



February 10, 2022

**RE: ATA COMMENTS ON FSMB'S DRAFT REPORT ON THE APPROPRIATE USE OF
TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE – JANUARY 2022**

Dear co-members of the FSMB Workgroup on Telemedicine:

On behalf of the American Telemedicine Association (ATA) and our members, I am writing to comment on the January 2022 draft of FSMB's Report on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.

The ATA is the only national organization whose sole purpose is advancing telemedicine in the United States. Our foremost objective is to provide Americans with affordable, high-quality health care at any place and any time. The use of telemedicine services eases the burden placed on the nation's health care infrastructure, allowing the system to deliver services to millions more patients efficiently and effectively. The ATA represents a diverse and expansive coalition of technology solution providers and payers, as well as partner organizations and alliances, working together to promote the implementation of telemedicine across the country, endorse responsible telemedicine policy, encourage government and market normalization, and deliver education and resources designed to further the integration of virtual care through the use of various innovative technologies.

Our organization applauds many of the updates and provisions that the Workgroup has included during the process of updating its model telemedicine policy for the first time since 2014.

First, we praise the Workgroup for including in its report several exceptions to licensure requirements that will enable safe and effective telemedicine interactions between patients and providers in several unique circumstances. These licensure exceptions apply to a) providers engaging in physician-to-physician consults, b) providers delivering infrequent and episodic care to existing patients, c) providers rendering follow-up care after delivering specialty care to a patient who crossed state lines to receive that specialty care, and d) providers engaging in specialty assessments and/or consultations.

Patients receiving care via telemedicine technologies stand to benefit from the widespread adoption of these exceptions. Permitting out-of-state experts to consult with a patient's physician via telemedicine technologies allows the patient to access the brightest minds in the medical field, increasing his or her chances of receiving the best care the health system has to offer. Moreover, the ATA would like to see legislatures and boards across the country enable patients to seek expert second opinions through any licensed physician, not only their treating physicians. Such a policy would expand patients' opportunity to access the advice of the nation's top medical experts regarding their diagnoses and treatment plans.

Additionally, enabling out-of-state providers to care for their patients who are away temporarily or who have returned to their home states after surgery makes it much easier to maintain a continuity of care between patients and the practitioners who know them best.

We would also like to express our concurrence with the Workgroup's understanding of how patients and providers may establish the physician-patient relationship via telemedicine. Our members believe that so



long as the patient agrees to the use of telemedicine as a means of receiving health care services, the technology is capable of meeting the standard of care for the condition presented by the patient, and the patient and provider have identified themselves and disclosed the appropriate credentials, a provider and patient should not be prohibited from establishing a professional relationship through the use of the appropriate telemedicine technologies. We appreciate that the Workgroup has clarified in its report that the patient-physician relationship may be established using either synchronous or asynchronous telemedicine technologies so long as the technologies used are appropriate to meet the standard of care.

We commend the Workgroup for considering equity in health care access as part of its report. One of telemedicine's most salient benefits is its ability to connect providers and patients efficiently and affordably. Telemedicine technologies can connect medically underserved populations, such as rural and minority communities, with licensed providers anywhere in the state or the country.

Finally, the ATA would like to thank the Workgroup for amending their report to reflect some of the changes we suggested in the previous iteration of our letter.

The ATA would also like to offer several suggestions for the Workgroup to consider for subsequent drafts of its report.

Section 2: Definitions

Our organization would like to reiterate its dedication to a technology-neutral telemedicine environment. Instead of vague generalities (e.g. "generally," "typically involves," etc.) and singling out particular modalities, such as emails, instant messages, and faxes, for exclusion from the list of approved telemedicine technologies, the ATA believes that legislatures and medical boards should make the maximum choice of technology available to patients and enable licensed providers to decide which modalities are appropriate to meet the standard of care for the condition presented by the patient. Allowing providers to be governed by the standard of care in determining which technologies are appropriate for rendering telemedicine services in any given situation ensures that a wide breadth of technologies can be utilized in the delivery of virtual health care without sacrificing the quality of that care. Towards that end, we recommend the Workgroup revise the definition of telemedicine as follows:

"Telemedicine means the practice of medicine using synchronous or asynchronous electronic communications, information technology or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provider. ~~Telemedicine is not an e-mail/instant messaging conversation or fax-based interaction. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient. Telemedicine may include audio only communications, but audio only communications should only be used as a substitute when a patient is unable or unwilling to access live interactive modalities or when audio only interactions are considered the standard of care for the corresponding healthcare service being delivered~~



At a minimum, we suggest that the Workgroup eliminates the language about audio-only communications being used “as a substitute when a patient is unable or unwilling to access live-interactive modalities” so as to clarify that it is sufficient to use audio-only modalities in all instances during which they enable the provider to meet the standard of care.

--

Section 4: Standard of Care

Subsection: “Informed Consent, Disclosure, and Functionality of Online Services Making Available Telemedicine Technologies

There are several elements on this subsection that we would like to see revisited. We have highlighted these proposed changes below:

The Workgroup states that appropriate informed consent includes the “identification... of the physician’s practice location.” We are unsure as to which safeguards this provision would provide the patient. The physician’s physical location is irrelevant if the physician has laid out his or her credentials for the patient and is confirmed as a licensed provider in the patient’s state. This provision would only pile on additional administrative burdens for providers without offering any meaningful protections for patients. It’s also unclear where this information should be provided (i.e., on the website or disclosed to patients).

