (OSHPD), a department of the California Health and Human Services Agency.

Recommendation 5

Require Office of Statewide Health Planning and Development (OSHPD) to develop and implement a plan to provide greater visibility for the State Health Workforce Pilot Project (HWPP), and require that OSHPD prioritize HWPP projects that utilize telehealth.

Rationale

The increasing availability of telehealth technologies allows less-trained health care personnel to deliver health care services, with the support of more highly trained health personnel, in separate locations. This offers opportunities to expand timelier, and often higher quality, health care services to all Californians. While technology, and California's statutory and legal construct, extend the reach of personnel such as physicians and dentists, state scope of practice laws for allied health professionals limit the possibilities of telehealth.

Established in 1972, the State Health Workforce Pilot Project (HWPP) permits the safe and supervised testing of new staffing approaches to delivering health care, to inform the Legislature about promising scope of practice changes.[50] Without the program, it was difficult if not impossible to test a new approach without violating the practice act. Also, it appeared that numerous entities were trying new approaches but their efforts were not coordinated. State officials saw that a great deal of local resources were being wasted on small projects, with limited experimental value. By designing a statewide process to consider waivers and experimentation on a larger scale, scope of practice changes could be more efficiently and safely tested.

California is the only state in the nation to have such a mechanism. Given its past successes, the promise of new technologies to support new models of health care delivery, and the availability of new federal funding for health IT workforce pilot programs, the Legislature should revitalize HWPP. In HWPP's history, 75 of the more than 100 successfully completed projects have led to changes in scope of practice law, policy or regulation.[51] Over the last 10 years, however, the program has been comparatively inactive, and many legislators are unaware of its existence.[52]

Revitalizing HWPP could not come at a better time. ACA has made federal funds available for new models of primary care, which will expand access to Americans underserved by current health care systems.

For example, federal funds will be available for expanding the use of alternative health care providers to operate community health centers in medically underserved areas. U.S. Health and Human Services Secretary Kathleen Sebelius recently announced the release of $15 million for the operation of nurse-managed health clinics. Such centers provide comprehensive primary care services to medically underserved communities.[53] However, according to the Nurse Practice Act in California, nurses must work in collaboration with physicians and have a written "standardized procedure" document on file detailing any practice restrictions or limitations required by the physician.[54] Through HWPP, pilot programs could be conducted to assess training needs and test the effectiveness of telehealth-aided collaboration models. Nurse-run clinics could be equipped with telehealth technologies that support more complex primary care cases than community clinics currently handle, and would have access to currently unavailable specialty care. HWPP provides a powerful vehicle for California to test and adapt different models, using telehealth technologies to meet some of California's most pressing access and efficiency needs.

Other States' Policies

Colorado, New Mexico, and Alaska have been experimenting with telehealth to expand scopes of practice for allied health professionals. Colorado expanded nurse practitioner scope of practice to allow larger caseloads of chronic heart failure patients, using at-home telehealth tools for vital sign monitoring, video visits, and patient education.[55]

New Mexico is training community health workers, supervised via telehealth technologies by University of New Mexico medical specialists, to increase access to services for communicable and chronic diseases in remote areas of the state. The state also established a new process to review scopes of practice for health care professionals, recognizing that advances in technology and changes in citizen demand for health care make many proposed changes necessary and beneficial.[56]

The Alaska Community Health Aide Program addresses the oral health needs of Alaska Natives in rural settings with a Dental Health Aide Program. The program provides a University of Washington primary care curriculum, which emphasizes community-level dental disease prevention. The curriculum incorporates innovative public health preventive and clinical strategies, including telehealth.[57]

Recommendation 6

Require OSHPD to receive assurances that each program receiving Song-Brown funds includes training on uses of telehealth to expand access to, and increase the efficiency of, needed care; and train prospective health professionals in the use of telehealth technologies, to the greatest extent possible.

Rationale

The state Song-Brown Program provides more than $7 million annually to primary care training programs in areas of California with poor access to health care, providing residents and students with experience in increasing access to medically underserved communities. The Song-Brown Health Care Workforce Training Act was passed by the California Legislature in 1973 to encourage program graduates to practice in designated underserved areas of California. Named for the co-authors of the Act, then-Assemblymember Willie Brown and then-Senator Alfred H. Song, it has expanded the training programs of family practice residents and primary care physician assistants. Later amendments added funding for osteopathic family physician and family nurse practitioner programs.[58]

The program has a large impact on primary care training in California. It funds 27 of the state's 38 family practice residency training programs; seven of the 22 family nurse practitioner programs; six of 10 physician assistant programs; and 34 of the 134 registered nurse programs in California.[59] Song-Brown is an excellent vehicle to promote the use of telehealth in addressing access barriers.

Recent national assessments of primary care training programs found that they often fail to give trainees experience using the equipment and care models that are needed to succeed in today's primary care practice settings.[60] Telehealth technologies make co-management among specialists, primary care providers and patients themselves possible. Use of these technologies decreases providers' feeling of isolation and disconnection from mainstream medicine when caring for underserved populations.[61] Trainees often cite provider isolation and the lack of medical support, compared to academic medical institutions, as reasons for their deciding not to practice with underserved populations. Thus, including these technologies in training programs is important, to show trainees how primary care functions can be more effectively supported, through the use of technology.

OSHPD should consider giving higher priority for funding to primary care programs that partner with specialty training programs using telehealth technologies, to help address access needs in specialty areas experiencing the greatest unmet need (e.g., neurology, endocrinology, and dermatology).[62]

Recommendation 7

Require OSHPD to incorporate mechanisms into loan repayment programs that assure telehealth technologies are being used to expand access to health care to underserved Californians. Certification criteria for approved sites and selection criteria for applicants should reflect the state's desire to maximize the use of telehealth technologies to the benefit of Californians with difficulty obtaining health care.

Rationale

The State of California, with support of federal matching funds, operates loan repayment programs for health professionals[63] who agree to a two- to four-year post-training service commitment in medically underserved areas. The programs receive $1 million per year in federal funds, but in September 2010 received an additional $2 million under the American Recovery and Reinvestment Act of 2009. The state currently requires that sites hosting health professionals offer a "comprehensive system of care."[64] To be considered comprehensive, sites should be encouraged to implement telehealth to the greatest extent possible, to help support providers in expanding health care services into underserved areas.

California continues to experience a shortage in PCPs, and long wait times for specialists, especially among rural residents, the uninsured, and Medi-Cal beneficiaries[65, 66] State and federal loan repayment programs have been in use since the early 1970s, to help attract newly trained providers to where they are most needed. As described in the prior recommendation, health personnel shortages and distribution problems require actions that will support professionals in settings with limited resources. Given the promise of telehealth for forming virtual multidisciplinary teams and providing access to vast resources for consults and other services, California should use its loan repayment programs to encourage the use of telehealth.

By assuring that sites and providers are equipped and trained to use telehealth, the loan program would increase the likelihood that providers stay in underserved areas beyond the repayment period and specialists continue to partner with clinicians serving the underserved. Telehealth programs have been found to reduce the sense of isolation and improve professional satisfaction among community health providers. Such programs are being seen as key to retaining health care providers in isolated and resource-poor areas.[67]

IV. Other Statutory Recommendations

Two additional Model Statute recommendations are proposed that are not found in current law. The first relates to the need for interoperability of telehealth equipment and software, so that data can be readily exchanged among telehealth devices, as well as with electronic health records (EHRs). The second would require the California Public Employees' Retirement System (CalPERS) to provide educational information to its enrollees about telehealth.

Recommendation 8

Require telehealth equipment and software vendors who seek to contract with the State of California to show that their products comply with current telehealth industry interoperability standards.

