**Randolph S. Sergent, Esq,** Chairman
**Ben Steffen**, Executive Director

December 5, 2023

The Honorable Joseline A. Pena-Melnyk,
Chair,
Health and Government Operations Committee
House Office Building, Room 241
Annapolis, Maryland 21401

**Re: HB0670, 2022 - Maryland Health Care Commission - Study on Expansion of Interstate Telehealth - Report (MSAR #14050)**

Dear Chair Pena-Melnyk,

As requested in your letter dated May 24, 2022, the Maryland Health Care Commission ("MHCC") conducted the Interstate Telehealth Expansion Study ("study") in accordance with *House Bill 670, Maryland Health Care Commission – Study on Expansion of Interstate Telehealth*, which was withdrawn by the sponsor during the 2022 session. The workgroup consisted of representation from Maryland health occupation boards, providers, payers, healthcare consumers, professional healthcare associations, liability insurance carriers, and select State agencies. Discussions centered on challenges and potential solutions to expanding State residents' access to telehealth services from out-of-state providers.

The attached report includes study findings from the workgroup and a literature review all of which guided the development of nine recommendations and four notable considerations; of these, five necessitate need for legislation, two regulations, and six policies. More work is needed to continue advancing interstate telehealth and ensure consumers access insurance carriers and select State agencies. The recommendations and notable considerations are intended to be a progressive first step and not an exhaustive list of all things to be considered in expanding interstate telehealth.

If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 301-717-7825 or ben.steffen@maryland.gov, or contact Tracey DeShields, Director, Policy Development and External Affairs at 410-764-3385 or tracey.deshields2@maryland.gov.

Sincerely,

Ben Steffen,
Executive Director

cc:

mhcc.maryland.gov

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4160 Patterson Avenue,
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The Honorable Bill Ferguson, President of the Senate
The Honorable Adrienne A. Jones, Speaker of the House of Delegates
The Honorable Pamela Beidle, Chair, Senate Finance
The Honorable Jheanelle K. Wilkins, Vice Chair, House Ways and Means Committee
The Honorable Nick Charles, Senator, Judicial Proceedings Committee
The Honorable Laura Herrera Scott, Secretary, Maryland Department of Health
Marie Grant, Assistant Secretary, Health Policy, Maryland Department of Health
House Health and Government Operations Committee
Senate Finance Committee
Jonny Dorsey, Deputy Chief of Staff, Governor's Office
June Chung, Deputy Legislative Office, Governor's Legislative Office
Jason Heo, Governor's Office
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Erin Hopwood, Committee Counsel, House Health and Government Operations,
Lisa Simpson, Committee Counsel, House Health and Government Operations,
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David Smulski, Committee Counsel, Senate Finance
David Sharp, Director, Center for Health Information Technology and Innovative Care Delivery
Nicole Majewski, Chief, Health Information Technology, MHCC
Tracey DeShields, Director of Policy Development and External Affairs, MHCC

# Interstate Telehealth Expansion Study

September 2023

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CHAIRMAN

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## INTRODUCTION

The Maryland Health Care Commission ("MHCC") conducted an Interstate Telehealth Expansion Study (or "study") in collaboration with stakeholders at the request of the Health and Government Operations ("HGO") Committee. The study focused on ways to expand interstate telehealth[1] to provide more options for residents to receive services from out-of-state practitioners (or "providers"). In a letter dated May 24, 2022 (see Appendix A), the HGO Chair noted support for the expanded use of telehealth since the COVID-19 Public Health Emergency (or "PHE")[2] and tasked MHCC with convening a workgroup[3] to address select questions and deliberate on other relevant policy issues (Figure 1). The questions were informed, in part, by House Bill 670, *Maryland Health Care Commission – Study on Expansion of Interstate Telehealth*, which bill sponsors elected to withdraw during the 2022 session of the General Assembly. The HGO Committee requested MHCC provide recommendations pertaining to the expansion of interstate telehealth by December 1, 2023.

**Figure 1: Study Scope**

1. How to address the health insurance coverage and medical liability issues associated with the use of out-of-state practitioners through telehealth?
2. Are interstate health compacts[4] sufficient for expanding the use of interstate telehealth?
3. Whether Maryland should alter its licensure practitioner requirements to further the availability of telehealth services while continuing to protect patients and, if so, how?
4. What impact will promoting out-of-state telehealth have on Maryland practitioners?
5. Other policy issues that the workgroup considers relevant to expanding access to telehealth services.

The MHCC convened a workgroup (January – March 2023) to discuss barriers and opportunities to expanding the delivery of telehealth services across state lines. The workgroup consisted of representatives from Maryland health occupation boards (or "boards"), providers, payers, health care consumers ("consumers"), professional associations, professional liability insurance carriers, and State agencies (see Appendix B). A qualitative approach was used to gather the opinions and experiences of workgroup participants noting key considerations and potential solutions for each question (see Appendix C). Input from stakeholders guided development of statutory, regulatory, or policy-based recommendations and other notable considerations. More work is needed by stakeholders to ensure that interstate telehealth provides consumers with

access to care in high-performing provider networks. The findings in this report are an important first step and should not be viewed as an exhaustive list of all things to be considered to advance interstate telehealth.

This report includes information on the landscape of interstate telehealth and supporting justification for nine recommendations and four notable considerations, of which five necessitate legislation, two regulation, and six policy. Some workgroup participants express less than full support for certain recommendations. Broad agreement exists for continued dialogue to build upon the existing interstate telehealth framework. Findings from the study are intended to guide State policymakers, health occupation boards, and other stakeholders in expanding interstate telehealth in ways that improve access to care and maintain continuity of care for Maryland residents.

## CURRENT LANDSCAPE

Use of digital information and communications technologies improves access to care, particularly in rural and underserved communities. Interstate telehealth is largely an issue of maintaining existing patient and provider relationships and is essential for patients and providers in contiguous states.[5] Providers who wish to practice across state lines are required to comply with state-specific laws and regulations.[6] States' health professional occupation boards maintain authority to license and regulate providers. This ensures providers practicing within a board's purview meet minimum professional qualifications, maintain ethical standards of care, and are disciplined, if necessary. Licensing requirements aim to protect consumers from unqualified providers and unprofessional behavior[7] and often require applicants to pass an exam specific to their specialty and background check.[8] Fees and timing to obtain health occupation licenses vary across states;[9] nationally, it takes about 60 days for a board to process a licensing application.[10] Maryland health occupation boards can grant a license within a few days or weeks following receipt of all required application materials; delays are often attributed to completion of the criminal background check.[11]

Coordination of health care licensing processes across state lines is increasing, in part due to the expansion of telehealth and to assist providers who move more frequently (e.g., military) and work or live across state borders.[12] Certain states, including Maryland, have expedited licensure tracks for out-of-state providers. The Maryland Board of Physicians ("MBP") recently implemented two alternative licensing approaches: licensure by endorsement (January 2023, all states) and licensure by reciprocity (March 2023, Virginia and Washington D.C.). Maryland law (2018)[13] requires each health occupation board to expedite the licensure process for a service member, veteran, or military spouse. On January 5, 2023, President Biden signed the *Military Spouse Licensing Relief Act* into law requiring states to improve licensure portability for military spouses (i.e., the ability to take and use their license across state lines).[14]

Many states, including Maryland, participate in licensure compacts. Compacts are voluntary and uniquely structured through formal, binding, legislatively enacted agreements between multiple states.[15, 16] Maryland has enacted legislation to participate in seven compacts of which four are established[17] (nurses,[18] physicians, psychologists, and physical therapists) and three are pending implementation (counselors, occupational therapists, and audiologists/speech-language pathologists). Four other compacts (advance practice nurses, social workers, physician assistants, dentists/dental hygienists) will become active once a certain number of states enact legislation to participate, a condition required to activate a compact;[19] Maryland has not enacted legislation to join these compacts (see Appendix D).

