Improving HIV-AIDS Treatment and Adherence through Telemedicine

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INTRODUCTION

“Hey motherfucker, I hear you’re dying of AIDS.”¹ John Doe faced a rude awakening as his co-workers mocked and harassed him after an intentional disclosure of his HIV positive status. John Doe had been diagnosed and living with HIV since 1985.² In 1996, Doe worked as a nighttime janitor for a company that contracted to clean the buildings of the Department of State.³ At that point, Doe had not disclosed his HIV status to anyone at his job.⁴ In April of 1996, Doe went to the emergency room because he was suffering from severe headaches, nausea, and high fever.⁵ He was discharged three days later and unable to return to work for another two weeks as a result of his health.⁶ His co-worker, Tijuana Goldring, also held a daytime position at the hospital at which Doe received treatment and discovered his HIV positive status.⁷ Before Doe returned to work, Goldring divulged her knowledge to another co-worker stating that Doe “had that shit” in reference to HIV or AIDS.⁸ The co-worker questioned the truthfulness of the statement and Goldring stated it was “for real” and that she had obtained her information “from the hospital.”⁹ Thereafter, Doe’s work environment was “‘like a living hell,’ as he was teased, ridiculed, pitied and scorned. Co-workers who had previously eaten with him now shunned him, and he was the object of snide remarks, stares, and unwanted attention.”¹⁰

² Id. at 924.
³ Id.
⁴ Id.
⁵ Id.
⁶ Id.
⁷ Id.
⁸ Id. at 943.
⁹ Id.
¹⁰ Id. at 944.
Although this dispute was resolved in the court, it presents an issue of intentional and unintentional disclosure that may have been resolved by the use of telemedicine—a patient’s use of any real time electronic means to establish communications between a health care service provider and a patient. Moreover, the case also illustrates many legal and social issues that plague those living with HIV/AIDS, the stigma attached to HIV/AIDS and the prevailing fear of obtaining treatment. The discriminatory and offensive treatment of those living with HIV/AIDS has deterred individuals living with HIV/AIDS from leaving work to attend treatments, and attending regular check-ups due to fear of being suspected, overheard, or even seen physically entering a facility known to treat those living with HIV/AIDS. Although there are no statistics detailing these effects, there is a plethora of literature discussing the detrimental impacts that influence those living with HIV/AIDS quality of life, treatment adherence, disease progression, and mortality in the United States and internationally.11

As a result, those living with HIV/AIDS are being deprived from starting, obtaining, and continuing treatment that could improve and lengthen their lives. Additionally, psychological issues manifest such as depression, anxiety, and stress. To remedy these problems, telemedicine treatment should be offered as an alternative medium to in-person treatment. The discovery of antiretroviral treatment has been a successful breakthrough in HIV/AIDS treatment and has lengthened the lives of those infected.\(^\text{12}\) Antiretroviral treatment involves taking a combination of three drugs that reduces the reproduction of HIV in the body.\(^\text{13}\) The first drug to treat HIV/AIDS was approved by the Food and Drug Administration in 1987.\(^\text{14}\) In the last decade, thirty-four (34) additional drugs were approved by the Food and Drug Administration.\(^\text{15}\) With the plethora of effective medicines to assist those living with HIV/AIDS live a normal health life, the stigma and fear attached to the disease has served as a disincentive for obtaining treatment.

The focus of this comment is to promote the health and improve access, adherence, and quality of health for those living with HIV/AIDS through the use of telemedicine. Although the problems addressed in this comment are national in scope, this comment will focus on the state of California to demonstrate potential solutions that the legislature and medical board can implement to resolve the problems. For those living with HIV/AIDS, providing telemedicine as an option for treatment will reduce the possibility of unintentional and intentional disclosures by allowing individuals living with HIV/AIDS to consult with physicians or health care providers from the privacy of a designated area or their home and to obtain access from renowned experts.


\(^\text{13}\) Id.


\(^\text{15}\) Id.
across the country. Simultaneously, telemedicine can also alleviate the emotional stress, embarrassment, pain and suffering caused by stigma and lack of understanding of the disease.

First, this comment will provide a general landscape and history of HIV/AIDS. Then, Part II will then discuss telemedicine and its effectiveness. Part III will examine how telemedicine can improve access to people living with HIV/AIDS and its recent legislative developments enabling those living with HIV/AIDS to fund this alternative. Thereafter, Part IV will discuss how cross-border licensing schemes present an obstacle to the general implementation of telemedicine and how telemedicine has been proven successful in a variety of settings. Potential solutions will be proposed to resolve the obstacle for cross-border licensing and the comment will conclude with an examination of the potential benefits derived from employing telemedicine in the treatment of HIV/AIDS.

Part I. Brief History and Statistics

HIV (Human Immunodeficiency Virus) has been present in the United States since the mid to late 1970s. HIV is a virus, if left untreated, can overwhelm the immune system and lead to acquired immunodeficiency syndrome (AIDS). HIV attacks and destroys specific cells of the immune system. These cells are called CD4 or T cells. When a sufficient number of CD4 and T cells are destroyed, the body cannot fight off infections and disease. At present, there is no cure for HIV, but with proper care, the virus can be controlled through antiretroviral treatment. The source of HIV can be traced back to a type of chimpanzee in West Africa.

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17 Id.
18 Id.
19 Id.
20 Id.
HIV spread because humans hunted these chimpanzees for meat and were exposed to the chimpanzees’ infected blood.\textsuperscript{22} Further research reveals that the chimpanzees were infected with simian immunodeficiency virus (SIV) which then mutated into HIV upon contact with humans.\textsuperscript{23} Moreover, the U.S. Department of Health and Human Services have provided global statistics finding that “33.4 million people are currently living with HIV/AIDS; more than 25 million people have died due to HIV/AIDS, and another 2.7 million were newly infected.”\textsuperscript{24} In 2011, the Centers for Disease Control and Prevention estimated that there were 1,144,500 people living in the United States aged 13 years and older who were living with HIV and approximately 180,900 people who were unaware that they were infected.\textsuperscript{25} Additionally, it is estimated that there are approximately 50,000 new HIV infections per year.\textsuperscript{26} Of those infected with HIV, approximately 63\% of new HIV infections can be attributed to male-to-male sex, 25\% to heterosexuals, and 8\% to injection drug users.\textsuperscript{27} By race and ethnicity, African Americans represent approximately 44\% of all new HIV infections, while Hispanics represent 21\%, Caucasians represent 31\%, and other racial and ethnic groups represent 2\%.\textsuperscript{28} The Center for American Progress suggests that the racial HIV disparity