Rationale

As the use of technology in health care, epitomized by the drive towards implementation of EHRs and health information exchanges, becomes more pervasive, the need for that technology to be interoperable is crucial.

Different systems and equipment must be able to communicate with each other on several levels. Hardware or equipment interoperability allows one piece of machinery to transmit data to another; software interoperability permits access in two or more different operating systems. California, as a prudent steward of public funds, should ensure that all telehealth equipment purchased by state entities be interoperable. The state should require that any vendor who wishes to contract with California be able to show that their telehealth products comply with industry interoperability standards.

California has a history of working towards interoperability of systems. In 2002, the California Public Safety Communication Act included language defining the statute as one that *"strives for interoperability of a statewide integrated public safety communication system."*[68] As with the interoperability of its public safety communication system, California needs to ensure that as it implements health care reform, all parts of the health care delivery system will be able to interact. The results will reduce costs and avoid waste of valuable and scarce state resources.

The telehealth industry in general complies with industry standards. There are a few vendors however, that develop and market products that are "proprietary" and unable to communicate/exchange data with similar units manufactured by competing vendors. Technology is also ever changing, as new discoveries are made, and products created. It is important that vendors adhere to industry standards and not market propriety equipment. Recognizing these hurdles, the Work Group acknowledged the difficulty in achieving complete interoperability, but members also recognized its importance as well. With a purchaser as large as the State of California insisting on proof of interoperability prior to purchase, the marketplace may increase efforts to reach that goal.

Recommendation 9

Require CalPERS to include telehealth services information in health benefits collateral materials for all beneficiaries.

Rationale

Californians overall are unfamiliar with telehealth, and the benefits it can offer. For example, telehealth services can help a patient avoid travel time to visit a specialist, or schedule an appointment at an earlier or more convenient time due to a greater choice of accessible doctors.

As the largest purchaser of health care services in the state, CalPERS should include information on telehealth services in its enrollment and benefits materials. By doing so, CalPERS will serve as a model to other health coverage programs in educating their members.

While a broad-based statewide telehealth education effort would be ideal, such a project may not be feasible in the current fiscal climate. However, in addition to the CalPERS distribution, the state also could consider using federal grants for telehealth education. For example, a $3.4 million federal consumer assistance grant awarded to California in 2010[69] will go to the Department of Managed Health Care, which is partnering with the California Office of the Patient Advocate to help consumers navigate their health care coverage.[70] If permissible, such funds should also be used to educate consumers on telehealth.

V. Other Policy Recommendations

This section includes four policy recommendations that are not proposed for the Model Statute, but would accelerate uptake of telehealth services. These recommendations may be implemented through separate statutes or regulations, or through the marketplace.

Recommendation 1

Require the Legislative Analyst's Office to conduct a study to identify the most promising practices using telehealth-delivered care that could benefit Medi-Cal and other state-financed health programs.

Rationale

Commercial payers and Medicare have demonstrated innovative approaches in using telehealth technologies to create new models of care. These programs have provided ample evidence to support the Institute of Medicine's aims for the nation's health care delivery system—that it be safe, timely, efficient, equitable, effective, and patient-centered. An analysis by the California Legislative Analyst's Office (LAO) for legislative and executive branch leadership could identify priorities for Medi-Cal with respect to technologies, populations, and geographies. Such a report could lay the groundwork for the California Department of Health Care Services to plan for a strategic deployment of telehealth services statewide.

Recommendation 2

Require state activities related to Health Information Technology/Health Information Exchange (HIT/HIE) to explicitly include telehealth advocate representation.

Rationale

California's eHealth landscape currently has a broad spectrum of planning and infrastructure programs taking place in state and other public/non-profit sectors. The California Health and Human Services agency notes on its website that:

> *Achieving electronic health information exchange (HIE) through the application of health information technology (HIT) is one of the cornerstones of the overall healthcare reform strategy in California. Effective application of HIT and the implementation of interoperable HIE are key strategies to achieve the goals of better health care outcomes, efficiencies in the delivery of healthcare, and strengthening our emergency and disaster response preparedness.*
>
> *The California Health and Human Services Agency (CHHS) serves as the lead agency on HIE and HIT issues for the State. CHHS works with the State Chief Information Officer (OCIO), the Department of Managed Health Care, the Business, Transportation and Housing Agency and others to oversee the State's HIE and HIT related efforts.*[71]

Given the integral role telehealth can play in the state's health care delivery system—which is becoming increasingly reliant on technology, and will see a huge influx of patients under health reform—planning and infrastructure programs should explicitly include telehealth considerations in all appropriate areas. The Secretary of CHHS and other program leaders should include telehealth in their eHealth goals, and ensure that telehealth representatives play meaningful roles in eHealth project activities.

Recommendation 3

Require practitioners providing volunteer health services via telehealth to be included in any legislation that allows for malpractice coverage to volunteers providing health services.

Rationale

In 2010, Senator Ellen Corbett, (D-San Leandro), authored SB 1031, which would have created the Volunteer Insured Physicians Program. The program, which would have been administered by the California Medical Board, would have provided malpractice coverage to volunteer physicians for uncompensated care to patients in qualified health care entities. SB 1031 failed to pass out of committee during the legislative session.

Allowing retired practitioners to volunteer their time from clinics or from home, using telehealth technologies, could help alleviate the workforce dilemmas discussed in this report's Introduction and Workforce sections. However, when practitioners retire, they typically allow their malpractice insurance to lapse. Even if a practitioner has coverage, it may be an additional expense to extend that coverage to volunteer activities.

Current California law only provides malpractice protection for volunteer physicians who render care in specific situations, such as emergency care at a college or high school athletic event.[72,73] Additionally, there is no specific protection for those physicians who provide volunteer services via telehealth. A program like the one proposed by SB 1031 could be an incentive for physicians to volunteer their services.

SB 1031 only covered services offered by a primary care physician. Telehealth is uniquely positioned to offer access to specialty services and other types of health care professionals. Should a bill like SB 1031 be introduced in a future legislative session, malpractice coverage for all telehealth practitioners, including physicians, advanced practice registered nurses, dentists, and optometrists should be included.

Other States' Policies

Many states provide charitable immunity protection and/or malpractice insurance programs for volunteer physicians. As of early 2009, 43 states had some form of protection for volunteer physicians in non-emergency circumstances, such as non-profit organizations, free clinics, government entities, etc.[74]

Recommendation 4

Require malpractice insurance vendors and professional societies to educate practitioners regarding their options for malpractice coverage for telehealth services.

Rationale

Malpractice coverage is available through commercial carriers for services provided via telehealth. However, CCHP research and anecdotal evidence points to a disconnect between what providers think they can have covered, and what malpractice insurers understand telehealth services to be.

Work Group members provided valuable insights from their own experiences with their respective carriers. Some members noted that they had to explain to their carriers what telehealth was, but were readily able to obtain coverage. The fact that carriers needed to be educated on the specifics of telehealth is an indicator of its under-utilization. Further, the fact that providers were uncertain about their ability to obtain coverage indicates a need for education on both sides. By requiring malpractice insurance vendors to inform practitioners of their options, providers would be educated and the insurance vendors would need to become educated on what they will be offering in their coverage.

VI. Conclusion

California established early national leadership in telehealth policy, with passage of the Telemedicine Development Act of 1996. In the ensuing years, little has changed in state law. Major developments in technology, broadband availability, and health care applications have expanded the potential of telehealth to assist with California's current health care challenges. With the passage of national health care reform—and the commensurate increase in public and private coverage—California has an exciting opportunity to again become a national leader in telehealth policy.

By extending the reach of health care providers, telehealth can help to increase access to health care for all Californians, improve quality of care, make the health care delivery system work more efficiently, and provide opportunities for greater self-management for patients.