Compacts aim to help providers navigate licensing outside of their home state.[20] In general, states' participation in compacts has increased since the PHE; however, compacts are not broadly adopted by all states, including more populous states like California and New York (see Appendix E).[21] Participation in compacts among Maryland contiguous states varies (see Appendix F). The decision to participate in a compact requires consideration of legal conflicts with compact provisions and state law, potential decreases in licensing revenue, and concerns around disciplining out-of-state providers, among other things.[22] In recent years, about a dozen states have enacted legislation for a telehealth-specific license or registration process, most of which were implemented after declaration of the PHE in 2020. A telehealth-only option can ease some administrative activities for obtaining a license by allowing out-of-state providers to register or apply for a permit to deliver telehealth services to residents if certain conditions are met; eligibility and requirements vary across states (see Appendix G).[23]

## RESPONDING TO COVID-19

Many states, including Maryland and the federal government, approved unprecedented telehealth flexibilities during the PHE to aid response efforts. This included flexibilities in licensing rules, which enabled interstate mobility for out-of-state providers by temporarily waiving requirements to be licensed in the state where a patient was located.[24] This allowed providers to deliver care without a state specific license as long as the provider had a license in good standing in another state.[25] Maryland authorized out-of-state providers with a license in their home state to deliver telehealth services to residents; other actions allowed for a provider-patient relationship to be established through telehealth and permitted coverage and reimbursement for audio-only (telephone) encounters. Most state emergency declarations with temporary licensing flexibilities ended in 2021.[26, 27] New Hampshire and Vermont passed legislation to continue some licensure flexibilities through June 30, 2023.[28]

Expansion of interstate telehealth helped alleviate challenges related to workforce shortages, maldistribution, and maintaining continuity of care.[29, 30] Notably, licensing restrictions lifted during the PHE improved options for consumers to receive care from a more diverse behavioral health workforce, particularly those from underrepresented racial and ethnic groups; this included access to out-of-state providers who speak languages other than English (Spanish,

Arabic, Korean, etc.).[31] Nationally, interstate telehealth from 2017 through 2020 occurred more often between patients and providers with an established relationship and accounted for less than one percent of all outpatient visits and five percent of all telehealth visits.[32] Percentages are higher in states that share boarders, such as Washington, D.C., Wyoming, and North Dakota where about 20 percent of telehealth visits occurred with out-of-state providers.[33]

## FINDINGS

The following nine recommendations and four notable considerations were developed in collaboration with stakeholders[34] and address questions the HGO Committee requested MHCC answer as part of the Interstate Telehealth Expansion Study. The recommendations and notable considerations offer potential solutions that build upon existing actions taken by health occupation boards or require further study. Blue text in parenthesis notes need for legislation, regulation, or policy changes to support expanding interstate telehealth. Supporting justification is included in the discussion section that follows each question.

### Health Insurance Coverage and Medical Liability

***Question 1:*** *How to address the health insurance coverage and medical liability issues associated with the use of out-of-state practitioners through telehealth?*

#### Recommendations

**a.** Payers should continue to expand consumer awareness efforts on potential out-of-pocket costs for in and out-of-network providers when seeking services in-person or by telehealth (policy)

**b.** Health occupation boards should require medical liability coverage for out-of-state providers who do not have an existing medical liability insurance policy through employment or by contract with an in-State hospital, facility, program, practice, carrier, or managed care organization licensed or certified under Maryland law (policy)

#### Discussion

The workgroup acknowledged the importance of consumer awareness and understanding of cost sharing associated with use of an out-of-state provider who may be out-of-network. Workgroup participants noted the potential for higher out-of-pocket costs (i.e., deductibles, copayments, and coinsurance) when care is delivered out-of-network. In certain states, including Maryland, use of out-of-network providers is about 10 times more common for behavioral health services due to limited availability of community mental health and substance

use disorder centers and providers who accept insurance.[35] Maryland law (January 2023) requires payers to implement a procedure where consumers may request a referral to an out-of-network provider if the member is diagnosed with a condition or disease that requires specialized health care services; approval prevents consumers from paying more when using an out-of-network provider.[36] Federal law aims to limit the amount consumers pay for care delivered out-of-network; the *No Surprises Act* (January 2022)[37] requires out-of-pocket costs be limited to in-network rates and bans providers from balance billing under certain circumstances.[38]

Uneven state requirements pertaining to provider liability insurance and potential risks for providers and consumers who participate in interstate telehealth was concerning to workgroup participants. Liability insurance is not required by federal law, and about 30 states, including Maryland, do not mandate coverage.[39] Requirements to have malpractice insurance exist for most payers as a condition of in-network participation and hospitals and health care facilities as a condition of employment. Maryland law requires physicians practicing in the State that do not maintain medical liability insurance to notify patients in writing.[40] Physician adherence to this law was unclear to workgroup participants.

### Interstate Health Compacts

***Question 2:*** *Are interstate health compacts sufficient for expanding the use of interstate telehealth?*

### Recommendations

**a.** The General Assembly should continue adopting legislation to implement interstate compacts to improve consumer access to providers, particularly for consumers in communities experiencing a practitioner shortage – uncodified language in Chapter 15/HB 448, *Health Care Practitioners – Telehealth and Shortage* (2020) (regulation)

**b.** Health occupation boards should develop new pathways to licensure; continue to begin/renew conversations regarding the development of licensure by reciprocity and endorsement agreements between Maryland and contiguous states (regulation)

### Discussion

Workgroup participants generally view compacts as one approach to advance interstate telehealth. Over 40 states, including Maryland, have taken laudable steps to implement compacts. Compacts provide states the opportunity to cooperatively reformulate policies to mediate cross-state care.[41] Workgroup participants noted the Interstate Medical Licensure

Compact ("IMLC") can be cost prohibitive, particularly for physicians seeking licensure in a small number of states. The IMLC is the only compact that requires applicants to complete all state licensure requirements and pay each state where licensure is sought (Maryland physician license $790 initial; $512 renewal[42]) in addition to a compact fee ($700 initial; $25/state renewal); in some circumstances, it can take longer than new expedited pathways (i.e., reciprocity and endorsement) implemented by MBP in early 2023. Workgroup participants favor compacts with a mutual recognition model[43] where providers maintain a license in their home state and apply for a multistate license or privilege (authorization) to practice in other compact states.[44] Of the seven compacts that Maryland has enacted legislation for, six are structured as a mutual recognition model (nurses, psychologists, physical therapists, counselors, occupational therapists, and audiologists/speech-language pathologists)(see Appendix D).[45]

The benefit of compacts is greater when bordering states join. The Psychology Interjurisdictional Compact is the only compact where all Maryland contiguous states (DE, PA, VA, WV) and D.C. participate. Participation in other compacts varies (see Appendix F). Compacts for counselors, occupational therapists, and audiologists/speech-language pathologists have been implemented by several contiguous states (DE, VA, WV); implementation of these compacts are in progress in Maryland and expected to be operational in 2024. Legislation to join compacts for advance practice nurses, social workers, physician assistants, and dentists/dental hygienists is anticipated to be introduced in 2024. Consideration of other potential approaches to obtain a license was supported by the workgroup.