\textsuperscript{22} Id.
\textsuperscript{23} Id.
\textsuperscript{28} Id.
is strongly correlated with the racial wealth gap.\textsuperscript{29} This is because “the high rates of HIV/AIDS [seen] among communities of color are not the result of high-risk behavior . . . , but structural inequalities that make them more likely to come in contact with the disease and less likely to treat it.”\textsuperscript{30}

In California, there were 45,966 people living with HIV in June 2013,\textsuperscript{31} while in 2014, there were 48,323 people living with HIV.\textsuperscript{32} In 2013, however, there were 2,252\textsuperscript{33} deaths from HIV while there were 2,632 in 2014.\textsuperscript{34} With respect to AIDS, in 2013, there were 73,308\textsuperscript{35} people living with AIDS, while in 2014, there were 74,059.\textsuperscript{36} There were 93,722 deaths associated with AIDS in 2013 whereas in 2014, there were 95,529 deaths.\textsuperscript{37} Overall, the total number of reported cases of individuals both living with HIV/AIDS in California in June of 2014 was 220,543.

More specifically, in Los Angeles County there were 45,474 people living with HIV/AIDS in December of 2012\textsuperscript{38} which increased to 46,912 by the end of 2013.\textsuperscript{39} Approximately 1500-2000 individuals are infected with HIV each year.\textsuperscript{40} Although the overall

\textsuperscript{30} Id.
\textsuperscript{34} http://www.cdph.ca.gov/programs/aids/Documents/June_2014_SemiAnnualReport.pdf
\textsuperscript{37} Id.
number of people living with HIV/AIDS has steadily increased since 2006, annual diagnosis of AIDS reveals that by gender, race/ethnicity and age, the development of AIDS has been reduced.\textsuperscript{41} This may be attributed to the accessibility and use of antiretroviral medications which reduce the viral load and prevents those living with HIV from progressing to the point of AIDS.\textsuperscript{42}

Likewise, the use and adherence to the medications also increases the quality and duration of life, thereby providing a partial explanation for the increasing number of people living with HIV/AIDS.\textsuperscript{43} For example in 2002, there were 715 deaths as a result of HIV/AIDS. In 2012, there were only 228.\textsuperscript{44} The corresponding number of people living with both HIV/AIDS in 2002 was 48,965 while in 2013 there were 74,462.\textsuperscript{45} In Los Angeles County, those living with HIV/AIDS are highly concentrated in the Metro area in which 38\% (17,085 people) or 1,594 people out of 100,000 people are living with HIV/AIDS.\textsuperscript{46}

Despite the positive results from the 2013 Annual HIV Surveillance Report, it fails to take into account the stigma and the social determinants of health which may detrimentally impact an individual’s decision to obtain treatment or care, or even at the very least to get tested for HIV/AIDS.\textsuperscript{47} This is because social determinants such as access to health care services, the availability of community-based resources, or social support have an “important role in facilitating or impeding one’s optimal health and well-being. [Thus,] [p]opulations that are

\textsuperscript{43}Id.
\textsuperscript{45}Id. at p. 7.
\textsuperscript{46}Id. at p. 40.
disproportionately impacted by social determinants experience greater health disparities.”

For example, “[i]income was shown to be an important predictor of a lack of health insurance among persons with HIV and, consequently, may be a reason why they are less likely to receive treatment.” Telemedicine or telehealth may further assist in reducing the impact of stigma and the social determinants of health.

**Part II. What is telemedicine?**

The purpose of Telemedicine, also known as telehealth is to provide health care services to the underserved populations who, due to geographic and/or economic barriers, are unable to access health care. Telehealth reduces barriers by connecting patients and providers over great distances. For example, it connects health professionals with patients in remote parts of the state, those with disabilities, or those with dialects not commonly found in their area. Telemedicine works by allowing patients to use any real time electronic means to establish communications between a health care service provider and a patient. Globally, the number of patients using telemedicine has risen from less than 350,000 in 2013 to an estimated seven million in 2018.

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48 Id.
49 Id.
51 Id.
52 Id.
53 Dan Bowman, *Patients using telehealth services to hit 7 million by 2018*, FierceHealthIT
California first enacted its telemedicine laws in 1996. In 2011, it later amended the definition of telemedicine by expanding the delivery mode of health care services. California now defines telehealth as:

[T]he mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

The California amendment reduced barriers to telehealth treatment which is now subject to the same medical record documentation, informed consent, privacy standards that apply to all other


health care encounters.\textsuperscript{57} However, any out of state physician seeking to provide health care services to California residents are still subject to the medical licensing laws of California with few exceptions.

In order to respond to the abundance of states introducing telehealth legislation (40 of 50 states as of 2013),\textsuperscript{58} Congress enacted The Telehealth Modernization Act of 2013. The purpose of the bill was to establish federal standards for telehealth to provide guidance to the states and also to ensure that health care providers maintain the same quality of treatment that would be provided if the patient were to be seen in person.\textsuperscript{59} Congress also saw the potential benefits that could be derived from telehealth in which it has the potential to “reduce costs, improve quality, change conditions of practice, and improve access to health care.”\textsuperscript{60}

To further promote telehealth, Congress also enacted the Telemedicine for Medicare Act of 2013 which amended Title 18 of the Social Security Act by permitting certain Medicare providers licensed in a state to provide telemedicine services to certain Medicare beneficiaries in a different state.\textsuperscript{61} As of September 2014, 47 states incorporated reimbursement for telehealth services in their public programs such as Medicaid.\textsuperscript{62} Only 19 states have enacted parity laws which means comparable coverage and reimbursement for telemedicine services to that of an in-person service.\textsuperscript{63} Only 2 states have enacted partial parity laws but limit coverage to a certain

\textsuperscript{57} California Physician’s Legal Handbook (2013).
\textsuperscript{58} H.R. 3750, 113th Cong. (2013) (enacted).
\textsuperscript{59} Id.
\textsuperscript{60} Id.
\textsuperscript{61} H.R. 3077, 113th Cong. (2013) (enacted).
\textsuperscript{63} Id.
geographical location.\textsuperscript{64} Likewise only 11 states provide coverage under state employee health plans.\textsuperscript{65}