For telehealth to reach its full potential as an integral part of our state's health care system, current law needs to be updated, and new statutes and regulations put into place. Restrictions deemed useful and prudent in 1996 are no longer necessary today. With more than a decade's worth of experience and data showing that telehealth is both safe and effective, it is time for the removal of all barriers to its adoption and use.

The recommendations in this report will help California achieve these goals, and once again take a leadership role and serve as a model for the nation.

Telehealth Law History

The history of California telehealth law begins with the Telemedicine Development Act of 1996 (TDA). This statute forms the foundation for state telehealth law.

The TDA prohibits health plans and health insurers, public and private, from requiring face-to-face contact between patient and provider for services appropriately provided through telemedicine. This includes Medi-Cal, the state's Medicaid program. However, it excludes provider-patient contact by telephone or e-mail.

State law also specifically requires Medi-Cal to cover tele-ophthalmology and tele-dermatology services via store & forward technology.

Subsequent telehealth legislation in California, for the most part, has amended and extended provisions of the original TDA.

1996

Telemedicine Development Act of 1996, SB 1665 (Thompson, M.), Chapter 864, Statutes of 1996

1. Defines "telemedicine" as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications;
2. Prohibits, as of Jan. 1, 1997, health plan contracts or health insurance policies from requiring face-to-face contact between providers and patients for services appropriately provided by telemedicine, subject to all terms and conditions of the contract or policy, except that health plans and insurers are not required to pay for consultations provided via telephone or fax;
3. Extends health plan and insurer prompt payment and claims processing requirements, and the related procedures health plans and insurers must have in place, to telemedicine;
4. Requires telemedicine services to be considered in determining compliance with the access to care standards imposed on health plans under the Knox-Keene Health Care Service Plan Act of 1975;
5. Prohibits until Jan. 1, 2001, for purposes of Medi-Cal, and subject to federal financial participation, a requirement of face-to-face contact for services otherwise covered by the Medi-Cal program, and appropriately provided through telemedicine, subject to billing and reimbursement policies developed by the California Department of Health Services (DHS);
6. Extends the face-to-face prohibition to Medi-Cal contracting health plans only to the extent that both of the following apply: a) Telemedicine services are covered by, and reimbursed under, the Medi-Cal fee-for-service program; and, b) Medi-Cal managed care plan contracts are amended to add coverage for telemedicine services and to make any appropriate capitation rate adjustments;

7. Requires the Medi-Cal program to pursue private or federal funding to conduct an evaluation of the cost-effectiveness and the quality of telemedicine services provided in Medi-Cal;
8. Requires health care providers, as defined, who have ultimate authority over the care or diagnosis of a patient, to obtain the written informed consent of patients prior to providing telemedicine services, except in an emergency where a patient cannot give consent, as specified. Specifies that information about risks and benefits of telemedicine must be provided verbally to patients, guarantees patients access to all medical information transmitted during a telemedicine consultation, and defines as unprofessional conduct the failure of a health care provider to obtain informed consent for telemedicine;
9. Exempts from California physician licensing laws physicians outside of California when in actual consultation within the state, or or when consulting across state lines with a physician licensed in California. States that the Act shall not be construed as altering the scope of practice of any health care provider; and,
10. Makes legislative findings and declarations related to the potential for telemedicine to address major challenges in health care access, costs and quality.

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1997

SB 922 (Thompson, M.), Chapter 199, Statutes of 1997

1. Clarifies that neither an electronic mail message nor a telephone consultation are included in the definition of telemedicine;
2. Revises the telemedicine informed consent requirements, including allowing a patient's legal representative to provide verbal and written consent. Eliminates the guarantee to patients of all medical information transmitted during a telemedicine consultation, and instead specifies that existing patient access to medical information and medical records apply to telemedicine consultations.

1998

AB 2780 (Gallegos), Chapter 310, Statutes of 1998 Budget trailer bill

1. Sets standards for the audio and visual telemedicine systems and equipment used for telemedicine services covered by Medi-Cal so that, at a minimum, the systems have the capability to meet the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes and the equipment meets specified quality standards;
2. Revises the TDA to include a definition of "interactive," as used in the definition of telemedicine, defining it as an audio, video, or data communication involving a real time (syncronous) or near real time (asynchronous) two-way transfer of medical data and information.

2000

AB 2877 (Thomson, H.), Chapter 93, Statutes of 2000 Budget trailer bill

- Eliminates the scheduled 2001 end date for telemedicine coverage in Medi-Cal, which was originally contained in the TDA, and makes permanent Medi-Cal coverage for telemedicine.

2002

AB 442 (Committee on Budget), Chapter 1161, Statutes of 2002 Budget trailer bill

- Requires California DHS to allow psychiatrists to receive fee-for-service reimbursement for telemedicine services in Medi-Cal until June 30, 2004, or until the state Department of Mental Health develops a reimbursement method for psychiatric services in Medi-Cal that is feasible for mental health plans, primary care providers, and psychiatrists providing the services, whichever is later.

2003

AB 116 (Nakano), Chapter 20, Statutes of 2003

- Applies the informed consent provisions of the TDA to dentists, podiatrists, psychologists, marriage and family therapists, and clinical social workers.

2005

AB 354 (Cogdill), Chapter 449, Statutes of 2005

- Extends the prohibition against the requirement of face-to-face contact between a health care provider and a patient for Medi-Cal to "store and forward" teleopthamology and teledermatology services, from July 1, 2006 to Jan. 1, 2009.

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2007

AB 329 (Nakanishi), Chapter 386, Statutes of 2007

- Authorizes the Medical Board of California (MBC) to establish a pilot program to expand the practice of telemedicine, and to implement the program by convening a working group. Specifies the purpose of the pilot program to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases, and delivering other health information. Requires MBC to make recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program.

AB 1224 (Hernandez), Chapter 507, Statutes of 2007

- Applies the informed consent provisions of the TDA to optometrists.

AB 234 (Eng), Chapter 586, Statutes of 2007

- Provides that no more than 125 hours of experience providing psychotherapy services via telemedicine may count toward the 3,000 hours of experience required to receive a Marriage and Family Therapist license.

2008

AB 2120 (Galgiani), Chapter 260, Statutes of 2008

- Extends until Jan. 1, 2013 Medi-Cal coverage for teleopthamology and teledermatology, via store and forward technologies.

2009

AB 175 (Galgiani), Chapter 419, Statutes of 2009

- Includes within the definition of teleopthamology and teledermatology store and forward services for Medi-Cal coverage consults by optometrists who are trained to diagnose and treat eye disease.

Center for Connected Health Policy

Telehealth Model Statute Frequently Asked Questions

1. *What is telehealth/telemedicine?*

- Telehealth is the use of digital technologies—such as telecommunications, health information, and videoconferencing—to deliver medical, health education, and public health services, by connecting multiple users in separate locations.

- Telehealth encompasses a broad definition of technology-enabled health care services. This definition includes telemedicine, which is the diagnosis and treatment of illness or injury. Telehealth services consist of diagnosis, treatment, assessment, monitoring, communications, and education.

- Telehealth is another tool utilized by health care professionals to provide the best possible treatment to patients.

2. *What are some of the uses of telehealth?*

Telehealth medical services are delivered in three main ways:

- **Live video conferencing**, which is used for real-time patient-provider consultations, provider-to-provider discussions, and language translation services. For example, primary care providers and patients in remote, rural communities can receive specialty care from urban medical center specialists, via a secure, high-quality video hookup.