### Practitioner Licensure Requirements

***Question 3:*** *Whether Maryland should alter its licensure practitioner requirements to further the availability of telehealth services while continuing to protect patients and, if so, how?*

- **a.** Allow the adoption of a mutual recognition for licensure by health occupation boards consistent with the Nurse Licensure Compact where the board recognizes the home state license; disciplinary action notifications are pushed to participating boards; any board can investigate and discipline a provider practicing in the State; and any participating board can discipline a provider based on findings in another state except where prohibited by State law (legislation)
- **b.** The General Assembly should enact legislation to allow health occupation boards to adopt a limited use telehealth out-of-state license (legislation)

**c.** Health occupation boards should permit providers with an active unencumbered license in another state to deliver telehealth services to preserve continuity of care for existing patients (legislation)

**d.** The General Assembly should enact legislation to allow an out-of-state health care entity* under common ownership with an in-State entity to deliver telehealth services to preserve the continuity of care for existing patients (legislation)

* *Includes hospitals and organizations that deliver health care services through a broad array of coverage arrangements or other relationships with practitioners, either by employing them directly or through contractual or other arrangements*

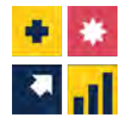
## Discussion

Workgroup participants support allowing health occupation boards to establish alternative licensure pathways that maintain quality and patient safety requirements. Nearly 15 states have telehealth registries or issue special permits allowing providers with a license in good standing from another state to deliver telehealth services to residents if they meet certain qualifications (see Appendix G).[46] Select states make allowances for practicing in contiguous states or obtaining a temporary license under certain conditions (e.g., agreeing to not open an office in that state); some states have telehealth-specific exceptions whereby an out-of-state provider may provide telehealth services to residents in a state where they are not located.[47]

Several workgroup participants believe a Maryland license should not be required in all circumstances (e.g., follow-up care, second opinions, and specialty assessments) for out-of-state licensed providers employed by a health care organization with hospitals, clinics, and other health care facilities in Maryland and other states. The workgroup discussed need for shared decision-making when a valid treatment relationship exists. Shared decision-making is a critical aspect of patient-centered care. Workgroup participants viewed the health care organization's credentialing process as sufficient for ensuring providers meet and maintain certain qualifications and standards. This process reviews many of the same documents required for licensure (e.g., education, training, licensure, registrations and certifications, sanctions, work history, and peer references).[48] The Centers for Medicare & Medicaid Services ("CMS") requires credentialing of hospital-based physicians. Credentialing is also required by CMS to bill Medicare and Medicaid and by most private payers.[49] Health occupation boards do not support allowing out-of-state providers to practice telehealth without a valid Maryland license given concerns about their inability to enforce rules and take disciplinary action, if necessary.[50]

### Promoting Out-of-State Telehealth

***Question 4:*** *What impact will promoting out-of-state telehealth have on Maryland practitioners?*



**Recommendation**

Health occupation boards should require out-of-state health care providers who treat Maryland residents to access and securely share patient health information electronically with primary care providers, except where prohibited by law (legislation)

## Discussion

The workgroup acknowledged the importance of electronic health data sharing across the care continuum. The ability to access, exchange, and integrate data is limited across different electronic health record systems[51] used by in-State and out-of-state providers. Bi-directional health data exchange as permitted by law is critical to ensure providers can make informed decisions about patient care and support continuity of care. Fragmentation complicates care management and subsequent administrative operations that can result in unnecessary spending and lower quality care (e.g., duplicate testing and medication errors).[52] Health information exchange services continue to become more widely diffused throughout the State and nation. Expanding interstate telehealth necessitates ensuring providers can appropriately and timely access a patient's health record securely through the State-Designated Health Information Exchange ("CRISP") or via another Maryland registered health information exchange.[53]

**Related Matters**

*Other policy issues that the workgroup considers relevant to expanding interstate-telehealth services.*

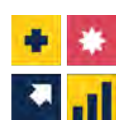
**Notable Considerations**

**a.** Where practical, health occupation boards should maintain comparable education and training requirements (policy)

**b.** Encourage health occupation boards to increase licensure digitization processes (policy)

**c.** Improve processes related to Maryland licensure requirements for service members, veterans, or military spouses (policy)

**d.** Encourage the Maryland Department of Public Safety and Correctional Services (DPSCS) to identify an alternative pathway to accept electronic background record checks from out-of-state vendors recognized in their state of origin (policy)



## Discussion

The workgroup discussed how licensure standards and processes among state health occupation boards may vary. Such processes aim to protect the health and safety of consumers.[54] Workgroup participants noted that boards should take reasonable measures to maintain the same or comparable in-State provider education and training requirements for out-of-state providers to minimize potential patient safety issues. Workgroup participants also mentioned that aspects of health occupation licensure processes create unintended negative effects. Increased digitization of the licensing processes will improve the application process. Barriers to technology adoption are somewhat related to structure and governance. Fostering digitization will minimize burden to individuals seeking a health care license in Maryland and increase licensure efficiencies.

The workgroup recognized that licensure processes for military service members and spouses are improving. Military-related moves between states pose significant challenges for families, particularly non-military spouses. More than one-third of military spouses work in occupations that require a license. Most spouses face a higher unemployment rate as compared to the general population largely due to mobility of military life.[55] Federal legislation signed into law earlier this year (*Military Spouse Licensing Relief Act*) provides licensing reciprocity in between states under certain circumstances for all professions except the practice of law.[56] Implementation is underway; processes and requirements to transfer a license could vary across states (e.g., if an individual is required to complete continuing education requirements for their home and new state). The law does not specify penalties if states do not accept or transfer a license.

Several workgroup participants noted how the background record check fingerprinting process is a hinderance to obtaining a license. The process can discourage out-of-state providers from seeking a Maryland license. DPSCS oversees the Criminal Justice Information System (CJIS) background record check. Fingerprinting must be completed at select Maryland sites. Out-of-state applicants can travel to a Maryland CJIS location or request in writing that a fingerprinting card be mailed to their address; fingerprints must be obtained by a local law enforcement agency and mailed to CJIS. Once CJIS receives the fingerprint card, a background check is usually completed within 10-15 days.

## SUMMARY

Interstate telehealth presents opportunity to increase access to somatic and behavioral health care in rural and urban communities and maintain continuity of care, particularly for individuals that live in bordering states or live outside the State for periods of time. Increasing diffusion of interstate telehealth can be complex absent a federal framework that enables a pathway for providers to obtain a license to practice nationally. Varying licensure rules across state health occupation boards and requirements around malpractice insurance and health

insurance coverage were considered to develop recommendations that aim to inform a progressive framework for advancing interstate telehealth . The workgroup acknowledges the need for a combination of approaches (i.e., changes in statute, regulation, and policy) to mitigate interstate telehealth diffusion challenges. Arguably, the workgroup views enabling alternative licensure pathways that maintain quality of care standards as most important to improve health equity and ensure access to care for underserved and vulnerable patients. Health occupation boards are making progress in adopting alternative licensure pathways, which includes the implementation of compacts. Absent more intervention to further support accessible cross-state care options beyond the PHE, interstate telehealth will continue to expand at a slow pace.


## ACKNOWLEDGEMENTS

The MHCC is grateful to stakeholders that participated in the Interstate Telehealth Expansion Study workgroup and their varied efforts to inform development of this report. Their thoughtful contributions are commendable.

## APPENDIX A

The following is a copy of the study request letter from the HGO Committee:

Joseline A. Peña-Melnyk
Chair

Ariana B. Kelly
Vice Chair

THE MARYLAND HOUSE OF DELEGATES
HEALTH AND GOVERNMENT OPERATIONS COMMITTEE

May 24, 2022

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

**RE: Study Request – Expansion of Interstate Telehealth**

Dear Mr. Steffen:

The Health and Government Operations Committee (Committee) requests the Maryland Health Care Commission (MHCC) to convene a workgroup to study the issues presented in House Bill 670, *Maryland Health Care Commission – Study on Expansion of Interstate Telehealth*, and to make recommendations on ways interstate telehealth can be expanded to allow State residents to use telehealth to receive health services from out-of-state providers.

