



July 20, 2023

The Honorable Christina Henderson
Chair, Committee on Health
Council of the District of Columbia
The John A. Wilson Building, S. 402
1350 Pennsylvania Avenue, NW
Washington, DC 20004

**RE: ATA ACTION RESPONSE TO DEPARTMENT OF HEALTH TESTIMONY
REGARDING B25-125, THE UNIFORM TELEHEALTH ACT**

Dear Chair Henderson and members of the Committee on Health,

Thank you again for the opportunity to testify in front of the Council on July 6th. I appreciate the time the Committee on Health and the Council at large are taking to diligently explore updates to telehealth laws in the District. I would also like to acknowledge the Bowser Administration's commitment to ensuring that all District residents have access to the care they need – a concern that we at ATA Action share. I am confident that the District of Columbia can become a leader in access to telehealth services by adopting the Uniform Telehealth Act.

To that end, I am writing to offer a response to testimony given by Aisha Nixon from the Office of Professional Licensing Boards within the Department of Health (“the Department”) at the July 6th hearing. The testimony provided by the Department includes some inconsistencies regarding the Uniform Telehealth Act on which we would like to provide additional clarity. Please note that in offering this clarity, ATA Action respects the hard work, public service and dedication of the Department administrators to ensure access to quality health services throughout the District.

The District’s current telehealth framework is at odds with most other jurisdictions and the Federation of State Medical Board’s Model Policies

An important aspect of providing cost-effective, accessible telehealth care is the ability to establish a patient-provider relationship asynchronously when clinically appropriate in accordance with the standard of care. Unfortunately, the District’s current telemedicine regulations prevent telehealth practitioners from doing so, as physician-patient relationships in D.C. can only be established by an “in-person interaction with a patient” or by using a “real-time” (synchronous) telemedicine exchange.¹ The asynchronous option is therefore unavailable

¹ See Medical Regulations, 17-4618.4, <https://dcregs.dc.gov/Common/DCMR/RuleDetail.aspx?RuleId=R0033558>.



to a multitude of telehealth providers in spaces like dermatology, optometry, sexual health, and other licensed medical professionals, in the same way such services are able to be offered in almost all other states.

ATA Action believes that licensed practitioners should be able to utilize the full range of available telemedicine technologies while delivering virtual care so long as the technologies being used are appropriate to meet the standard of care for the condition presented by the patient. Enacting the Uniform Telehealth Act would ensure District residents' access to asynchronous telemedicine services that meet the same standard of care for those services delivered in-person.

This would also bring the District into conformity with the policy principles enumerated in the Federation of State Medical Board's most recent update *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practices of Medicine*,² which was ratified by the organization in April 2022. In its "Standard of Care" section, it clearly articulates that "a physician patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met." The American Medical Association also endorsed these model policies in full.³

Telehealth does not merely benefit rural patients; clear evidence establishes the veracity of telehealth services for urban, minority and LGBTQ+ communities, as well as Medicaid recipients

The Department intimated that the Uniform Telehealth Act is not needed in the District because it does not have the same challenges as "jurisdictions that are rural and far from access." Yet, telehealth does not only benefit patients who live in rural areas or at distant locations from in-person services. By expanding both the scope of telehealth modalities and the number of providers capable of practicing telehealth in the District, the Uniform Telehealth Act can help address barriers to access affecting patients in urban settings.

Those who work 9-5 jobs with little flexibility often are unable to spend enough time away from work or their family in order to see a practitioner in-person. When appropriate under the standard of care, telehealth services can offer faster, more convenient options. Many of these options include asynchronous clinical intake and, if appropriate, asynchronous services if convenient for patients. Telehealth services can also be better tailored to reach patients in specific communities. For example, telehealth providers such as [Mend](#) (medical care; 10 million patients) and [Iris Telehealth](#) (behavioral health; 2.3 million patients) focus on providing culturally competent

² The Appropriate Use of Telemedicine Technologies in the Practice of Medicine, The Federation of State Medical Boards Workgroup on Telemedicine, April 2022. <https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf>