- **Store and forward technologies**, which electronically transmit pre-recorded videos, digital images such as X-rays and photos, and electronic copies of test results, between primary care providers and medical specialists. For example, primary care providers can take photos of patient skin conditions, and email the photos and test results to dermatologists, via a secure, high-speed network; the dermatologists, in turn, can review the case at their convenience and email back diagnoses and treatment plans.

- **Patient monitoring**, in which electronic devices transmit patient health information to health care providers. For example, patients with chronic conditions, such as diabetes, can check their vital signs with "smart" monitoring devices, which automatically deliver the information to their health care providers, via a secure, high-speed network; providers, in turn, can stay in close contact with their patients, keeping them healthy and avoiding costly medical services.

3. *Why does the current law need to be updated?*

- California's Telemedicine Development Act of 1996 (TDA) was groundbreaking legislation. However, the TDA needs to be updated, to accommodate technology advances in health care over the past 15 years, encourage more consistent payment policies, reduce administrative burdens on providers, and incorporate telehealth more fully into state workforce laws.

- We now know that telehealth improves access to care and quality of care, and increases efficiencies in health care delivery. Modernizing the TDA will provide California with a platform for innovation in telehealth, and move us once again to the forefront nationally in this important health care arena.

4. ***How does telehealth improve access for patients and providers?***

- Telehealth increases access to care for patients in medically underserved communities, both urban and rural—care that otherwise might not be obtainable.

- Telehealth helps remove socioeconomic barriers to care, such as families missing work/pay to travel to provider offices, families not having access to affordable transportation, or having to pay for child care to accommodate travel time.

- Telehealth makes more effective use of limited specialist time because specialists can use telehealth to assess patient conditions before in-person visits.

- Telehealth reduces the isolation of providers in remote areas by providing a means of consulting with distant specialists, while also offering those providers educational opportunities.

5. ***How does telehealth make services more cost-efficient?***

- Telehealth patient monitoring programs help keep patients with chronic diseases healthy, and avoid unnecessary medical costs, such as hospitalizations and nursing home care.

- Hospital-based telehealth specialty programs, which connect community hospitals with major medical centers, improve patient outcomes and lower the cost of treatment.

- Telehealth services can lower the need for patient transportation and provider travel.

6. ***Is the quality of care in telehealth as good as an in-person visit?***

- Numerous studies have shown that the quality of telehealth services equals or exceeds that of in-person consults.

7. ***How are resources kept in the community with telehealth?***

- By not traveling to see specialists, patients and their resources remain in their own communities.

- Telehealth programs allow local hospitals and clinics to perform services, such as lab tests and x-rays, that they otherwise would lose to specialists in other communities.

- Community hospital telehealth specialty programs, which connect local facilities with major medical centers, keep patients in their communities for treatment, instead of requiring transfers to other medical centers.

8. ***Is telehealth vulnerable to fraud and abuse?***

- Fraud and abuse can be found in all areas of California's health care system. However, after 15 years of experience in California with the TDA, there has been no indication that fraud is any more pervasive in telehealth services than with in-person services.

- Efforts on the federal level, such as the joint efforts of the Department of Justice (DOJ) and Health and Human Services through the Health Care Fraud Prevention & Enforcement Action Team (HEAT), are providing models on how to combat fraud and abuse for all components of the health care system.

- There are no indications in Medicare that telehealth is more susceptible to fraud and abuse than health services delivered in-person.

American Psychological Association

Practice Directorate, Legal & Regulatory Affairs

Telehealth 50-State Review

March 2010

State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
ALABAMA	No	Yes (Code of Ala. §34-24-500) - Physicians must hold a full license or Special Purpose License to practice across state lines - Licensed out-of-state physicians must apply for a Special Purpose License - Term "telehealth" not used		No	Class C Misdemeanor (Code of Ala. §34-26-42): - Required $100-500 fine - No possible imprisonment
ALASKA	No	No		Yes (12 AAC 60.035) - May practice psychology for no more than 30 days in a 12-month period - A psychologist may only request this once during his/her lifetime - Must apply for license exemption in advance	Class B Misdemeanor (Alaska Stat. §08.86.210; §12.55.035; §12.55.135) - Possible fine up to $2000 AND/OR - Possible imprisonment up to 90 days
ARIZONA	Yes (A.R.S. §36-3601, 36-3602, 36-3603) - Psychologists are included under the definition of "health care providers" who may practice telemedicine - Statute not drafted by the Arizona Psychology Board	Yes (A.R.S. §36-3601, 36-3602, 36-3603) - The term telemedicine is defined and may be practiced within the state by various "health care providers" - However, health care providers must practice telemedicine through the Arizona Telemedicine Network, which is run by the University of Arizona Health System - With limited exceptions, patients		Yes (A.R.S. §32-2073) - May not exceed 20 days per year - Does not appear to require an application for exemption in advance - The client, public, or consumer must be made aware that the psychologist is not licensed in the state	Class 2 Misdemeanor (A.R.S §32-2084, §13-707; 13-802) - Possible fine up to $750 AND/OR - Possible imprisonment up to 4 months

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
		must provide verbal or oral consent before telemedicine procedures may be performed			
ARKANSAS	No	Yes (A.C.A. §17-95-206) - Any out-of-state physician performing care on an in-state patient must hold an Arkansas medical license - Does not use the terms telehealth or telemedicine		No	General Misdemeanor (A.C.A. §17-97-301) - Required $500-$1000 fine - No possible imprisonment
CALIFORNIA	Yes (Cal. Bus & Prof Code §2904.5) - Statute explicitly includes psychologists under the "licentiate" definition, and telemedicine statute applies to the profession - Statute not drafted by the California Psychology Board	Yes (Cal. Bus & Prof Code §2290.5) - Statute defines telemedicine - Applies to activities between patient and practitioner - Practitioner must be licensed in CA for statute to apply - Requires licentiate to acquire verbal and written consent from patient - Exemptions for emergency situations		Yes (Cal. Bus & Prof Code §2912) - Licensed out-of-state psychologists may practice for a period not to exceed 30 days in California - Statute does not include a pre-registration requirement	General Misdemeanor (Cal. Bus & Prof Code §2970) - Possible fine up to $2000 AND/OR - Possible imprisonment up to 6 months
COLORADO	No	Yes (C.R.S. §12-36-106; § 25.5-5-414) - Statute includes "the delivery of telemedicine" as an action falling under the practice of medicine - Accordingly, a physician must hold an in-state license to use telemedicine procedures - Definition and legislation intent		No	Class 2 Misdemeanor (first-offense) or Class 6 Felony (subsequent offense) (C.R.S. §12-43-226) Class 2 Misdemeanor: - Required $250-$1000 fine or 3-12 months imprisonment or both Class 6 Felony: - Required $1k-$100k fine

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
		of telemedicine provision expressed (25.5-5-414)			- Required 12-18 months imprisonment
CONNECTICUT	No	No		No	General Misdemeanor (Conn. Gen. Stat. §20-193) - Possible $500 fine AND/OR - Possible imprisonment up to 5 years
DELAWARE	No	No		Yes (24 Del. C. §3510) - Licensed out-of-state psychologist may practice for no more than 6 days per calendar year - Statute does not require advanced registration	General Misdemeanor (24 Del. C. §3520) - Required $500-$1000 fine for first offense - Required $1000-$2000 fine for subsequent offense AND/OR - Possible imprisonment up to 1 year for each violation
DISTRICT OF COLUMBIA	No	No		Yes (CDCR 17-4014; CDCR 17-4007) - Licensed out-of-state health professionals may be granted a temporary license or certificate by reciprocity from the board regulating the occupation - Licensure requirements in the home state must be "substantially equivalent" to the requirements in the District - Valid for 90 days - Boards may also issue written temporary licenses to an individual when "necessary to protect the health and welfare of	As of March 2010, the preexisting D.C. Code provisions regulating psychologists have been repealed and appear to be under revision.