The Committee supported the expanded use of telehealth that occurred during the COVID-19, Public Health Emergency. Patients and health care practitioners have become accustomed to using telehealth and its use has become a standard in many practices. The Committee is interested in identifying the best approaches for enabling access to telehealth, protecting patients, and ensuring an adequate supply of health care providers to Maryland residents. The Committee requests that MHCC convene a workgroup composed of affected stakeholders to discuss challenges and identify solutions with out-of-state providers delivering telehealth services. The Committee requests that the workgroup provide specific recommendations on the following questions:

(1) How to address the health insurance coverage and medical liability issues associated with the use of out-of-state practitioners through telehealth?

(2) Are interstate health compacts sufficient for expanding the use of interstate telehealth?

(3) Whether Maryland should alter its licensure practitioner requirements to further the availability of telehealth services while continuing to protect patients and, if so, how?

(4) What impact will promoting out–of–state telehealth have on Maryland practitioners?

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301-858-3770 · 410-841-3770 · 800-492-7122 Ext. 3770

(5) Other policy issues that the workgroup considers relevant to expanding access to telehealth services.

The Committee requests the workgroup identify statutory changes that are needed to allow Maryland residents to receive health services from out-of-state practitioners. The Committee seeks recommendations from MHCC by December 1, 2023. Please let the Committee know as soon as possible if MHCC would be willing to undertake this task and contact Lisa Simpson, Committee Counsel, with any questions.

Sincerely,

Joseline A. Peña-Melnyk

## APPENDIX B

| Interstate Telehealth Workgroup | |
|---|---|
| **Organization** | **Name** |
| Aetna/CVS | Zachary Peters |
| Alcohol and Other Drug Abuse Advisory Council, Montgomery County | Laura Mitchell |
| American Counseling Association | Lynn Linde |
| Bellamy Genn Group | Gil Genn |
| CareFirst BlueCross BlueShield | Susan Drake |
| CareFirst BlueCross BlueShield | Jenny Ozor |
| CareFirst BlueCross BlueShield | Deborah Rivkin |
| Cigna | Kimberly Robinson |
| Community Behavioral Health Association of Maryland | Lori Doyle |
| Community Behavioral Health Association of Maryland | Shannon Hall |
| Federation of State Medical Boards | John Bremer |
| Federation of State Medical Boards | Lisa Robin |
| HomeCentris Healthcare | Kelly McMahon |
| Hospice & Palliative Care Network | Peggy Funk |
| Johns Hopkins Medicine | Rebecca Canino |
| Johns Hopkins Medicine | Brian Hasselfeld |
| Johns Hopkins Medicine | Helen Hughes |
| Johns Hopkins University and Medicine | Annie Coble |
| Kaiser Permanente | Dennis Truong |
| Kennedy Krieger Institute | Jennifer Crockett |
| Kennedy Krieger Institute | Anna Dorsey |
| League of Life & Health Insurers of Maryland | Matt Celentano |
| Legal Action Center | Ellen Weber |
| Maryland State Board of Chiropractic Examiners | Sharon Oliver |
| Maryland Board of Dental Examiners | Helen Lee-Virgil |
| Maryland Board of Physical Therapy Examiners | Laurie Kendall-Ellis |
| Maryland Board of Physicians | Madeline DelGreco |
| Maryland Board of Physicians | Matthew Dudzic |

| Interstate Telehealth Workgroup | |
|---|---|
| **Organization** | **Name** |
| Maryland Board of Physicians | Christine Farrelly |
| Maryland Board of Physicians | David Finkler |
| Maryland Board of Physicians | Carol Ritter |
| Maryland Hospital Association | Diana-Lynn Hsu |
| Maryland Board of Professional Counselors and Therapists | Laura Berg |
| Maryland Board of Social Work Examiners | Daphne McClellan |
| Maryland Insurance Administration | Robert Baron |
| Maryland Insurance Administration | David Cooney |
| Maryland Insurance Administration | Pam O'Brien |
| Maryland Managed Care Organization Association | Jennifer Briemann |
| Maryland Speech-Language-Hearing Association | MaryLee Casper |
| Medical Mutual Liability Insurance Society of Maryland | Derek Yarmis |
| MedStar Telehealth Innovation Center | Ethan Booker |
| Mid-Atlantic Association of Community Health Centers | Delaney McGonegal |
| Montgomery County Medical Society | Farhana Arastu |
| Montgomery County Medical Society | Susan D'Antoni |
| Morgan State University | NaToya Mitchell |
| Nemours Children's Health | Patrick Barth |
| Nemours Children's Health | Carey Officer |
| Neurocrine Biosciences, Inc. | Karla Kiriako |
| RCM&D | Denise Shope |
| Public Policy Partners | Robyn Elliott |
| Rural Maryland Council | Megan D'Arcy |
| Rural Maryland Council | Charlotte Davis |
| University of Maryland Medical System | Todd Crocco |
| Schwartz, Metz, Wise & Kauffman, P.A. | Steven Wise |
| Takoma Therapy | Janet Svirsky |
| Wellpoint | Kathleen Loughran |

APPENDIX C

# INTERSTATE TELEHEALTH WORKGROUP

*For Discussion Purposes Only*

**TASK**: The House Health and Government Operations Committee ("HGO Committee") requested the Maryland Health Care Commission ("MHCC") conduct an interstate telehealth study ("study") by convening a workgroup composed of stakeholders that may be affected by or have an effect on expanded interstate telehealth practice.[57] The study scope was informed by House Bill 670, *Maryland Health Care Commission – Study on Expansion of Interstate Telehealth*, which bill sponsors elected to withdraw during the 2022 legislative session.[58] A final report detailing study findings, recommendations, and supporting rationale is due to the HGO Committee by December 1, 2023.

**APPROACH**: Discussion items that follow were requested by the HGO Committee and serve as a guide for the workgroup in formulating potential solutions to address challenges to interstate telehealth. For purposes of discussion, key areas of focus are underlined. Noted challenges impact expansion of interstate telehealth and may be perceived to be general challenges associated with telehealth and in-person care. Potential solutions are ideas aimed at addressing the challenges identified and will inform development of recommendations for expanding interstate telehealth.

**1.** How to address the **health insurance coverage** and **medical liability issues** associated with the use of out-of-state practitioners through telehealth?