\textbf{A) The Effectiveness of Telemedicine}

Several studies also illustrate the effectiveness and the quality of care of telemedicine. In Pennsylvania, a clinical trial revealed that the patient-centered medical home was a promising model to decrease costs while also improving access to high quality health care.\textsuperscript{66} The study was conducted between 2008 and 2010 and the participating sites “achieved lower medical and pharmacy costs; more efficient delivery of service, such as lower hospital admissions and readmissions and less use of hospital emergency departments.”\textsuperscript{67}

A study on telepsychiatry revealed that a “psychiatric interview conducted over videoconferencing is reliable for diagnostic assessment and treatment recommendations.”\textsuperscript{68} Likewise, “retrospective review of medical records comparing clinical outcomes of patients seen by [interactive TV] (IATV) and those in-person showed no significant difference found in the percentage of change in Global Assessment of Functioning (GAF) between the two groups suggesting clinical outcomes were not affected by the use of IATV.”\textsuperscript{69} Telemedicine has also been successful in other realms of health care services such as telenursing for patients with heart

\begin{flushleft}
\textsuperscript{64} Id.  \\
\textsuperscript{65} Id.  \\
\textsuperscript{67} Id.  \\
\textsuperscript{69} Id.
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failure,\textsuperscript{70} teleneurology,\textsuperscript{71} diabetes,\textsuperscript{72} and telecardiology.\textsuperscript{73} Accordingly, those living with HIV/AIDS can also realize the benefits from utilizing telemedicine services.

Other factors that show telemedicine is an effective mode to treat patients include cost. Cost effectively, the average estimated cost of a telehealth visit ranges from $40-50 dollars while an in-person visit can cost as much as $176 dollars.\textsuperscript{74} Likewise, the Department of Veterans Affairs has reported treating approximately 690,000 veterans by mode of telemedicine.\textsuperscript{75} Adam Darkins, Chief Consultant for telehealth services at Veterans Affairs reported that veterans that participated in telemedicine programs had reduced hospital admission rates and emergency room visits.\textsuperscript{76} Despite telemedicine’s positive results, inconsistent cross-border licensing schemes pose a barrier to its success.

Moreover, telemedicine will prove critical as a greying physician population and the shortage of physicians grow. It is estimated that by 2025, there will be a shortage of approximately 130,000 physicians.

\textsuperscript{71} Craig J., et. al., \textit{The cost-effectiveness of teleneurology consultations for patients admitted to hospitals without neurologists on site}, J. OF TELMEDICINE AND TELECARE 6 (suppl 1): S1: 46-9 (2000).
\textsuperscript{74} Dale H. Yamamoto, December 2014, Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services.
When patients go in to receive treatment for HIV/AIDS, the chances of seeing a physician that has worked with HIV/AIDS for decades is good. This is because the outbreak in the 1980’s forced a lot of physicians into the specialty. “Most of the infectious disease doctors in the 1980s got into HIV because it fell on our shoulders,” said Howard Edelstein, MD, a doctor at the Alameda County Medical Center in Oakland who began to specialize in HIV/AIDS care at the end of this first wave in the late ’80s. “It’s been the same doctors for a long time.”77 However, many of these longtime HIV/AIDS physicians and nurses are also retiring.

As a result, “retirements may increase caseloads for doctors who specialize in HIV/AIDS treatment and, as a result, make the specialty even less attractive for young doctors.” 78 Additionally, the specialty “already has trouble competing with more lucrative specialties. Infectious diseases in general and AIDS in particular rank among the lowest paying medical professions for the amount of training required.” 79 In 2010, there were 7,149 active physicians specializing in infectious diseases. 80 Likewise, there were 794,862 active physicians overall. With the shortage of physicians and in particular the shortage of physicians specializing in HIV/AIDS, it is imperative that those living with HIV/AIDS have access to physicians that specialize in such treatment. These specialized physicians may not reside in the patient’s home state, leaving patients with inexperienced physicians.

78 Id.
79 Id.
Moreover, with the fear of discrimination, patients may opt to be treated by an out-of-state physician to avoid unintentional disclosures of their status.

**Part III. How can telemedicine improve access to people living with HIV/AIDS?**

Telemedicine can improve health care access to people living with HIV/AIDS by eliminating the possibility of an intentional or unintentional disclosure of one’s status. This is because telemedicine offers services relating to primary care and specialist referral services, remote patient monitoring, consumer medical and health information, and medical education. Utilizing telemedicine from the privacy of a designated location or the patient’s home protects the patient’s mental, physical, and emotional wellbeing resulting from ridicule, embarrassment, rejection, or potential harm by intentional or unintentional disclosures. This was illustrated in the opening of the introduction.

![United States Treatment Cascade, From HIV Diagnosis to Viral Suppression](image)

Moreover, the chart above reveals the general numbers of how many people living with HIV/AIDS are diagnosed, linked to care, retained in care and are on antiretroviral therapy. Given the enormous success of antiretroviral therapy in suppressing the viral load, there should be a higher percentage of people on antiretroviral therapy and a higher percentage of those with a suppressed viral load.\(^81\) The study using this chart has discussed stigma and discrimination as being one set of reasons for such low percentages.\(^82\)

Likewise, the lack of understanding of HIV/AIDS disease and its transmission has instilled a fear of the unknown among the general public. This is because HIV/AIDS is not only negatively associated with lifestyle choices, but it is a life-threatening illness with no cure. The primary route of HIV infection is attributed to behavioral risk factors such as sex and the sharing of needles.\(^83\) Additionally, early AIDS metaphors such as death, punishment, shame, or guilt have increased fears, thereby reinforcing and legitimizing discrimination and stigma.\(^84\) In 1987, the director of the [World Health Organization] Global Programme on AIDS, Jonathan Mann described three phases of the HIV/AIDS epidemic: “the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial.”\(^85\) The latter has been most difficult to eradicate.\(^86\) Stigma often stems from the underlying stigmatization of sex.\(^87\) This is because sex


\(^{82}\) Id.


\(^{84}\) Id.

\(^{85}\) Id.

\(^{86}\) Id.