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
				the citizens of the District" - To qualify under this, an individual must be (i) an applicant from another jurisdiction applying for licensure by reciprocity or endorsement or (ii) an applicant who has meet all qualifications for a license and has applied to take the next scheduled licensure examination - Also, valid for 90 days	
FLORIDA	No	No	See Board's opinion dated 06/05/06 stating that teletherapy constitutes practice of psychology requiring Florida licensure http://www.doh.state.fl.us/mqa/psychology/Petitions/DOH_06-0976.pdf	Yes (Fla. Stat. §490.014) - Licensed out-of-state psychologist may practice for no more than 5 days in any month and no more than 15 days in any calendar year - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Florida - No advanced registration requirement	1st Degree Misdemeanor (Fla. Stat. §490.012; §775.082; §775.083) - Possible fine up to $1000 AND/OR - Possible imprisonment up to 1 year
GEORGIA	Yes (Ga. Comp. R. & Regs. r. 510-5-.07) - Provision stipulates that psychologists practicing through electronic transmission must meet the same legal and ethical standards as if providing	Yes (O.C.G.A. §43-34-31) - Any out-of-state physician performing care on an in-state patient must hold an Georgia medical license - Does not use the terms telehealth or telemedicine	See § 510-5-.07(2) of Georgia Rules Of State Board Of Examiners Of Psychologists-- http://rules.sos.state.ga.us/docs/510/5/07.pdf)	Yes (O.C.G.A. §43-39-7) - Licensed out-of-state psychologist may practice for no more than 30 days in any calendar year - Licensure requirements in the home state of the psychologist must be equivalent to or exceed	General Misdemeanor (O.C.G.A. §43-39-19) - Required $100-$1000 fine AND/OR - Possible imprisonment up to 12 months

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
	services in person - This standard applies to psychologists who are licensed in Georgia and to psychologists residing outside of the state that provide services to patients located in-state.			the licensing requirements in Georgia - At least 5 days advanced registration requirement (§510-0-.03)	
HAWAII	No	Yes (HRS §453-1.3) - Allows for the use of telemedicine by physicians only - To establish a physician-patient relationship with a patient located in Hawaii, the physician must hold a valid Hawaiian medical license		Yes (9) - Licensed out-of-state psychologist may practice for a period not to exceed 90 days in any calendar year - Must petition the board for a temporary permit in advance - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Hawaii	General Misdemeanor (HRS §465-15) - Possible fine up to $1000 AND/OR - Possible imprisonment up to one year
IDAHO	No	Yes (Idaho code §54-1705; §54-1723A) - Idaho allows telepharmacy practices by in-state licensed pharmacists and out-of-state licensed pharmacists who first register with the state board - Statute defines the practice of telepharmacy across state lines to when a patient is located within the state and pharmacist is located outside the state		Yes (Idaho code §54-2305) - The Board has the power to adopt rules allowing for out-of-state licensed practitioners to practice in the state for a period not to exceed 30 days - Does not mention advanced registration requirements	General Misdemeanor (Idaho Code §54-2310) - Possible fine up to $1000 AND/OR - Possible imprisonment up to 6 months

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ILLINOIS	No	Yes (§225 ILCS 60/49.5) - Telemedicine statute for medical profession – not for psychologists - Doctor practicing telemedicine must be licensed in Illinois - Defines telemedicine practices which do NOT include: periodic consultations between licensed IL doctor and out-of-state patient, and second opinions - Statute explicitly subjects an out-of-state violator to the jurisdiction of IL state courts		Yes (§225 ILCS 15/11.5) - Licensed out-of-state psychologists may practice for up to 10 days in the state per year - Must apply for temporary authorization in advance	Civil Penalty (225 ILCS 15/16.5) - Required civil penalty fine not to exceed 10k for each offense
INDIANA	No	Yes (Burns Ind. Code Ann. §25-22.5-1-1.1) - Providing diagnostic or treatment services to in-state patients through electronic communications is included in the practice of medicine and requires an in-state medical license - Statute does not use the terms telemedicine or telehealth		Yes (Burns Ind. Code Ann. §23-33-1-4.5) - Licensed out-of-state psychologists may receive a temporary permit for not more than 30 days every 2 years - Must apply in advance for the permit	Class A Misdemeanor (Burns Ind. Code Ann. §25-33-1-15; 35-50-3-2) - Possible fine up to $5000 AND/OR - Possible imprisonment up to 1 year
IOWA	No	No	** Iowa has created a state-run telecommunication network to more efficiently coordinate communications on state government matters (751 IAC 1.1 (17A, 8D) ** This network is accessible to various	Yes (645 IAC 240.8 (154B)) - Licensed out-of-state psychologists may practice for a period not to exceed 10 consecutive business days or 15 business days in any 90 day period - Must file a summary of	"Serious" Misdemeanor (Iowa Code §147.86) - Statute silent as to fine and/or imprisonment penalties for committing this infraction - Iowa Psychology Board may impose civil fine up to $1000 (645 IAC 242.3)

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
			professionals, including psychologists (751 IAC 7.11 (8D))	intention with the board beforehand - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Iowa	
KANSAS	No	Yes (K.A.R. §100-26-1) - Services rendered to in-state patients must be performed by physicians holding a Kansas medical license - This includes electronic communications made to patients - However, out-of-state physicians may provide oral, written, or electronic communications to in-state patients provided these services are incidental to lawfully performed services - Statute does not use the terms telemedicine or telehealth		Yes (K.S.A. §74-5316a) - Licensed out-of-state psychologists may practice for no more than 15 days per year - Practitioners may request an additional 15 days when good cause is shown for the additional time period - Must submit an application and receive board approval before practicing	Class A Misdemeanor (K.S.A. §74-5341; §21-4502; §21-4503a) - Possible fine up to $2500 AND/OR - Possible imprisonment up to 1 year
KENTUCKY	Yes (§KRS 319.140) - Applicable telehealth provision for psychologists - Defines telehealth as the use of audio, video, or other electronic means to deliver health care - Requires informed consent by patient and confidentiality measures	Yes - Identically worded telehealth provisions exist for many other health professions, such as: Physicians (KRS §311.5975); Chiropractors (KRS §312.220); Dentists (KRS §313.255); Nurses KRS §314.155)		Yes (KRS § 319.015) - Licensed out-of-state psychologists may practice for no more than 30 days every 2 years - Must register with the board beforehand	General Misdemeanor (KRS §319.990) - Possible fine up to $500 AND/OR - Possible imprisonment up to 6 months

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
	- 201 KAR 26:215 (Section 5) allows an out-of-state licensed psychologist to practice via telephonic or electronic methods on in-state patients after receiving board approval				
LOUISIANA	No	Yes (La. R.S. §37:1276.1; §37:1271) - Statute grants in-state licensed physicians the right to practice telemedicine in the state - Licensed out-of-state physicians may also practice telemedicine if they apply for a telemedicine license in Louisiana - Telemedicine license holders agree to not open an in-state office, to not meet with Louisiana patients, and to not receive calls in Louisiana from patients		Yes (La. R.S. §37:2365) - Licensed out-of-state psychologist may practice psychology in the state for a period not to exceed 30 days in any calendar year - However, the out-of-state psychologist's practice must be associated with a psychologist who is licensed in Louisiana - The out-of-state psychologist's state also must have a similar license exception privilege in place	General Misdemeanor (La. R.S. §37:2360) - $100-$500 fine AND/OR - Possibly imprisonment up to 6 months