³ Sheldon A. Wasserman, American Medical Association, *AMA support for Board Report 22-3: Report of the Federation of State Medical Boards (FSMB) Workgroup on Telemedicine*, April 21, 2022, <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-4-21-Wasserman-FSMB-Telemedicine-Final.zip%2F2022-4-21-Wasserman-FSMB-Telemedicine-Final.pdf>.

services aimed at “addressing issues like language barriers, low literacy rates, and lack of knowledge about racial and ethnic minority health.”⁴ Many telehealth providers have similar internal policies addressing cultural competency and ethnic backgrounds. Telehealth providers also have a larger pool of practitioners with a wider diversity than any single brick-and-mortar clinic is able to provide. Streamlining the pathways for out-of-state providers to serve District residents with the Uniform Telehealth Act (in addition to the licensure compacts the District is already a member of) will provide residents with greater access to these larger, more diverse provider pools.

Telehealth is often a more approachable care modality option compared to in-person care for patients who face widespread stigma, particularly in the LGBTQ+ community.⁵ For example, [Folx Health](#) and [Circle Medical](#) both provide gender affirming care, HIV prevention medications, and other sexual health services in, arguably, a safer environment (the comfort of the patient’s home). [Bicycle Health](#) offers specialized Substance Use Disorder treatment options for LGBTQ+ persons, who experience substance use disorder at a higher rate than the population average. These providers not only offer better privacy, the physicians who work with Folx, Circle and Bicycle have far more specialized knowledge in assisting LGBTQ+ individuals (and more often are from this community themselves) than an average doctor at a brick-and-mortar location. Indeed, similarly tailored brick-and-mortar services are unlikely to be conveniently available in the patient’s geographic area at all. *This is particularly important for the District of Columbia, which has the highest self-identifying proportion of residents identifying as LGBT (10% of the population), more than any U.S. state.*⁶

There is ample evidence showing telehealth services are having a real impact on both access to care and opinions of telehealth among these communities. Consider the following findings:

- *Highest rates of “telehealth visits were among those covered by Medicaid (28.3%) and Medicare (27.4%), individuals who are Black (26.8%), and those earning less than \$25,000 (26.8%)”* according to the U.S. Department of Health and Human Services survey (the largest publicly available survey of its kind) of 1.2 million adults across all 50 states and Washington D.C between 2021 and 2022.⁷

⁴ Iris Telehealth, *How to Provide Culturally Competent Care Through Telehealth*, May 9, 2022, <https://iristelehealth.com/blog/how-to-provide-culturally-competent-care-through-telehealth/>.

⁵ Studies indicate that 28% of transgender and gender non-conforming individuals experience discrimination when seeking medical care, 50% experience a lack of provider knowledge, and 19% have been refused care altogether. Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, National Center for Transgender Equality, page 72 (2011), https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.

⁶ Gary J. Gates and Frank Newport, Gallup, *LGBT Percentage Highest in D.C., Lowest in North Dakota*, February 15, 2013, <https://news.gallup.com/poll/160517/lgbt-percentage-highest-lowest-north-dakota.aspx>.

⁷ U.S. D.H.H.S., Office of Health Policy, *Updated National Survey Trends in Telehealth Utilization and Modality*, April 19, 2023, <https://aspe.hhs.gov/sites/default/files/documents/7d6b4989431f4c70144f209622975116/household-pulse-survey-telehealth-covid-ib.pdf>.

- 75% of Black, 65% of Hispanic, and 70% of Medicaid covered adults support expansion of asynchronous telehealth options according to a February 2023 survey of 1,008 voters and telehealth users.⁸
- Expanded interstate licensure policies, such as the Interstate Medical Licensure Compact (IMLC) and the Psychology Interjurisdictional Compact (PSYPACT), are directly associated with increased provider availability for mental health services according to researchers at Harvard Medical School and RAND Corporation,⁹ providing evidence that licensure flexibility does, in fact, increase access to care.
- For trans-individuals, “telehealth increased access and convenience of care, particularly for those geographically far from trans-inclusive health care resources” according to researchers with the City University of New York.¹⁰ Other findings indicate that “over 75% [of LGBTQ+ individuals] reported interest in telemedicine outside of the COVID-19 pandemic.”¹¹ Put another way, telehealth options are critical for reaching marginalized groups with more cultural and community appropriate care.