\(^{87}\) Id.
is associated with sexually transmitted diseases, promiscuity, homosexuality, sexual deviance
and prostitution.\textsuperscript{88}

Additionally, stigma can be gender-related. With respect to women, the impact of
HIV/AIDS reinforces pre-existing economic, cultural, social disadvantages, educational and
unequal access to information or services. Likewise, heterosexual transmission has been
associated with both male and female behaviors.\textsuperscript{89} More specifically, women are viewed as
promiscuous, therefore their sexual behavior is inconsistent with gender norms, whereas an
assumption exists in which males need multiple sexual behaviors.\textsuperscript{90} Class and Racial stigma also
affect discrimination. As noted above, African Americans have the highest percentage rate for
those living with HIV/AIDS. Attached to that number is the assumption that African Americans
participate in more risky sexual behavior than other racial groups.\textsuperscript{91} Class affects stigma because
poverty increases susceptibility to HIV/AIDS.\textsuperscript{92}

Although academics, clinics and health institutions have attempted to inform the general
public about these misconceptions regarding transmission and treatment, the disease is still
looked upon with negativity. Some transmission myths include, but are not limited to: (1)
breathing the same air as someone who is HIV-positive; (2) touching a toilet seat or doorknob
handle after an HIV-positive person; (3) drinking from a water fountain; (4) hugging, kissing, or
shaking hands with someone who is HIV-positive; (5) sharing eating utensils with an HIV-
positive person; and (6) using exercise equipment at a gym.\textsuperscript{93} As a result, those living with

\textsuperscript{88} Id.
\textsuperscript{89} Id.
\textsuperscript{90} Id.
\textsuperscript{91} Id.
\textsuperscript{92} Id.
\textsuperscript{93} The Top 10 Myths and Misconceptions About HIV and AIDS, WEBMD, http://www.webmd.com/hiv-aids/top-10-
HIV/AIDS are discriminated against in a variety of service areas such as, but not limited to health care services, employment opportunities, benefits, and education.

For example, in December of 1987, John McGann discovered he was afflicted with AIDS. McGann was an employee at H & H Music and received health benefits from H & H Music’s group medical plan. The plan offered lifetime medical benefits of up to $1,000,000 to all employees. When McGann submitted his first claim for reimbursement, he disclosed that the treatment he received was for AIDS. Thereafter, McGann met with officials at H & H Music to discuss his illness. Subsequently, H & H Music informed all employees that changes would be made in their medical coverage which included a provision that limited benefits payable for AIDS-related claims to a lifetime maximum of $5,000. Here, McGann’s employer changed the group medical plan directly after McGann disclosed what he was being treated for. Accordingly, there is a strong inference that McGann was discriminated against due to his illness.

Likewise, in 1992, a dentist, Dr. Donald Clausen refused to treat a patient that tested positive for HIV and was fined $15,000 for patient’s mental anguish and suffering. Similarly, Sidney Abbott had contracted HIV and went in to Dr. Randon Bragdon’s office for a dental appointment. Before treatment, she filled out a Patient Registration and Health Record form in which she noted that she had HIV. Thereafter, Dr. Bragdon notified Abott that he would not

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95 Id.
96 Id.
97 Id.
98 Id.
99 Id.
102 Id.
be able to treat her in his office due to his infectious disease policy, but that he would treat her in a hospital setting. Additionally, there are thirty-two states and two U.S. territories that criminalize HIV transmission through shared needles, bodily fluids, and sex. Some of these criminalization laws do not require actual intent to transmit HIV nor actual transmission. In Iowa, Nick Rhoades was imprisoned for twenty-five years for failing to disclose to his one-time partner that he was HIV positive. Rhoades was on antiretroviral medications and used protection, but failed to disclose his status. Although Rhoades’ partner tested negative for HIV, Rhoades spent nine months in jail.

"I spent six weeks in solitary confinement," he says. "I was in a cell for 23 hours a day with a camera on 24 hours a day. I was allowed just one visit per week. I could not see out a window. "For nine months I never saw the sun, except for one time on my way to a medical appointment. I was taken to that medical appointment in my orange jumpsuit and my cuffs and shackles. A mother and daughter saw me in the waiting room and got up and moved away from me. I felt pretty less than human."

In Michigan, a man “was charged under the state’s anti-terrorism statute with possession of a ‘biological weapon’ after an altercation with a neighbor. Prosecutors equated his HIV infection with ‘possession or use of a harmful device.’” In New York, a man was “sentenced

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103 Id.
105 Id.
107 Id.
108 Id.
109 Id.
111 Id.
to 10 years for aggravated assault after biting a police officer.” 112 These examples illustrate the discriminatory motivations behind these acts, the laws, and the lack of understanding of how HIV is transmitted.

The ignorance and variety of methods that are used to alienate those living with HIV/AIDS has detrimental effects on their quality of health and adherence to treatment. Those living with HIV/AIDS suffer from higher rates of depression and health risk factors. 113 This is due in part to stigma. 114 “HIV/AIDS related stigma can be described as a process of devaluation of people either living with or associated with HIV/AIDS.” 115

Moreover, approximately 20% of teens experience depression before they turn 18. 116 People living with HIV/AIDS have depression rates as high as 30 to 40%. 117 Some studies have examined how the relationship between stigma and depression affect youths. The findings illustrate that in a group of 310 HIV-infected young men who have sex with men, high levels of stigma are positively correlated with low self-esteem and higher depression. 118 Stigma affects HIV prevention, support, and adherence as: it increases stress; deters people from getting tested; it deters safer behaviors; it can deter those living with HIV/AIDS from seeking HIV prevention services or having those services offered or integrated into a broader health community; it may cause delay in obtaining HIV/AIDS treatment for fear of discrimination; it may induce fear of

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112 Id. See also, People v. Plunkett, 19 N.Y.3d 400 (2012).
114 Id.
115 Id.
social and familial rejection; and it may decrease the motivation for those living with HIV/AIDS from staying healthy.\textsuperscript{119}

Besides alleviating the stresses related to intentional and unintentional disclosures, telemedicine provides greater access to patients because resources and health care treatment are not limited geographically. Patients can choose physicians or experts in other counties or states so long as they meet the state’s licensing requirements. It also enables them to continue with follow-up treatment without the travel or wait time.