| Coverage and Liability Considerations | Potential Solutions |
|---|---|
| • Consumer awareness of cost-sharing and the potential for higher out-of-pocket costs when care is delivered by an out-of-state provider who is not in-network<br>• Uneven provider liability insurance requirements that create risk for providers and consumers<br><br>*The above are applicable to in-person and virtual services delivered by in and out of state providers* | • Payers should continue to expand consumer awareness efforts on potential out-of-pocket costs for in and out-of-network providers when seeking services in-person or by telehealth (policy)<br>• Health occupation boards should require medical liability coverage for out-of-state providers who do not have an existing medical liability insurance policy through employment or by contract with an in-State hospital, facility, program, practitioners, carrier, or managed care organization licensed or certified under Maryland law (policy) |

| 2. Are **interstate health compacts** sufficient for expanding the use of interstate telehealth? | |
|---|---|
| **Compact Diffusion Issues** | **Potential Solutions** |
| • Support for compacts varies among some providers and health occupation boards; state adoption and implementation vary<br>  • Interstate Medical Licensure Compact ("IMLC") – active; 32 member states/territories including Maryland (active contiguous states: DE, WV); financial and operational challenges for eligible physicians<br>  • Nurse Licensure Compact ("NLC") – active; 39 member states/territories including Maryland (active contiguous states: DE, VA, WV); automatic reciprocity with no additional steps for nurses to practice across participating states<br>  • Advance Practice Nurse Compact – not yet active (model legislation proposed in Maryland in 2023 advanced in the House but not in the Senate; enacted in contiguous states: DE)<br>  • Psychology Interjurisdictional Compact ("PSYPACT") – active; 36 member states/territories including Maryland (active contiguous states: DC, DE, PA, VA, WV)<br>  • Counseling Compact – in implementation phase; 19 member states/territories including Maryland (enacted in contiguous states: DE, VA, WV) | • The General Assembly should continue adopting legislation to implement interstate compacts to improve consumer access to providers, particularly for consumers in communities experiencing a practitioner shortage – uncodified language in Chapter 15/HB 448, Health Care Practitioners – Telehealth and Shortage (2020) (regulation)<br>• Health occupation boards should continue to develop new pathways to licensure; begin/renew conversations regarding the development of licensure by reciprocity and endorsement agreements between Maryland and contiguous states (regulation) |

| 2. Are **interstate health compacts** sufficient for expanding the use of interstate telehealth? | |
|---|---|
| **Compact Diffusion Issues** | **Potential Solutions** |
| ◦ Social Work Licensure Compact – not active; model legislation proposed in some states (not yet introduced in Maryland or contiguous states)<br>◦ Occupation Therapy Licensure Compact – in implementation phase; 25 member states/territories including Maryland (contiguous states that have enacted legislation: DE, VA, WV and expected to be introduced in DC)<br>◦ Physical Therapy Compact – active; 28 member states/territories including Maryland (active contiguous states: DE, VA, WV)<br>◦ Dental and Dental Hygienist Compact – not active; model legislation proposed in some states (not yet introduced in Maryland or contiguous states)<br>◦ Physician Assistants Compact – not active; model legislation proposed in some states (not yet introduced in Maryland or contiguous states)<br>• Some states require Compact users to provide supplemental application information and pay State licensure fees; Compacts may not be an efficient approach for providers when licensure is sought in only a few states | |

| 3. Whether Maryland should alter its **licensure practitioner requirements** to further the availability of telehealth services while continuing to protect patients and, if so, how? | |
|---|---|
| **Licensure Complexities** | **Potential Solutions** |
| • Aligning stakeholder support for alterative licensure approaches while reasonably maintaining patient safety and quality standards<br>• Maintaining existing provider-patient relationships through multiple state licenses to minimize gaps in care | • Allow the adoption of a mutual recognition for licensure by health occupation boards consistent with the NLC where the board recognizes the home state license; disciplinary action notifications are pushed to participating boards; any board can investigate and discipline a provider practicing in the State; and any participating board can discipline a provider based on findings in another state except where prohibited by State law (legislation)<br>• The General Assembly should enact legislation to allow health occupation boards to adopt a limited use telehealth out-of-state license (legislation)<br>• Health occupation boards should permit providers with an active unencumbered license in another state to deliver telehealth services to preserve continuity of care for existing patients<br>• The General Assembly should enact legislation to allow an out-of-state health care entity* under common ownership with an in-State entity to deliver telehealth services to preserve continuity for existing patients (legislation)<br>** Includes both hospitals and organizations that deliver health care services through a broad array of coverage arrangements or other relationships with practitioners, either by employing them directly or through contractual or other arrangements* |

| **4.** What impact will **promoting out-of-state telehealth** have on Maryland practitioners? | |
|---|---|
| **Effect on Maryland Practitioners** | **Potential Solutions** |
| • Reduced capability for providers to access summary of care documents to support care delivery | • Health occupation boards should require health care providers who treat Maryland residents to access and securely share patient health information electronically with primary care providers, except where prohibited by law (legislation) |

**5. <u>Other policy issues</u>** that the workgroup considers relevant to expanding access to telehealth services.

| Effect on Maryland Practitioners | Potential Solutions |
|---|---|
| • Concerns that establishing new or expedited processes with reduced oversight by Maryland regulatory bodies could lead to patient harm and disadvantage in-State providers<br>• Licensure portability for military service members, veterans, and their spouses<br>• Processes to obtain a health occupation license are not fully electronic | • Where practical, health occupation boards should maintain comparable education and training requirements (policy)<br>• Encourage health occupation boards to increase licensure digitization processes (policy)<br>• Improve processes related to Maryland licensure requirements for service members, veterans, or military spouses (policy)<br>• Encourage the Maryland Department of Public Safety and Correctional Services to identify an alternative pathway to accept electronic background record checks from out-of-state vendors recognized in their state of origin (policy) |

## APPENDIX D

| Compact Types and Counts<br>*As of May 2023* | | | | |
|---|---|---|---|---|
| **Compact Name/ Provider Type**<br>*Status of compact legislation enacted in Maryland:*<br>* *Established*<br>** *Pending implementation* | # of States | | | **Model** |
| | **Enacted: Full** | **Enacted: Delayed or Partial** | **Pending Legislation** | |
| **Interstate Medical Licensure Compact (IMLC)***<br>*Physicians* | 31 | 7 | 4 | Expedited Licensure |
| **Nurse Licensure Compact (NLC)***<br>*Registered Nurses, Licensed Practical Nurses* | 36 | 4 | 8 | Mutual Recognition – Multistate License |
| **Physical Therapy Compact (PT Compact)***<br>*Physical Therapists* | 29 | 4 | 11 | Mutual Recognition – Privilege to Practice |
| **Psychology Interjurisdictional Compact (PSYPACT)***<br>*Psychologists* | 35 | 3 | 4 | Mutual Recognition – Multistate License |
| **Emergency Medical Services Compact (EMS Compact)**<br>*Emergency Medical Technicians and Paramedics* | 14 | 8 | 0 | Mutual Recognition – Multistate License |
| **Counseling Compact****<br>*Counselors* | N/A | 26 | 12 | Mutual Recognition – Privilege to Practice |
| **Occupational Therapy Compact (OT Compact)****<br>*Occupational Therapists* | N/A | 25 | 9 | Mutual Recognition – Privilege to Practice |
| **Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC)****<br>*Audiologists, Speech-Language Pathologists* | N/A | 25 | 9 | Mutual Recognition – Privilege to Practice |
| **Social Work Licensure Compact**<br>*Social Workers* | N/A | 1 | 6 | Mutual Recognition – Multistate License |
| **Advance Practice Nurse Compact (APRN Compact)**<br>*Advance Practice Nurses* | N/A | 3 | 6 | Mutual Recognition – Multistate License |
| **Physician Assistant Compact (PA Compact)**<br>*Physician Assistants* | N/A | 1 | 5 | Mutual Recognition – Privilege to Practice |

| **Compact Types and Counts**<br>*As of May 2023* | | | | |
|---|---|---|---|---|
| **Compact Name/ Provider Type**<br>*Status of compact legislation enacted in Maryland:*<br>* *Established*<br>** *Pending implementation* | # of States | | | **Model** |
| | **Enacted: Full** | **Enacted: Delayed or Partial** | **Pending Legislation** | |
| **Dental & Dental Hygienists Compact (DDH Compact)**<br>*Dentists, Dental Hygienists* | N/A | 3 | 4 | Mutual Recognition – Privilege to Practice |

**Expedited Licensure Model:** Providers must request an individual license from each state in which they intend to practice, but the compact makes the application process more efficient than it otherwise would be through data centralization and harmonized application requirements.