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MAINE	No	Yes (CMR 02-373-001) - Statute defines telemedicine as the practice of medicine through the use of any electronic means - Telemedicine occurs in the state where the patient is located at time of examination - Physicians practicing telemedicine in Maine must hold a Maine license		No	Class E Crime (10 M.R.S. §8003-C; §1252) - Required $100-$2000 fine AND/OR - Possible 6 months imprisonment
MARYLAND	No	Yes (COMAR 10.41.06.01; Md. Health Occupations Code Ann. §2-205) - The terms telehealth and telemedicine are defined by the Board of Examiners for Audiologists - Statute grants the Board of Audiologists the right to govern the use of telehealth communications by its professionals - Telemedicine defined by the Board of Physicians (COMAR 10.32.05.02)		Yes – psychologist may petition the Board in writing for a temporary exception to practice psychology in Maryland http://www.dhmh.state.md.us/psych/htm/faq.htm	General Misdemeanor (Md. Health Occupations Code Ann. §18-404) - Possible fine up to $500 AND/OR - Possible imprisonment up to 6 months
MASSACHUSETTS	No	No	See policy on Massachusetts Board of Registration of Psychologists website: http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Licensee&L2=Div	No Note that Section 123 exempts, inter alia, persons eligible for licensure under section 119 who provide consultative services for a fee no more than one day a	General Misdemeanor (ALM GL ch. 112, §122) - Possible fine up to $500 AND/OR - Possible imprisonment up to 3 months

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
			ision+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Psychologists&L4=Statutes+and+Regulations&L5=Board+Policies+and+Guidelines&sid=Eoca&b=terminalcontent&f=dpl_boards_py_policy_electronic_services&csid=Eoca	month from penalties for unlicensed practice outlined in Section 122.	
MICHIGAN	No	No		No	Felony (MCL §333.16294) - Silent as to fine and/or imprisonment penalties
MINNESOTA	No	Yes (Minn. Stat. §147.032) - Grants licensed out-of-state physicians who annually register with the state board the right to practice telemedicine - Cannot open an office within the state, meet with patients in the state, or receive phone calls in the state from patients - Not subject to telemedicine registration requirements when responding to an emergency, when providing services on a irregular or infrequent basis, or when providing services in consultation with a licensed Minnesota physician	** Mental health services provided by two-way interactive video are covered for insurance purposes (Minn Stat. 256B.0625) ** Same rates apply for insurance repayment as if face-to-face services provided	Yes (Minn. Stat. §148.916) - Licensed out-of-state psychologists may practice in the state for no more than 7 calendar days - May practice up to 30 days per year if apply for a guest licensure - Application for guest licensure must be received at least 30 days before the expected date of practice and be approved by the board	Gross Misdemeanor (Minn. Stat. §138.941; §609.0341) - Possible fine up to $1000 AND/OR - Possible imprisonment up to 1 year
MISSISSIPPI	No	Yes (Miss. Code Ann. §73-25-34)		Yes (CMSR 50-021-001)	General Misdemeanor (Miss. Code

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		- Defines telemedicine as the practice of medicine by a physician located out-of-state on a patient located in-state - Must hold an in-state license to practice telemedicine within the state - Exception exists when a licensed in-state physician requests the assistance of an out-of-state physician on a patient matter		- Licensed out-of-state psychologist may practice for no more than 10 days during a consecutive 12 month period - Must report nature of practice intention and provide a copy of current license to the board before practicing	Ann. §73-31-23) - Possible fine up to $300 AND/OR - Possible imprisonment up to 60 days
MISSOURI	No	Yes (§334.010 R.S. Mo.) - Services rendered "across state lines" to in-state patients must be performed by physicians holding a Missouri medical license - Various exceptions exist for this rule – the primary one allowing for the situation where an out-of-state physician's services are rendered in consultation with a licensed Missouri physician and the Missouri physician maintains the ultimate source of authority		Yes (§337.045 R.S. Mo.) - Licensed out-of-state psychologist may practice for no more than 10 consecutive business days in any 90 day period - Also, aggregate may not exceed 15 business days in any 9-month period - No mention of a need to pre-register	Class A Misdemeanor (§337.065 R.S. Mo.; §558.011) - Possible fine up to $1000 AND/OR - Possible imprisonment up to 1 year
MONTANA	Yes (Mont. Admin. R. 24.189.607) - A professional relationship with a psychologist may be established in a context where services are	Yes (Mont. Code Anno., §37-3-301) - Montana issues four types of physician licenses, one being a telemedicine license - Telemedicine license given to		Yes (Mont. Code Anno., §37-17-104) - Licensed out-of-state practitioner may practice for no more than 60 days during a calendar year	General Misdemeanor (Mont. Code Anno. §37-17-312) - Possible fine up to $500 AND/OR - Possible imprisonment up to 6 months

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
	transmitted via electronic or related methods - The context must also be (i) two-way, (ii) interactive, (iii) real-time, (iv) simultaneous, (v) continuous, and (vi) providing for both audio and visual interaction	licensed out-of-state physicians who perform evaluations relating to treatment or correction of in-state patient's physical or mental conditions (§37-3-342) - May only practice telemedicine and not authorized to practice medicine while physically present in the state (§37-3-343) - Must apply to the board for licensure and meet various requirements (§37-3-345) - Montana also allows telepharmacy practices (Mont. Admin. R. 24.174.1302)		- If practicing for more than 10 days the psychologist must report to the department the nature and extent of the services	
NEBRASKA	No	Yes (R.R.S. Neb. §38-2024) - Licensed out-of-state physicians rendering services to in-state patients must hold a Nebraska medical license - This statute does not use the terms telemedicine or telehealth - Nebraska also allows for telepharmacy practices (R.R.S. Neb. §71-2445)		Yes (R.R.S. Neb. §38-3119) - Licensed out-of-state practitioner may practice for no more than 30 days per year - Must notify the department of the nature and location of practice - Department must issue a letter granting the psychologist the right to practice. - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Nebraska	Class II Misdemeanor (R.R.S. Neb. §38-3130) - Possible fine up to $1000 AND/OR - Possible imprisonment up to 6 months
NEVADA	No	No		Yes (Nev. Rev. Stat. Ann. §641.410)	Gross Misdemeanor (Nev. Rev. Stat. Ann. §641.440; §193.140)

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
				- Licensed out-of-state practitioner may practice for no more than 30 days in any calendar year provided s/he is invited as a consultant by a psychologist licensed in Nevada - Must submit an application for approval at least 30 days before beginning the practice - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Nevada	- Possible fine up to $2000 AND/OR - Possible imprisonment up to 1 year
NEW HAMPSHIRE	No	Yes (RSA 329:1-b) - New Hampshire allows for teleradiology - Must be performed by an individual holding a New Hampshire medical license	** New Hampshire Telemedicine Act (2009) defines telemedicine and requires that its practice be covered under health care (RSA 415-J:3)	No	Class A Misdemeanor (RSA §330-A:23; 625:9, 651:2) if a natural person - Possible fine up to $2000 AND/OR - Possible imprisonment up to 1 year Felony if committed by any other person (§330-A:23)
NEW JERSEY	No	No		Yes (N.J. Stat. §45:14B-6) - Licensed out-of-state practitioner may practice for no more than 10 consecutive business days or 15 business days in any 90 day period - Must provide a minimum of 10 days written notice of intention to practice	General Misdemeanor (N.J. Stat. §45:1-11; §45:1-25) - Possible fine up to 10k for first offense - Possible fine up to 20k for subsequent offense(s) - No mention of imprisonment