For example, the Veterans Affairs Hospital in Los Angeles conducted a study comparing telemedicine with in-person subspecialty visits for hepatitis C and HIV.\textsuperscript{120} The results demonstrated that there was a higher completion rate for those participating in telemedicine appointments as opposed to in-person visits.\textsuperscript{121} Using regression analysis, telemedicine was a strong indicator of clinic completion. Satisfaction surveys also revealed that patients preferred telemedicine to in-person clinic visits.\textsuperscript{122} Additionally, there was a dramatic reduction in the health visit time, the median being 340 (the range being 250-440 minutes).\textsuperscript{123} The study further illustrated that transportation and distance represented a huge barrier to accessibility, which directly affected adherence to treatments.\textsuperscript{124}

Given the nursing shortage, the Online Journal of Issues in Nursing also published a study to determine the effectiveness of telehealth technology in assisting case managers

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\textsuperscript{119} How does stigma affect HIV prevention and treatment?, UCSF (May 2006) http://caps.ucsf.edu/factsheets/stigma/.
\textsuperscript{121} Id.
\textsuperscript{122} Id.
\textsuperscript{123} Id.
\textsuperscript{124} Id.
\end{flushleft}
effectively manage their caseloads of HIV/AIDS clients. The study consisted of six “[p]atients and health care providers [that] used two-way interactive audio and/or video to collect and transmit clinical data. [The] service provide[d] remote assessment, education and data collection.” Overall, patients did not like the lack of social interaction with the nurse, but they were satisfied with the convenience and mastering the technology. Notwithstanding, issues of privacy and brief technological malfunctioning were voiced as concerns. Overall, other research has established that there are high levels of patient satisfaction associated with telemedicine as a result of travel, waiting time and accessibility of specialists. There is also high satisfaction with provider-patient communication.

Moreover, accessibility is further improved as 46 states require either Medicaid, private insurance or both types of coverage for telehealth services. More specifically, California’s insurance code prevents health insurers and managed care plans from excluding coverage for telemedicine services solely because the service did not involve a face-to-face encounter between patient and provider.

126 Id.
127 Id.
128 Id.
130 Id.
132 Cal. Insur. Code § 10123.85; Health Sect. Code §1374.13; see also State Coverage for Telehealth Services, NAT'L CONFERENCE OF STATE LEGISLATURE, http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx; see also Cal. Bus. & Prof. Code §2290.5 and Cal. Health & Safety Code §1374.13 “No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.”
Part IV. State Licensing Requirements as an Obstacle for Successful Telemedicine Implementation

A significant problem with the success rate of telemedicine is the state licensing requirements for health care professionals seeking to provide telemedicine treatment intrastate. Licensing and re-licensing requirements vary by health care profession and are conducted at the state-level.\(^{133}\) There are 69 different licensing jurisdictions in the United State, and each state’s board of medical licensing functions similarly but uses slightly different guidelines.\(^{134}\) Thus, health care professionals are “subject to each state’s differing regulations and standards.”\(^{135}\)

As a result, health care professionals are then saddled with satisfying “different requirements in multiple jurisdictions” which “can be quite burdensome for a practicing physician.”\(^{136}\) The purpose of a licensing scheme is to protect the health and safety of consumers by promoting quality in a specific health care profession and ensuring liability can be found when health treatment goes awry.\(^{137}\) However, when a health care professional already has a license and seeks to treat an out-of-state patient, obtaining an intrastate license is a “formidable hurdle”\(^{138}\) to effective treatment and does no more to protect consumer safety.

A study conducted by the American Telemedicine Association found that “decades of evidence-based research highlighting positive patient compliance, clinical outcomes and

\(^{136}\) Id. at 317.
\(^{137}\) Medical Licensure, AMA, http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure.page (“Increasing public demand for protection, coupled with the growth in the number and sophistication of fraudulent practitioners over the past 2 decades, has resulted in stronger and more complex licensing boards and licensing statutes throughout the country.”) (last visited Feb. 24, 2015).
increasing telemedicine utilization have been met with a mix of strides and stagnation in state-based policy.” This is further evidenced by the fact that “no state achieved a top score for licensure policies,” meaning each state has their own policy regarding licensure. In the study, 23 states and the District of Columbia received a score of an A (suggesting a policy landscape that supports telemedicine), 26 states received a score of a B (suggesting there is some policy landscape support of telemedicine, but there is room for improvement), and 1 state received a score of a C (suggesting that there are many barriers to the use of telemedicine). Without a uniform cross-state licensing scheme, the success of telemedicine is frustrated. The Federal Communications Commission recognized this frustration when it found that the licensing and relicensing scheme “limit[ed] practitioners’ ability to treat patients across state lines. This hinders access to care, especially for residents of states that do not have needed expertise in-state.”

Table A further illuminates the success of telemedicine in more specific categories. For physician-patient encounter, states were assessed by examining state policies that support or obstruct telemedicine use before, during and after a patient encounter. With respect to telepresenter experience, states were assessed according to requirements for telepresenters or health care providers being present during a telemedicine encounter. Finally, licensure and out-of-state practice was measured by each state’s medical board licensure requirements for out-

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139 Latoya Thomas & Gary Capistrant, State Telemedicine Gaps Analysis Physician Practice Standards & Licensure (September 2014).
140 Id.
141 Id.
142 Id.
144 Latoya Thomas & Gary Capistrant, State Telemedicine Gaps Analysis Physician Practice Standards & Licensure (September 2014).
145 Id.
of-state telemedicine providers. This includes reciprocity for bordering states, conditional licenses, and physicians consulting other physicians.

<table>
<thead>
<tr>
<th>State</th>
<th>Overall Grade</th>
<th>Physician-Patient Encounter</th>
<th>Telepresenter Experience</th>
<th>Licensure &amp; Out-of-State Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>C</td>
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<td>B</td>
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<tr>
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<td>AR</td>
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<td>C</td>
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<tr>
<td>VT</td>
<td>B</td>
<td>B</td>
<td>A</td>
<td>C</td>
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</tbody>
</table>

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146 Id.
147 Id.
148 Id.
Table B presents a survey of cross-border licensing laws each state has implemented to accommodate telemedicine. States that list “no reference found” means the health care provider must undergo the state’s individual licensing application requirements.