**Mutual Recognition Model – Multistate License**: A provider's license in their home state serves as authorization for them to practice in all other member states.

**Mutual Recognition Model – Privilege to Practice**: A provider's license in their home state authorizes them to apply for a privilege to practice in individual member states.

**Enacted Full:** Actively issuing and accepting compact licenses or privileges to practice.

**Enacted Partial**: Providers who reside in the state cannot apply to practice in other states through the compact, but providers from member states that have fully implemented the compact can practice in the state.

**Enacted Delayed:** Compact is in the implementation phase after enacting compact legislation, or implementation is delayed due to specific reasons for an individual state (e.g., awaiting FBI approval around criminal background check processes); the Social Work Compact, APRN Compact, PA Compact, and DDH Compact will not go into effect until a predetermined number of states enact the model legislation (number varies by compact).

## APPENDIX E

| State Approaches to Licensing Out-of-State Providers<br>*As of May 2023* | | | | | | | |
|---|---|---|---|---|---|---|---|
| Stat e | Compact | | | | Telehealth Registration | Telehealth License/ Permit | Special Exceptions |
| | IMLC | NLC | PTC | PSYPACT | | | |
| AL | ✓ | ✓ | | ✓ | | | ✓ |
| AK | | | | | | | ✓ |
| AZ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| AR | | ✓ | ✓ | ✓ | | | ✓ |
| CA | | | | | | | |
| CO | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| CT | ✓ | | | ✓ | ✓ | | ✓ |
| DE | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| D.C. | | | ✓ | ✓ | | | |
| FL | | ✓ | | | ✓ | | |
| GA | ✓ | ✓ | ✓ | ✓ | | | |
| HI | | | | | | | |
| ID | ✓ | ✓ | | ✓ | | | |
| IL | ✓ | | | ✓ | | | ✓ |
| IN | ✓ | ✓ | ✓ | ✓ | | | |
| IA | ✓ | ✓ | ✓ | | | | |
| KS | ✓ | ✓ | | ✓ | ✓ | | |
| KY | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| LA | ✓ | ✓ | ✓ | | ✓ | ✓ | |
| ME | ✓ | ✓ | | ✓ | ✓ | | ✓ |
| MD | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| MA | | | | | | | |
| MI | ✓ | | | ✓ | | | ✓ |
| MN | ✓ | | | ✓ | ✓ | | ✓ |
| MS | ✓ | ✓ | ✓ | | | | ✓ |
| MO | | ✓ | ✓ | ✓ | | | ✓ |
| MT | ✓ | ✓ | ✓ | | | | |
| NE | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| NV | ✓ | | | ✓ | | | ✓ |
| NH | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| NJ | | ✓ | | ✓ | | | |
| NM | | ✓ | | | | ✓ | |
| NY | | | | | | | |
| NC | | ✓ | ✓ | ✓ | | | |
| ND | ✓ | ✓ | ✓ | | | | |
| OH | ✓ | ✓ | ✓ | ✓ | | | ✓ |

| State Approaches to Licensing Out-of-State Providers<br>*As of May 2023* | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Stat e** | **Compact** | | | | **Telehealth Registration** | **Telehealth License/ Permit** | **Special Exceptions** |
| | **IMLC** | **NLC** | **PTC** | **PSYPACT** | | | |
| **OK** | ✓ | ✓ | ✓ | ✓ | | | |
| **OR** | | | ✓ | | | | ✓ |
| **PA** | | | | ✓ | | | ✓ |
| **RI** | | | | | | | ✓ |
| **SC** | | ✓ | ✓ | | | | |
| **SD** | ✓ | ✓ | ✓ | | | | |
| **TN** | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| **TX** | ✓ | ✓ | ✓ | ✓ | | | |
| **UT** | ✓ | ✓ | ✓ | ✓ | | | ✓ |
| **VT** | ✓ | ✓ | | | ✓ | ✓ | ✓ |
| **VA** | | ✓ | ✓ | ✓ | | | ✓ |
| **WA** | ✓ | | ✓ | ✓ | | | ✓ |
| **WV** | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| **WI** | ✓ | ✓ | ✓ | ✓ | | | |
| **WY** | ✓ | ✓ | | ✓ | | | ✓ |

**IMLC:** Interstate Medical Licensure Compact

**NLC:** Nurse Licensure Compact

**PTC:** Physical Therapy Compact

**PSYPACT**: Psychology Inter-Jurisdictional Compact

**Telehealth Registration:** A system in which out-of-state providers licensed in good standing in one state may provide telehealth services in another state after they complete that state's telehealth registration requirements.

**Telehealth Special License:** A system in which out-of-state providers licensed in good standing in one state are issued a special license or permit to deliver telehealth services in another state if they meet state requirements and pay applicable fees.

**Special Exceptions**: State laws that allow for the provision of telehealth by providers not licensed in a state under certain circumstances, such as provider-to-provider consults, follow-up care when an existing patient-provider relationship exists, or to offer pro-bono services.

**Sources:**
Center for Connected Health Policy: www.cchpca.org/topic/cross-state-licensing-professional-requirements/
Federation of State Medical Boards:
www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf

## APPENDIX F

| Distribution of Compacts – Maryland and Contiguous States<br>*As of August 2023* | | | |
|---|---|---|---|
| **Compact** | **Maryland** | **D.C. and Contiguous States** | **Pending Legislation** |
| **Interstate Medical Licensure Compact (IMLC)**<br>*Physicians* | Active | D.C., DE, PA, WV | N/A |
| **Nurse Licensure Compact (NLC)**<br>*Registered Nurses, Licensed Practical Nurses* | Active | DE, VA, PA, WV | D.C. |
| **Physical Therapy Compact (PT Compact)**<br>*Physical Therapists* | Active | D.C., DE, VA, WV | N/A |
| **Psychology Interjurisdictional Compact (PSYPACT)**<br>*Psychologists* | Active | D.C., DE, PA, VA, WV | N/A |
| **Counseling Compact**<br>*Counselors* | Implementation Phase | DE, VA, WV | D.C. |
| **Occupational Therapy Licensure Compact (OT Compact)**<br>*Occupational Therapists* | Implementation Phase | DE, VA, WV | D.C., PA |
| **Audiology & Speech-Language Pathology Interstate Compact (ASLP-IC)**<br>*Audiologists, Speech-Language Pathologists* | Implementation Phase | DE, VA, WV | PA |
| **Social Work Licensure Compact**<br>*Social Workers* | Not Active | N/A | N/A |
| **Advance Practice Nurse Compact (APRN Compact)**<br>*Advance Practice Nurses* | Not Active | DE | N/A |
| **Dental and Dental Hygienist Compact (DDH Compact)**<br>*Dentists, Dental Hygienists* | Not Active | N/A | PA |
| **Physician Assistant Compact (PA Compact)**<br>*Physician Assistants* | Not Active | N/A | N/A |
| **EMS Compact**<br>*Emergency Medical Technicians and Paramedics* | Not Active | DE, PA, VA, WV | N/A |

**Maryland**
***Active:*** Maryland providers can apply for licenses or privileges to practice in other member states and Maryland can issue licenses or privileges to practice to providers in member states.
***Implementation Phase:*** Maryland has enacted legislation to join the compact, but the compact administrative infrastructure and processes are still in development (a process that takes about two years after a requisite number of states pass compact legislation).
***Not Active:*** Maryland has not enacted legislation to join the compact.