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
				- Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in New Jersey	
NEW MEXICO	No	Yes (N.M. Stat. Ann §61-6-11.1) - Telemedicine license granted to out-of-state physicians practicing on in-state patients - Must file for this license to practice telemedicine - Licenses can be renewed		Yes (N.M. Stat. Ann. §61-9-10.1) - Licensed out-of-state practitioner may practice for up to 6 months in New Mexico - Temporary license expires after 6 months and is not subject to extension or renewal - Must register with the board by completing an application form and paying a fee (N.M. Stat. Ann. §16-22.5-13)	General Misdemeanor (N.M. Stat. Ann. §61-9-14) - Possible fine up to $1000 AND/OR - Possible imprisonment up to 3 months
NEW YORK	No	No		Yes (NY CLS Educ §7605) - Licensed out-of-state practitioner may practice for up to 10 consecutive business days in any period of 90 consecutive days - May also not exceed 15 aggregated business days in any such 90 day period - Must file with the department before practicing	Class E Felony (NY CLS Educ §6512; §70.00; §80.00) - Possible fine not to exceed the higher of $5000 or double the amount of gain from the commission of the crime - Required imprisonment of 1-4 years
NORTH CAROLINA	No	Yes (NC Gen. Stat. 90-18) - Services rendered in-person or by use of electronic	See website for copy of Board's opinion: http://ncpsychologyboard.org/office/ElectronicServices.	Yes (N.C. Gen. Stat. §90-270.4) - Licensed out-of-state practitioner may practice for up	Class 2 Misdemeanor (N.C. Gen. Stat. §90-270.17; §14-3) - Possible 6 months imprisonment

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
		communications to in-state patients must be performed by physicians holding a North Carolina medical license - Exceptions exist for physicians who provide services on an irregular basis in consultation with a licensed North Carolina physician or personal at a medical school - Statute does not use the terms telehealth or telepractice	htm	to 5 days in any calendar year - Must notify board in advance - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in North Carolina	
NORTH DAKOTA	No	No	** Telemedicine mentioned in a statute covering control substances dispensed by means of the internet (N.D. Cent. Code §19-03.1-22.4) - Reference s the definition of telemedicine under 21 USCS §802	Yes (N.D. Cent. Code §43-32-30) - Licensed out-of-state practitioner may practice for up to 30 days in any calendar year - Must notify the board in advance	Class B Misdemeanor (N.D. Cent. Code §43-32-31) - Possible fine up to $1000 dollars AND/OR - Possible imprisonment up to 30 days
OHIO	No	Yes (ORC Ann. 4731.296) - Any licensed out-of-state physician wishing to practice telemedicine in-state must file for an application for a telemedicine certificate - State may also grant a special activity certificate to any licensed person seeking to practice medicine at a special activity, program, or event taking place in the state (§4731.294) - Special certificate valid for the		Yes (ORC Ann. 4732.22) - Licensed out-of-state practitioner may practice for a period not to exceed 30 days in a year - Must be approved by the board - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Ohio	General Misdemeanor (ORC Ann. 4732.99) - Required fine between $100 and $500 dollars AND/OR imprisonment for not less than 6 months nor more than 1 year

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
		shorter of 30 days or the duration of the specific event or activity			
OKLAHOMA	No - No specific statutory rules toward telehealth and the psychology field - However, the term telemedicine is defined and mentioned in the Mental Health Law of 1986 (see 43A Okl. St. §1-103; 5-206	Yes (36 Okl. St. §6802) - Practice of telemedicine defined - Requires the patients' informed consent (§6804) - Statute provides very little regulation guidance	** Telemedicine practices covered under health care plans (36 Okl. St. §6803) ** See *Kennedy v. Freeman* (919 F.2d 126) ** See Attorney General of Oklahoma Opinion 00-041 http://www.oklegal.onenet.net/oklegal-cgi/ifetch?okag+1210534610808+F	Yes (59 Okl. St. §1353) - Licensed out-of-state practitioner may practice for no more than 5 days during a calendar year - Must notify the board before practicing	General Misdemeanor (59 Okl. St. §1374) - Possible fine up to $500 dollars AND/OR - Possible imprisonment up to 6 months
OREGON	No	Yes (Or. Admin R. 410-130-0610) - Very vague definition of telemedicine found under medical surgical services statute - Defines as the use of telephonic or electronic communication to medication information from one site to another to improve a patient's health status - Provides no other guidance	** Detailed insurance provider rules for telemedicine services under Or. Admin R. 410-130-0610 ** Detailed procedures for individuals performing unlicensed practice of law violations (ORC 675.020(2); 675.010(4))	Yes (ORS §674.063; Or. Admin. R. 858-010-0055) - Licensed out-of-state practitioner may practice for a period of not more than 180 days in any 24 month period - Must submit an application to the board before practicing - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Oregon - In addition, visitor's permits may be issued to licensed out-of-state psychologists who do not intend to seek full licensure in Oregon	Class C Misdemeanor (ORS §675.990; §161.615) - Possible fine up to $6250 dollars AND/OR - Possible imprisonment up to 1 year

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
				- Must submit an application for a visitor's permit and include specifics such as location where planning on practicing - Visitor's permits are valid for no more than 30 days in any 12-month period	
PENNSYLVANIA	No	No		No	General Misdemeanor (63 P.S. §1211) For 1st offense: - Possible fine up to $1000 dollars AND/OR - Possible imprisonment up to 6 months For each additional offense: - Required fine of $2000 AND/OR imprisonment of not less than 6 months nor more than 1 year
RHODE ISLAND	No	No	Email communication from RI Board Administrator dates 4/20/10 indicates that the RI psychology board views provision of tele-mental services as requiring licensure in RI. It may also be possible to provide services under the temporary licensure provision. RI General Law 5-44-23 (h). It should be noted that the board	Yes (R.I. Gen. Laws §5-44-23) - Licensed out-of-state practitioner may practice without obtaining an in-state license for up to 10 days per calendar year with no more than 5 days of this activity occurring consecutively - No requirement to register in advance	General Misdemeanor (R.I. Gen. Laws §5-44-21) - Possible fine up to $500 dollars

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
			equates 1 teletherapy session to using 1 calendar day of the 10 calendar day limit		
SOUTH CAROLINA	No	Yes (S.C. Code Ann §40-47-20(36)(e)) - The "practice of medicine" includes services rendered by out-of-state physicians in-person or by the use of electronic communications to in-state patients - Must hold a South Carolina medical license to perform such services - Statute does not mention telehealth or telemedicine		Yes (S.C. Code Ann §40-55-110) - Licensed out-of-state practitioner may practice for up to 60 days in the calendar year if successfully petition the board for a temporary permit - Petition must be made before practice begins - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in South Carolina	Felony (S.C. Code Ann §40-55-170) - Required fine up to 50k or imprisonment up to 1 year
SOUTH DAKOTA	No	Yes (S.D. Codified Laws §36-4-41) - Services rendered by out-of-state physicians to in-state patients are considered the practice of medicine - Resultantly, out-of-state physicians must hold a South Dakota medical license - Another statute allows for practice of telepharmacy in the state (S.D. Codified Laws §36-11-72) and establishes the basic rules for practicing telepharmacy		Yes (S.D. Codified Laws §36-27A-2) - Licensed out-of-state practitioner may not practice for an aggregate exceeding 20 days during a calendar year - If exceed 10 consecutive days of practice in any year then must report to the board in writing the nature and extent of practice	Class 2 Misdemeanor (S.D. Codified Laws §22-6-2) - Possible $500 dollar fine AND/OR - Possible 30 days imprisonment