<table>
<thead>
<tr>
<th>State</th>
<th>Requires Full License</th>
<th>Cross-Border Licensing</th>
<th>Medicaid</th>
</tr>
</thead>
</table>
| AL    | X                     | • Alabama Admin. Code 540-X-15-.05 – a distant site provider must have a current and unrestricted Alabama License.  
• Code of Alabama Sec. 34-24-502-507 (2012) – “a special purpose license allowing practitioners licensed in other states to practice across state lines may be issued.”  
• An exemption exists if a physician on one state needs to consult with a physician in another state. |
| AK    | X                     | No reference found.    | No reference found. |
| AZ    | X                     | Arizona Revised Statute Sec. 32-1421 (2012) an out-of-state doctor may engage in a single or infrequent consultation with an Arizona physician. |
| Fee for Service and Managed Care A consultation by a non-Arizona licensed provider may occur if:  
• It is to a specific patient in the AHCCCS program;  
• The provider is registered with AHCCCS; |
<table>
<thead>
<tr>
<th>State</th>
<th>X</th>
<th>Out-of-state provider regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AR</strong></td>
<td>X</td>
<td>An out of state physician utilizing an electronic medium who performs an act that is part of a patient care service that was initiated in Arkansas, including interpretation of an X-ray, that would affect the diagnosis or treatment, is engaged in the practice of medicine and subject to regulation by the Arkansas State Medical Board. <em>AR Code Revised 17-95-206 (2012)</em></td>
</tr>
<tr>
<td><strong>CA</strong></td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>CO</strong></td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>CT</strong></td>
<td>X</td>
<td>CT General Statutes Sec. 20-12 (2012). Department of Public Health may establish a process of accepting an applicant’s license from another state and may issue that applicant a license to practice medicine in the state without examination, if certain conditions are met. Medical Assistance Program – No reference found.</td>
</tr>
<tr>
<td><strong>DC</strong></td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>DE</strong></td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>FL</strong></td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>GA</strong></td>
<td>X</td>
<td>GA Admin. Code Sec. 360-3-.07 Must be a Georgia licensed practitioner. GA Dept. of Community Health, GA Medicaid Telemedicine Handbook, p. 3, (Nov. 2012). Providers must have a Georgia license.</td>
</tr>
<tr>
<td><strong>HI</strong></td>
<td>X</td>
<td>HI Revised Statutes § 453-2(b)(6). Out-of-state radiologists may provide services in Hawaii. HI Revised Statutes Sec. 453-2(3). Commissioned medical officers or psychologists employed by the US Department of Defense and credentialed by Tripler Army Medical Center are exempt from licensing requirements when providing services to neighbor island beneficiaries within a Hawaii national guard armory. No reference found.</td>
</tr>
<tr>
<td><strong>ID</strong></td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td><strong>IL</strong></td>
<td>X</td>
<td>No reference found. For medical services, the provider rendering the service at the distant site can be a physician, physician assistant, podiatrist or advanced practice nurse, who is licensed by the State of Illinois or by the state where the patient is located. For psychiatric services, the provider rendering the service at the distant site must be a physician licensed by the State of Illinois, or by the state where the patient is located, who has completed an approved general psychiatry residency program or a...</td>
</tr>
<tr>
<td>State</td>
<td>X</td>
<td>Reference</td>
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<tr>
<td>IN</td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td>IA</td>
<td>X</td>
<td>No reference found.</td>
</tr>
<tr>
<td>KS</td>
<td>X</td>
<td>A provider must be licensed in Kentucky with the exception of persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a Kentucky-licensed physician. <strong>KY Revised Statutes § 311.560 (2012).</strong></td>
</tr>
<tr>
<td>KY</td>
<td>X</td>
<td>A provider must be licensed in Kentucky with the exception of persons who, being nonresidents of Kentucky and lawfully licensed to practice medicine or osteopathy in their states of actual residence, infrequently engage in the practice of medicine or osteopathy within this state, when called to see or attend particular patients in consultation and association with a Kentucky-licensed physician. <strong>KY Revised Statutes § 311.560 (2012).</strong></td>
</tr>
</tbody>
</table>
| LA    | X | A telemedicine license may be issued to out-of-state physicians, as long as they hold a full and unrestricted license in another state or U.S. territory. Out-of-state telemedicine providers cannot open an office, meet with patients or receive calls from patients within Louisiana. A licensed health care provider must be in the examination room with the patient during telemedicine services. **LA Revised Statutes 37:1276.1 (2012).**  
**Newly Passed Law (Effective Aug. 1, 2014)**  
LA state agencies and professional boards can regulate the use of telehealth including licensing of out-of-state healthcare providers. **LA Revised Statutes HB 1280 (2014).** |
| ME    | X | No reference found. |
| MD    | X | MD has exceptions to its MD-only licensed physicians for physicians practicing in the adjoining states of Delaware, Virginia, West Virginia, and Pennsylvania. **MD Health Occupations Code Annotated Sec. 14-302 (2012).**  
A physician providing services through telemedicine must have a Maryland license if they are located in Maryland, or if the patient is in Maryland. **COMAR 10.32.05.03** |
| MA    | X | No reference found. |
| MI    | X | No reference found. |
| MN    | X | A physician licensed in another state can provide telemedicine services to a patient in Minnesota if their license has never been revoked or restricted in any state, they agree to not open an office in Minnesota and they register with the state’s board. **MN Statute Sec. 147.032(1)** |
| MS    | X | Physicians practicing telemedicine must have a Mississippi medical license. However, a valid Mississippi license is not required where the evaluation, treatment and/or medicine given by a physician outside of Mississippi is requested by a physician duly licensed to practice medicine in Mississippi, and the physician who has requested such evaluation, treatment and/or medical opinion has already established a doctor/patient relationship. **MS stat. 37:1124(3)** |
relationship with the patient to be evaluated and/or treated. In order to practice telemedicine a valid “physician patient relationship” must be established. The elements of this valid relationship are: 1. verify that the person requesting the medical treatment is in fact who they claim to be; 2. conducting an appropriate examination of the patient that meets the applicable standard of care; 3. establishing a diagnosis through the use of accepted medical practices, i.e., a patient history, mental status exam, physical exam and appropriate diagnostic and laboratory testing; 4. discussing with the patient the diagnosis, risks and benefits of various treatment options to obtain informed consent; 5. insuring the availability of appropriate follow-up care; and 6. maintaining a complete medical record available to patient and other treating health care providers. Code of MS Rules 50-013-2635 (2012).

|-------|---|-------------------------------------|

**MO** | X | No reference found. |

**MT** | X | Montana issues telemedicine licenses to out-of-state physicians that only allows the physician to practice telemedicine in the specialty the physician is board certified or meets the current requirements to take the examination to become board certified. This license does not authorize the physician to practice medicine while physically present within the state. *MT Code Annotated, 37-3-343.* |

**NE** | X | No reference found. |

**NV** | X | Nevada issues special-purpose licenses to out-of-state physicians for telemedicine services. Physicians must:
- Hold a full, unrestricted license in another state;
- Not have any disciplinary or other action taken by any state or jurisdiction;
- Be certified by the American Board of Medical Specialties.
*NV Revised Statutes Sec. 630.261(e).* |

**NH** | X | No reference found. |

**NJ** | X | No reference found. |

**NM** | X | NM issues telemedicine licenses to providers who hold a full, unrestricted license in another state and has good moral character.
*NM Statutes Annotated, 1978 Sec. 61-6-11.1 (Sunset date of July 1, 2016) and 16.10.2.11.* |