**Contiguous States**
- PA enacted legislation for IMLC (2016), NLC (2021), and EMS Compact (2023); implementation delayed.
- DE enacted legislation for the EMS Compact (2017); implementation delayed. DE also enacted legislation for the APRN Compact (2021); compact won't go into effect until a minimum number of states enact legislation.
- D.C. enacted legislation for the PT Compact (2021); implementation is in progress.

**Pending Legislation** Compact legislation was proposed in 2023 and under consideration.

## APPENDIX G

| Telehealth-Only Options by State<br>*As of May 2023* | | | | | |
|---|---|---|---|---|---|
| **State/ Statute**<br>**Permissive or Mandated*** | **Year Enacted** | **Option** | **Fee** | **Eligible Providers** | **Notable Provisions** |
| **AZ**<br>AZ Revised Statute Sec. 36-3606<br><br>Permissive | 2021 | Registration | Fees set by boards (~$100-$500* annually) | All Providers | Requires registered agent and proof of liability coverage |
| **CT**<br>SB 2 (2022 Session), Sec. 33<br><br>Permissive | 2022 | Registration | No Fee | Behavioral Health Care Providers | Requires proof of liability coverage<br><br>Allows the Commissioner to issue an order allowing out-of-state providers to practice w/out a CT license for a limited amount of time<br><br>Current Commissioner's Order expires 9/30/2023<br><br>Providers must apply for licensure, certification, or registration with the Connecticut Department of Public Health within 30 days of completing enrollment or secure a compact license within 90 days of completing enrollment |
| **DE**<br>Title 24, Ch. 60, Sec. 6002.<br><br>Permissive | 2021 | Registration | No fee | All Providers*<br><br>*Excludes providers in states that are members of a compact that DE participates in | Only applies to care delivered where there is an existing patient-provider relationship |
| **FL**<br>Section 456.47, Florida Statutes<br><br>Mandated | 2019 | Registration | No fee | All Providers | Requires registered agent and proof of liability coverage |
| **KS**<br>KS Statute Sec. 65-28-135<br><br>Permissive | 2021 | Waiver | $100 annually | All Providers | Requires proof of liability coverage |

| **Telehealth-Only Options by State**<br>*As of May 2023* | | | | | |
|---|---|---|---|---|---|
| **State/ Statute**<br>**Permissive or Mandated*** | **Year Enacted** | **Option** | **Fee** | **Eligible Providers** | **Notable Provisions** |
| **LA**<br>LA Revised Statutes 40:1223.4<br>Permissive | 2016 | Permit | Fees set by boards (~$50-$300 annually) | All Providers | |
| **ME**<br>Sec. 1. 32 MRSA §3300-D<br>Permissive | 2015 | Registration | $500 biennially | Physicians | For consultative purposes only |
| **MN**<br>MN Statute Sec. 147.032<br>Permissive | 2021 | Registration | $75 annually and $100 initial application fee | Physicians | |
| **TN**<br>TN Code Annotated Sec. 63-6-209(b)<br>Permissive | 2021 | License | Fee set by boards ($410 biennially for osteopathic physicians) | Physicians | Telemedicine licensure only available for out-of-state osteopathic physicians |
| **NM**<br>Administrative Code 16.10.2.8 & 16.10.2.11<br>Mandated | 2021 | License | $100 annually | Physicians | |
| **VT**<br>26 V.S.A. § 3053<br>Mandated | 2022 | Registration and License | ***Registration*:** 50% of the renewal fee for the profession<br>***License*:** 75% of the renewal fee for the profession | All providers | ***Telehealth registration*** restricted to providers with 10 or less Vermont patients/clients for not more than 120 consecutive days from date the registration was issued; can only be reactivated once every three years<br><br>***Telehealth license*** restricted to providers with 11-20 unique Vermont patients or clients in 2-year period |

| Telehealth-Only Options by State<br>*As of May 2023* | | | | | |
|---|---|---|---|---|---|
| **State/ Statute**<br>**Permissive or Mandated*** | **Year Enacted** | **Option** | **Fee** | **Eligible Providers** | **Notable Provisions** |
| **WV**<br>WV Code Sec. 21-17-3<br><br>Mandated | 2021 | Registration | Fees set by boards (~$100-$300 annually) | All providers | Providers prohibited from prescribing abortifacient (added 2023 session) or any controlled substance listed in Schedule II of the Uniform Controlled Substance Act |

*Some laws are permissive in nature, allowing the state health occupation boards or agencies to create telehealth-only registration, permits, or licenses, but not requiring the development of these options. Other states mandate these options be put in place. States that have permissive statutes allowing telehealth-only but where a current pathway does not exist (i.e., the pathway was never developed or was terminated after the PHE ended) were not included in the table (e.g., GA, NV, TX).

*Telehealth-only registration, licenses, waivers,* and *permits* enable providers licensed and in good standing in another state to register and deliver care via telehealth to residents. Requirements vary by state, but generally all telehealth-only options require providers to comply with all applicable laws and rules in the state, consent to the state's jurisdiction for disciplinary action or legal proceedings, and follow state standards of care for their profession. These pathways also prohibit providers from opening an office or providing in-person health care services in the State. Other requirements are highlighted in the *Notable Provisions* column.

**Sources:** Center for Connected Health Policy: www.cchpca.org/topic/cross-state-licensing-professional-requirements/; Federation of State Medical Boards: www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf

## ENDNOTES

[1] For purposes of this report, references of "interstate telehealth" refer to the provision of telehealth services to patients located in Maryland by a licensed or authorized provider located in another state.
[2] The Department of Health and Human Services first declared a PHE in January of 2020. The PHE ended on May 11, 2023.
[3] The workgroup convened three times from January through March 2023. Participants included stakeholders that are affected by or have an effect on expanded interstate telehealth. Refer to Appendix B for a listing of participants.
[4] Health care compacts allow a provider who holds primary licensure in a compact state to obtain a multistate license or expedited single-state license(s) to practice in other participating states.
[5] Ellimoottil C. *Takeaways From 2 Key Studies on Interstate Telehealth Use Among Medicare Fee-for-Service Beneficiaries.* JAMA Health Forum. 2022;3(9):e223020. doi: 10.1001/jamahealthforum.2022.3020.
[6] Center for Connected Health Policy, Professional Requirements, *Cross State Licensing*. Available at: www.cchpca.org/topic/cross-state-licensing-professional-requirements/.
[7] Bipartisan Policy Center, *What Eliminating Barriers to Interstate Telehealth Taught Us During the Pandemic*, November 2021. Available at: bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/11/BPC-Health-Licensure-Brief_WEB.pdf.
[8] *Ibid*.
[9] Bowen Center for Health Workforce Research and Policy, *Annual License Renewal Fees for Select Health Occupations by State*, February 2020. Available at: scholarworks.iupui.edu/server/api/core/bitstreams/ce9dac43-36c9-4e26-84a2-9e8ffc99a444/content.
[10] U.S. Department of Health and Human Services, *Licensure Across State Lines*. Available at: telehealth.hhs.gov/licensure/licensing-across-state-lines.
[11] States do not share fingerprints with other state Criminal Justice Information Systems (CJISs) or to receive electronic fingerprints from private vendors in other states. More information is available at: www.dpscs.state.md.us/publicservs/bgchecks.shtml.
[12]See n.7, *Supra*.
[13] MD Health Occupations Code § 1-704 (2018).
[14] *The Military Spouse Licensing Relief Act* is a provision of the *Veterans Auto and Education Improvement Act* and requires states to recognize a military spouse's license at a similar scope of practice and in the discipline to the one held in the previous state, provided that the military spouse provides a copy of such military orders to the new state's licensing authority; remains in good standing with the original state's licensing authority (and with any other state authorities that granted similar licenses); and complies with the new state licensing authority's rules for standards of practice, discipline, and fulfillment of any continuing education requirements.
[15] See n.7, *Supra*.
[16] Compacts aim to streamline licensing application processes and may reduce cost for providers.
[17] For purposes of this report, "established compact" refers to compacts that are currently granting licenses or privileges to practice and does not include compacts that are in the implementation phase.
[18] Maryland was the first state to join the Nurse Licensure Compact in 1999 and began operating under the Enhanced Nurse Licensure Compact in January 2018.
[19] Interstate compacts typically activate when triggered by a pre-set number of states joining the compact. This number varies across compacts, but typically falls in the range of 7-10 states. More information is available at: licensing.csg.org/compacts/.
[20] The Council of State Governments, *Occupational Licensure: Interstate Compacts in Action,* April 2020. Available at: compacts.csg.org/wp-content/uploads/2020/11/OL_Compacts_InAction_Update_APR_2020-3.pdf.
[21] Health Leaders, *Interstate Medical Licensure Compact Sees Growth During Pandemic,* April 2021. Available at: www.healthleadersmedia.com/clinical-care/interstate-medical-licensure-compact-sees-growth-during-pandemic
[22] Florida Office of Policy Planning and Government Accountability, *Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts,* October 2019. Available at: oppaga.fl.gov/Documents/Reports/19-07.pdf.
[23] Eligibility requirements for a telehealth license, permit, waiver, or registration varies across states and is restricted to certain practitioner types in some states.
[24] Federation of State Medical Boards, *U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19,* April 2023. Available at: www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf.