The draft also states that appropriate patient informed consent must include a requirement for “express patient consent to forward patient-identifiable information to a third party.” The ATA believes that this requirement is in excess of what is required by the Health Insurance Portability and Accountability Act (HIPAA) and inconsistent with the actual practices of in-person providers. HIPAA contains several categories of data sharing that do not require patient consent or authorization. For example, a HIPAA-covered entity or business associate is not required to obtain patient consent or authorization prior to sharing their data for treatment, payment, or health care operations. We recommend revising this requirement to state

“... express patient consent to forward patient-identifiable information to a third party, if consistent with the state and federal law.”

In the same subsection, the Workgroup outlines a list of lengthy requirements applicable for “*online services used by physicians providing medical services using telemedicine technologies.*” Without any definition of “online services,” the ATA is unclear when these requirements are applicable. We suggest the following change:

~~*Online services used by*~~ *Physicians providing medical services using telemedicine technologies.*

If the Workgroup intends to limit the requisite disclosures and requirements in this subsection to only a subset of providers, the ATA believes the FSMB should clarify why certain providers are exempt.



Additionally, the Workgroup keeps in language from the 2014 Guidelines that there must be a “clear mechanism” for patients to “provide feedback regarding the online platform and quality of services” and “register complaints, including filing a complaint with an applicable state medical and osteopathic board.” This kind of mechanism does not exist for in-person interactions, so it’s unclear why it needs to exist for online health care platforms.

Continuity of Care and Referral for Emergent Situations

The report reads as follows:

“An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.”

The requirement for a “formal, written protocol” as part of each patient’s emergency plan holds telehealth to a different standard of care. It may also create confusion for patients and could be counterproductive in a true emergency. Under current practice, if a provider were to tell an existing patient to go to the emergency room during a phone call or in-person visit, the provider would not also provide a formal, written emergency plan to the patient. Would this requirement change that expectation?

We recommend deleting this paragraph, as the details surrounding a telemedicine provider’s responsibilities to a patient referred to the emergency room are covered in the two paragraphs following this one. Alternatively, the Workgroup could revise it to require telemedicine providers to have established protocols for referral in case of emergency without the requirement that such protocols be shared with each patient who is referred.

We would also like to comment on language in the last paragraph of the same subsection. The Workgroup writes:

Physicians have an obligation to support continuity of care for their patients. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient may be considered patient abandonment or result in discipline from the Board.

Patient abandonment is earlier defined in the draft as the provider “terminating a health care physician-patient relationship.” The above paragraph then goes on to equate “termination” with any time a provider determines that they cannot treat a patient for a particular condition via telehealth. Unless the provider agrees to treat the patient in the first place, no physician-patient relationship has been established. Providers cannot abandon patients with whom they have no relationship.

Further, this paragraph could be read to suggest that a telehealth provider has an obligation to refer – and possibly “make arrangements” up to the next level of care – for the patient in order to avoid charges of patient abandonment, even if the relationship hasn’t been terminated or no physician-patient relationship was established. This is not the standard applied to in-person care settings.



The ATA agrees and supports that physicians delivering care via telemedicine technologies, as in every care setting, have an obligation to support continuity of care. We suggest that the FSMB clarifies its language regarding patient abandonment to avoid holding telemedicine to a higher standard of care than care delivered in person.

--

Privacy and Security of Patient Records & Exchange of Information

The Workgroup urges telemedicine providers to implement a set of policies and procedures regarding "documentation, maintenance, and transmission of the records of the encounter" while using telemedicine technologies, enumerating seven concerns that such policies and procedures should address.

The ATA would like to note that language in HIPAA, as well as that in similar privacy laws, typically takes a more flexible approach. For example, under HIPAA, covered entities and business associates must "implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements" of HIPAA. This flexibility offers businesses the opportunity to scale their privacy and security regimes as their programs (and compliance burdens) evolve over time.

We recommend that the Workgroup offer a list of suggested (but not required) topics for policies and procedures relating to patient privacy and security alongside a broader mandate encouraging telemedicine providers to implement reasonable policies and procedures which ensure the proper and secure documentation, maintenance, and transmission of medical records.

--

Finally, we would like to comment on the Workgroup's statements regarding coverage and payment for telemedicine services. While the ATA agrees that health plans should provide coverage for telemedicine services on the same basis and to the same extent as comparable services provided in person, we believe that it is most common for legislatures (and not medical boards) to set policy regarding such matters.

--

Thank you for the opportunity to provide additional comments. We look forward to working with you to advance best practices in the field of telemedicine. If you have any questions or would like to discuss the industry's perspective further, please contact me at kzebley@americantelemed.org.

Kind regards,

A handwritten signature in black ink, appearing to read "Kyle Zebley".

Kyle Zebley
Vice President of Public Policy
American Telemedicine Association