**NY** | X | No reference found. |

**NC** | X | No reference found. |

**ND** | X | The ND Medical Board may engage in reciprocal licensing agreements with out-of-state licensing agencies, but is not required to do so. *ND Century Code Sec. 43-17-21 (2012).* |

**OH** | X | Ohio issues telemedicine certificates that allow the holder to engage in the practice of telemedicine in the state. Providers with telemedicine certificates cannot practice in OH without a special activity certificate. *OH Revised Code Annotated, Sec. 4731.296(C).* |
<table>
<thead>
<tr>
<th>State</th>
<th>Outcome</th>
<th>Reference</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>OK</td>
<td>X</td>
<td>The State Board of Osteopathic Examiners has the authority to issue a telemedicine license. <strong>OK Statute, Title 59, Sec. 633</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td>OR</td>
<td>X</td>
<td>Out-of-state physicians may receive a license to practice across state lines in Oregon, as long as they are fully licensed in another state and meet certain requirements. <strong>OR Revised Statutes Annotated Sec. 677.139.</strong></td>
<td>The referring and evaluating practitioner must be licensed to practice medicine within the state of Oregon or within the contiguous area of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider. <strong>OR Administrative Regulation 410-130-0610(2)(a).</strong></td>
</tr>
<tr>
<td>PA</td>
<td>X</td>
<td>Pennsylvania issues extraterritorial licenses to physicians residing or practicing in an adjoining state, near the Pennsylvania boundary, and whose practice extends into Pennsylvania to practice in Pennsylvania. Pennsylvania bases its granting of this license on the availability of medical care in the area involved, and whether the adjoining state extends similar privileges to Pennsylvania physicians. <strong>PA Statutes Annotated, Title 63 Sec. 422.34(a) and (c)(2).</strong></td>
<td>No reference found.</td>
</tr>
<tr>
<td>RI</td>
<td>X</td>
<td>RI allows physicians who have a license in good standing in another state to consult with RI licensed physicians or provide teaching assistance. Physicians not present in RI may not provide consultation to a patient without an established physician-patient relationship, unless that patient is in the physical presence of a physician licensed in RI. <strong>RI General Law, Sec. 5-37-14.</strong></td>
<td>No reference found.</td>
</tr>
</tbody>
</table>
| SC    | X       | An applicant who holds a valid medical license issued by another state can be licensed through reciprocity in South Dakota if:  
- The applicant completed a residency program in the US or Canada;  
- Has passed one of the listed licensure examinations. (Please see rule for list);  
- Is in good standing with their state’s professional board; and  
- Has completed a state and federal criminal background investigation. **SD Regulation 20:78:03:12.** | No reference found. |
| SD    | X       | An applicant who holds a valid medical license issued by another state can be licensed through reciprocity in South Dakota if:  
- The applicant completed a residency program in the US or Canada;  
- Has passed one of the listed licensure examinations. (Please see rule for list);  
- Is in good standing with their state’s professional board; and  
- Has completed a state and federal criminal background investigation. **SD Regulation 20:78:03:12.** | No reference found. |
| TN    | X       | Tennessee may issue telemedicine licenses to board certified physicians from out of state. **TN Code Annotated Sec. 63-6-209(b).** | No reference found. |
| TX    | X       | A telemedicine license may be issued for out of state providers. **TX Admin. Code, Title 22, Sec. 172.12 & TX Occupation Code Section 151.056.** | No reference found. |
| UT    | X       | An out-of-state physician may practice without a Utah license if:  
- The physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience;  
- The services are rendered as a public service and for a noncommercial purpose;  
- No fee or other consideration of value is charged. | Health care providers must be licensed in Utah. **UT Physician Medicaid Manual, pg. 18, May 2014.** |
expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance;
• The physician does not otherwise engage in unlawful or unprofessional conduct. **UT Code Annotated Sec. 58-67-305.**

A mental health therapist licensed in another state can provide short term transitional mental health therapy or transitional substance use disorder counseling remotely if:
• The mental health therapist is present in the state where he/she is licensed;
• The client relocates to Utah, and was a client immediately before the relocation;
• The therapy or counseling is provided for a maximum of 45 days after the client relocates;
• Within 10 days of the client’s relocation, the mental health therapist provides a written notice to the Division of Occupational and Professional Licensing of their intent to provide therapy/counseling remotely; and
• The mental health therapist does not engage in unlawful or unprofessional conduct. **Laws of UT. 68-61-307**

<table>
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<tr>
<th>VT</th>
<th>X</th>
<th>No reference found.</th>
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<tbody>
<tr>
<td>VA</td>
<td>X</td>
<td>No reference found.</td>
<td>No reference found.</td>
</tr>
<tr>
<td>WA</td>
<td>X</td>
<td>Out-of-state, licensed practitioners may deliver telemedicine or telehealth services, as long as they do not open an office or appoint a place of meeting patients or receive calls within the state. <strong>Revised Code of WA Sec. 18.71.030 (2012).</strong></td>
<td>No reference found.</td>
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<tr>
<td>WV</td>
<td>X</td>
<td>No reference found.</td>
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<tr>
<td>WI</td>
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<tr>
<td>WY</td>
<td>X</td>
<td>No reference found.</td>
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</table>

At present, California requires all out-of-state physicians seeking to become a telemedicine provider apply for a California license. This places a substantial burden on out-of-state physicians with expertise in potentially needed fields in California. Although the Medical Board of California approves and rejects applications for licenses, the California Business Code and Professions section 2052 requires an individual to have a license before seeking to offer any sort of health care treatment.

California’s two exceptions: (1) applicants holding a federal position with an unrestricted medical license from another state to apply, and (2) under the TELEmedicine for MEDicare Act of 2013 “Amends title XVIII (Medicare) of the Social Security Act to permit certain Medicare
providers licensed in a state to provide telemedicine services to Medicare beneficiaries in a different state.” 149  Although California has made some progress, the TELEmedicine for MEDicare Act only accommodates a small population. No other laws exist to accommodate out-of-state physicians.

Attempts at resolving this artificial barrier to telemedicine treatment across state lines are currently underway. For example, the Federation of State Medical Boards developed a Uniform Application process in 2004.