[25] Good standing generally means a license that: (1) is not currently revoked, suspended, or subject to a probationary period or a practice restriction or limitation; (2) was not surrendered while under or to avoid an investigation or disciplinary action; (3) was not revoked, suspended, or subject to a probationary period or a practice restriction or limitation at the time the license expired, lapsed, terminated, or was cancelled.
[26] See n.7, *Supra*.
[27] Governor Hogan enacted a Maryland State of Emergency in March of 2020, which expired on July 1, 2021. A State of Emergency was enacted on January 4, 2022 for the duration of 30-days.
[28] New Hampshire SB 277 extended the expiration for temporary and emergency licenses for health care workers, if they were obtained on or before Jan. 31, 2022, through June 30, 2023. Vermont passed legislation that extended pandemic-era license waivers through June 30, 2023. More information is available at: www.connectwithcare.org/state-telehealth-and-licensure-expansion-covid-19-chart/.
[29] See n.7, *Supra*.
[30] U.S. Department of Health and Human Services, *HHS Fact Sheet: Telehealth Flexibilities and Resources and the COVID-19 Public Health Emergency*, May 2023. Available at: www.hhs.gov/about/news/2023/05/10/hhs-fact-sheet-telehealth-flexibilities-resources-covid-19-public-health-emergency.html
[31] Ann M. Nguyen, Magda Schaler-Haynes, Jolene Chou, Molly Nowels, Danielle H. Llaneza, Elissa Kozlov; *Increasing Access to a Diverse Mental Health Workforce Through Emergency Reciprocity Licensure*. Journal of Medical Regulation, Volume 109, Issue 1, March 2023; 109 (1): 5–21. doi: doi.org/10.30770/2572-1852-109.1.5
[32] Juan J. Andino, Ziwei Zhu, Mihir Surapaneni, Rodney L. Dunn, and Chad Ellimoottil. *Interstate Telehealth Use by Medicare Beneficiaries Before And After COVID-19 Licensure Waivers, 2017–20*. Health Affairs 2022 41:6, 838-845. Available at: www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01825.
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[36] Chapter 270 (Senate Bill 707) and Chapter 271 (House Bill 912) of the 2022 Laws of Maryland, *Health Insurance - Provider Panels - Coverage for Nonparticipation*: www.mgaleg.maryland.gov/2022RS/chapters_noln/Ch_272_sb0707T.pdf.
[37] 116th Congress (2019-2020): *H.R.3630 - No Surprises Act*. Congress.gov, Library of Congress, July 11, 2019, www.congress.gov/bill/116th-congress/house-bill/3630 .
[38] Centers for Medicare & Medicaid Services, *No Surprises: Understand Your Rights Against Surprise Medical Bills*, January 2022. Available at: www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills.
[39] Some states require minimum levels of liability insurance or require insurance to qualify for liability reforms in the state.
[40] Maryland Code Annotated, Health Occupations Article §14-508 (effective date October 1, 2017). More information is available at: www.mbp.state.md.us/forms/malpractice_notice.pdf.
[41] Healthcare Dive, *As Cross-State Telemedicine Waivers Expire, Virtual Care Advocates Focus on Long-Term Policy Changes*, September 2022. Available at: www.healthcaredive.com/news/cross-state-telemedicine-waivers-expire-virtual-care-advocates-focus/625389/.
[42] Maryland fees are higher for foreign medical students.
[43] Under a mutual recognition model, a licensee receives a multistate license from the compact state in which the licensee has established residence or purchases a privilege from the compact.
[44] Under a mutual recognition model, licensees only need one state license to be granted a privilege or authorization to practice in other states. More information is available at: www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf.
[45] Health occupation boards that have adopted a mutual recognition model experience a loss of revenue, which may impact on their ability to operate solely on user fees.
[46] JDSupra, *Developments in Interstate Telehealth Licensing*, December 2022. Available at: www.jdsupra.com/legalnews/developments-in-interstate-telehealth-3935324/.
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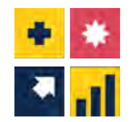

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[49] Jama, *Modernize Medical Licensing, and Credentialing, Too—Lessons From the COVID-19 Pandemic*, January 2021. Available at: www.jamanetwork.com/journals/jamainternalmedicine/fullarticle/2775344.
[50] The authority to discipline a licensee for failing to follow Maryland's requirements derives from the license itself. Without a Maryland license, health occupation boards have no authority to enforce Maryland law. At most, they can refer the case back to the licensing state and hope they can act, which is not a guarantee.
Essentially, this forces us to assume that other states will take on the responsibility of enforcing Maryland's laws, and removes the ability of Maryland patients to go through their own regulatory bodies when receiving certain care.
[51] United States Government Accountability Office, Report to Congressional Requesters, *Electronic Health Information Exchange*, April 2023. Available at: www.gao.gov/assets/gao-23-105540.pdf.
[52] PEW Charitable Trusts, *Improved Provider Coordination Can Reduce Health Care Costs*, December 2019. Available at: www.pewtrusts.org/en/research-and-analysis/articles/2019/12/09/improved-provider-coordination-can-reduce-health-care-costs.
[53] A list of HIEs registered to operate in Maryland is available here: mhcc.maryland.gov/mhcc/Pages/hit/hit_hie/hit_hie_registration.aspx.
[54] The Hamilton Project, *Reforming Occupational Licensing Policies,* March 2015. Available at: www.brookings.edu/wp-content/uploads/2016/06/thp_kleinerdiscpaper_final.pdf.
[55] U.S. Department of Defense, *DOD Releases Military Spouse Licensure Report*, February 2020. Available at: www.defense.gov/News/Releases/Release/Article/2091431/dod-releases-military-spouse-licensure-report/.
[56] Under the new law, any military spouse or servicemember with a professional license can transfer it to all 50 states unless the new state already participates in a compact and the military spouse or service memeber currently work within the compact, in which case, the compact precedes the federal law.
[57] A copy of the HGO letter is available at: mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/ist/MHCC_Expansion_IST_Wrkgrp_Req_Ltr_20220524.pdf
[58] A copy of the bill is available at: mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0670?ys=2022RS

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