American Psychological Association

Practice Directorate, Legal & Regulatory Affairs

Telehealth 50-State Review

March 2010

State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
TENNESSEE	No	Yes (Tenn. Code Ann. §63-6-209) - Board may issue telemedicine licenses to licensed out-of-state physicians - Telemedicine license allows out-of-state physicians to diagnose and treat patients in Tennessee across state lines - Statute creates certain exceptions where a telemedicine license is not required (Tenn. Comp. R. & Reg. R. 0880-2-.16 - These exceptions include: emergency situations, where less than 1% of physicians' practice consists of telemedicine practices across state lines (or contact occurs less than once a month or involves fewer than 10 patients on annual basis), uncompensated practice		Yes (Tenn. Code Ann. §63-11-211) - Licensed out-of-state practitioner may practice for no more than 12 days per year for such purposes as special training or consultation, speciation evaluation or intervention, or serving as an expert witness - Must receive board approval in advance	Class B Misdemeanor (Tenn. Code Ann. §63-11-206; 40-35-111) - Possible fine up to $500 AND/OR - Possible imprisonment up to 6 months
TEXAS	No	Yes (Tex. Occ. Code §111.002-004) - Specific statute allowing for the practice of telemedicine and telehealth - Requires informed patient consent and confidentiality - Statute grants the Texas State Board of Medical Examiners, in consultation with the commissioner of insurance, the	See Texas State Board of Examiners of Psychologists' website for policy statement on telepractice: http://www.tsbep.state.tx.us/newsletter_12_2.html	Yes (Tex. Occ. Code §501.263; 22 TAC §463.27) - The Board may grant licensed out-of-state practitioners a temporary permit to practice - Must submit an application to the board - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in	Class A Misdemeanor (Tex. Occ. Code §501.503; Tex. Penal Code §12.21) - Possible fine up to $4000 dollars AND/OR - Possible imprisonment up to 1 year - Additional civil penalty of $1000 for each day of the violation

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
		power to adopt additional rules; this most likely would include regulating cross-border matters – although no specific statutory rules exist on this issue) - Requires a face-to-face consultation between a patient and physician when the physician has not seen the patient following an initial telemedicine service - Texas has created pilot telehealth programs for other health professions (Tex. Gov't Code §531.02171)		Texas - Temporary license is valid for a period not longer than 30 days from the time the application is approved - Licensed out-of-state practitioner must be supervised by a licensed Texas psychologist	
UTAH	No	Yes (U.A.C. R432-100-32) - Grants hospitals the right to engage in telemedicine practices - If a hospital chooses to use telemedicine, the hospital itself must develop and implement governance practices	** Establishes rules governing reimbursement policies when telemedicine health care services are provided to patients (Utah Code Ann. §26-18-13)	Yes (Utah Code Ann. §58-1-307) - Licensed out-of-state practitioners may practice in the state only if called for a consultation by an individual licensed in Utah - Services performed must be limited to the consultation - Time period is not to exceed the duration of the consultation event - No specific language requiring advanced notification to the board	3rd Degree Felony (Utah Code Ann. §58-61-501) - Possible fine up to $5000 dollars AND/OR - Possible imprisonment up to 5 years
VERMONT	Yes (26 V.S.A §3018) - Psychologists who provide	No	See the Vermont Board of Psychological Examiners website for disclosure	Yes (CVR 04-030-270) - Licensed out-of-state	General Misdemeanor (3 V.S.A. §127; 26 V.S.A. §3002)

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
	services via electronic means are deemed to be engaging in telepractice - Must hold an in-state license to conduct telepractice on Vermont based patient		requirements (per Rule 3.10) for psychologists who provide services via the Internet or other electronic means: http://vtprofessionals.org/opr1/psychologists/telepractice.asp Rule 3.10 – Telepractice: http://vtprofessionals.org/opr1/psychologists/rules/PSY_Rules.pdf	practitioner may practice for no more than 10 days or 80 hours in any 12-month period - Must apply with the Board in advance	- Possible fine up to $5000 dollars AND/OR - Possible imprisonment up to 1 year
VIRGINIA	No	No	See policy statement issued by Virginia Board of Counseling that we were informed by the Virginia Board of Psychology that it, too, relies on regarding telehealth issues: http://www.dhp.state.va.us/counseling/guidelines/115-1.4%20Technology-Assisted.doc	Yes (Va. Code Ann. §54.1-3601) - Licensed out-of-state practitioner may apply for a temporary license in Virginia - Must work in consultation with a licensed in-state psychologist - Board sets time frame in its discretion	Class 1 Misdemeanor or Class 6 Felony (Va. Code Ann. §54.1-111; 18.2-10) 1st offense = Class 1 Misdemeanor - Possible fine up to $2500 dollars AND/OR - Possible imprisonment up to 12 months Additional offense within 36 month period = Class 6 Felony - 12 months imprisonment and fine up to $2500 dollars AND / OR mandatory imprisonment between 1-5 years ** Mandatory civil penalty between $200-$5000 per violation

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
WASHINGTON	No	Yes (Rev. Code Wash. §74.09.735) - Registered nurses allowed to practice telemedicine in home health care service situations		Yes (Rev. Code Wash §18.83.082) - Licensed out-of-state practitioner may practice for a period not to exceed 90 days within a calendar year - Must petition the board in advance - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Washington	Gross Misdemeanor (Rev. Code Wash. §18.83.180; 9.92.020) - Possible fine up to $5000 dollars AND/OR - Possible imprisonment up to 1 year
WEST VIRGINIA	No	Yes (W. Va. Code §30-3-13) - Definition of telemedicine as the use of electronic technologies to diagnosis and treat in-state patients by out-of-state physicians - Must hold a valid in-state license or be licensed under the provisions of this article to conduct telemedicine - Applies to the practice of medicine, surgery, or podiatry		Yes (W. Va. Code §30-21-3) - Licensed out-of-state psychologist may practice for a period not to exceed 10 days in any calendar year - Must not establish a regular place of practice in the state - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in West Virginia - Must petition the board in advance	General Misdemeanor (W. Va. Code §30-21-13) - Possible fine up to $500 dollars AND/OR - Possible imprisonment up to 6 months
WISCONSIN	Yes (Wis. Adm. Code Psy. 2.14) - Explicitly notes that	No		Yes (Wis. Stat. §455.03) - Licensed out-of-state psychologist may practice for not	General Misdemeanor (Wis. Stat. §455.11) - Possible fine up to $200 AND/OR

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	psychologists provide services in the state whenever the patient is located in the state - This holds true regardless of whether the psychologist is temporary located in the state or providing electronic or telephonic means from the state where the psychologist is licensed - Never uses any form of the word telehealth See Wisconsin Psychology Examining Board website – Practice FAQs for Board's position on teletherapy & internet therapy: http://drl.wi.gov/profdetail.asp?pdetailid=2759&profid=44&locid=0			more than 60 working days in any year without holding a valid Wisconsin license - Must report to the board the nature and extent of practice if exceed 20 working days within a year - Licensure requirements in the home state of the psychologist must be equivalent to or exceed the licensing requirements in Wisconsin	- Possible imprisonment up to 6 months

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State	Psychologist Telehealth Provision	General Telehealth Provision	Other Notable Activities	Temporary / Guest License Availability	Penalties for Violation
WYOMING	No	Yes (Wyo. Stat. §33-26-102) - Telemedicine is defined as the practice of medicine by electronic communications from a physician in a location to a patient in another location - No rules or guidance is provided - Applies to physicians and surgeons		Yes (Wyo. Stat. §33-27-117) - Licensed out-of-state practitioner may practice for not more than 30 working days in any year - Must report the nature and extent of the practice to the board if that practice exceeds 20 working days in any one calendar year - Licensure requirements in the psychologist's home state must be equivalent to or exceed the licensing requirements in WY	General Misdemeanor (Wyo. Stat. §33-27-119) - Possible fine up to $750 dollars AND/OR - Possible imprisonment up to 6 months