The Uniform Application seeks to standardize, simplify, and streamline the licensure application process, allowing physicians to apply to multiple state boards. 150 When a physician completes his Uniform Application, he can send it to another participating board without reapplying. 151 Any updates to the application will incur a service charge of $50. 152 Likewise, the Uniform Application is then combined with the Federation Credentials Verification Service (FCVS). 153 The combination will eliminate redundant data entry. 154 Information from a physician’s FCVS profile can pre-populate information from the Uniform Application. As a result, there will be greater time savings thereby improving a state’s ability to respond to emergencies and accommodate telemedicine. 155 The problem, however, is that only 20 state medical boards have adopted the Uniform Application process.

Another potential solution is to offer reciprocity. Most states have already enacted legislation surrounding the use of telemedicine. Among the states, three general categories of

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151 Id.
152 Id.
153 Id.
154 Id.
155 Id.
licenses have been offered: (1) a special telemedicine license, (2) a full license, and (3) a full license with exceptions. Exceptions include infrequent consultations, emergency care, and consultations. A special telemedicine license is a separate licensing scheme that allows a health care provider to become a telemedicine provider. A full license is generally the normal application process a health care professional would undergo. Finally a full license with exceptions just permits a health care professional to engage in infrequent consultations, emergency care and consultations with out-of-state physicians. Although many states require out-of-state health care providers to obtain a full license in which they would like to offer treatment, there are also some alternatives.156

Many states permit an out-of-state health care practitioner to practice through mutual recognition, reciprocity or endorsement agreements. These agreements with certain conditions placed upon them recognize an out-of-state health practitioner’s license. For example, in Florida, “[a]n applicant who has actively practiced medicine in another state for at least 2 of the immediately preceding 4 years; or An applicant who completed an ACGME, CFPC or RCPSC approved postgraduate training program in a teaching hospital within two years preceding filing of the application; or An applicant who passed a board approved clinical competency exam within the year preceding filing the application” may obtain licensure by endorsement.157

Another solution is to adopt a special-purpose license or permit. In 1996, the Federation of State Medical Boards issued a Model Act to Regulate the Practice of Medicine Across State Lines.158 The Model Act proposed the adoption of a full and unrestricted special-purpose license or permit that would enable health care professionals to apply to and practice in all jurisdictions.

156 Gupta, supra n. 129 at 394.
157 Florida 458.313 Licensure by endorsement
However, only ten state medical boards have adopted such a scheme. These states include Alabama,\textsuperscript{159} Louisiana,\textsuperscript{160} Minnesota,\textsuperscript{161} Montana,\textsuperscript{162} Nevada,\textsuperscript{163} New Mexico,\textsuperscript{164} Ohio,\textsuperscript{165} Oregon,\textsuperscript{166} Tennessee\textsuperscript{167} and Texas.\textsuperscript{168} For example, Louisiana’s introduction paragraph to the “Telemedicine Permit Qualification/Instructions” state:

A telemedicine permit is required when a physician does not maintain a physical practice location in this state to engage in the practice of medicine in this state via telemedicine. Telemedicine is defined as the practice of health care delivery, diagnosis, consultation, treatment and transfer of medical data by a physician using interactive telecommunication technology that enables a physician and patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously per §7503 of the rules. Once permit is granted, it must be renewed annually.

Note: Interpretation of diagnostic studies/testing including pathology, echocardiograms, ultrasound, intraoperative monitoring, radiological procedures, radiology or nuclear medicine requires a full Louisiana medical license only.\textsuperscript{169}


\textsuperscript{163} Applications & Other Licensing Forms, NV STATE BD. OF MED. EXAMINERS http://www.medboard.nv.gov/New_OtherForms.htm (last visited Feb. 26, 2015).


\textsuperscript{166} Practice of Medicine Across State Lines (Telemedicine) Practice Description Form, OR MED. BD. http://www.oregon.gov/omb/OMBForms1/mddo-telemedicine-request.pdf (last visited Feb. 26, 2015).


One reason for a state’s unwillingness to participate in intrastate licensing is to protect in-state providers from outside competition.\textsuperscript{170} This is because states have an incentive to impose high costs of interstate business because it creates “a monopoly for in-state health care providers.”\textsuperscript{171} The American Medical Association has stated that telemedicine has “crystallized the tension between the states’ role in protecting patients from incompetent physicians and protecting in-state physicians from out-of-state competition.”\textsuperscript{172}

In reviewing the options above, California can either join the states already existing in the Uniform Application process, it can enact legislation granting reciprocity or endorsement agreements, or it can enact legislation establishing special-purpose licenses. Most states seeking to retain their state autonomy by not relinquishing control over the application process would opt out of joining the Uniform Application process. However, California can enact legislation granting reciprocity or endorsement agreements or a special-purpose license, but only permit these agreements and licenses where the state in which the out-of-state health care provider is licensed also offers the same for California health care providers.

This will alleviate the concern of out-of-state competition because California health care providers can offer services to those states as well. In fact, it may increase services rendered due to the limited resources or expertise in smaller states such as Montana. For example, Montana has a little over 60 hospitals whereas in 2007, California reported 400 general acute care hospitals.\textsuperscript{173} By quelling out-of-state competition, states like California may be incentivized to

\textsuperscript{171} Gupta, supra n. 129 at 394.
enact such legislation which would not only open a new market of health care practice for current physicians, but will create a national telemedicine market that will expand accessibility and quality of care for patients across the nation.

CONCLUSION

Telemedicine has been proven successful in a varying number of specialty areas and should prove successful in the treatment of HIV/AIDS as well. This is especially important when factors such as stigma, fear, and discrimination are present. Despite the focus on California, the information conveyed regarding the treatment of HIV/AIDS and the use of telemedicine is a national problem in which these solutions may be applicable.

Congress’ recent support by passing federal legislation regarding telemedicine has also demonstrated its ability to effectively serve patients in the most cost efficient way, yet by still expanding the resources that are available to patients. Though there are still a number of concerns regarding confidentiality, quality of treatment and accessibility, the advent of technology and the implementation of protocols to safeguard personal health information should diminish those concerns. However, licensing is telemedicine’s biggest adversary.174 Accordingly, states should consider enacting legislation that incorporates an endorsement agreement, reciprocity agreement, or a special-purpose license that is conditioned upon another state having similar arrangements in order to safeguard in-state physicians from intrastate competition and increasing accessibility and quality of care for patients nationally.

174 Ryan Mcskill, State Licensing a Major Hurdle for Telehealth, MHEALTHINTELLIGENCE (Mar. 9, 2015) http://mhealthintelligence.com/news/state-licensing-a-major-hurdle-for-telehealth ("For telehealth, one of the biggest issues is State licensing.").