Certainly, there are persistent, complicated equity issues regarding telehealth service delivery. However, this largely reflects the wider systemic problems in healthcare generally, and should not discount the incredible steps many telehealth providers have taken, and continue to build on, to address equity issues. Indeed, the American Telemedicine Association seeks to put health equity at the forefront of telehealth discussions and has published [recommendations on improving these efforts in telehealth](#).

Many telehealth providers provide services that are covered by Medicaid

The Department testified that telehealth providers operating in multiple states “are unlikely to accept Medicaid”; this is not accurate. For example [Teladoc Health](#) which is the first and largest telemedicine company in the United States, offers 24/7 care to Medicaid enrollees. Other traditional providers of health services that accept Medicaid have adopted robust telehealth services, such as [Planned Parenthood of Metropolitan Washington, D.C., Inc.](#)

Maintaining laws that limit telehealth modalities and licensure do nothing to actually better enable access to Medicaid covered services. Conversely, the Uniform Telehealth Act’s modality

⁸ Public Opinion Strategies, *National Telehealth Survey Key Findings*, April 25, 2023, <https://pos.org/wp-content/uploads/2023/04/Hims-Hers-National-Survey-Memo.pdf>.

⁹ Ryan K. McBain et al., *Expansion of Telehealth Availability for Mental Health Care After State-Level Policy Changes from 2019 to 2022*, June 13, 2023, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805968>.

¹⁰ Alexa B. D’Angelo et al., *Health and Access to Gender-Affirming Care During COVID-19: Experiences of transmasculine individuals and men assigned female sex at birth*, November 3, 2021, <https://journals.sagepub.com/doi/pdf/10.1177/15579883211062681>.

¹¹ Rogers, B.G., Coats, C.S., Adams, E. et al. Development of Telemedicine Infrastructure at an LGBTQ+ Clinic to Support HIV Prevention and Care in Response to COVID-19, Providence, RI. *AIDS Behav* 24, 2743–2747 (2020). <https://doi.org/10.1007/s10461-020-02895-1>.



and provider registration provisions will marginally increase the range of asynchronous and synchronous services offered in the District as well as the total number of providers available to Medicaid recipients in real terms, even if a majority of telehealth services generally are captured by patients with private insurance as the Department notes in their testimony.

The Department’s concerns regarding licensure confusion and fraud contradict current District policies and rely on unsound inferences

The Department contends that creating a “bifurcated pathway for licensure of some providers (who already provide telehealth and in-person care) and other providers (who only provide telehealth) will introduce confusion and possible fraud.”

Yet, the Department’s current processes indicate this fear of confusion is misplaced. As the Department notes, they have already adopted the Psychology Interjurisdictional Compact (PSYPACT) which, as the Department states, “is an interstate compact designed to facilitate the practice of telepsychology...across state boundaries.”¹² In other words, the Department already operates a licensure program that bifurcates a pathway to licensure for providers who only provide telehealth (telepsychology) and a separate pathway for those providing in-person care. ATA Action is not aware of any confusion engendered by this bifurcated licensure system. The Uniform Telehealth Act would simply operate in a similar fashion, but be applied to all health practitioner licensure boards.

Furthermore, the Uniform Telehealth Act’s registration provisions empower the licensure boards to ensure patient safety. Although a registration may be simpler and a more efficient option than full licensure, each professional health board would have the authority to develop review processes for registration of out-of-state practitioners, to discipline providers who do not meet District standards, and to act swiftly to suspend registered practitioners in cases of malpractice.

Finally, the Department’s only basis for stating that the registration system may cause fraud relies on a likely unintentional mischaracterization of a federal criminal case in Florida (“Operation Nightingale”). A simple review of Operation Nightingale’s facts reveals this claim is far from the truth.¹³

Operation Nightingale has nothing to do specifically with licensure compacts – nursing schools in Florida sold fraudulent diplomas to students, which *state licensing boards failed to adequately review while administering national examinations*. To be clear, the fraudulent activity itself could have occurred whether or not states were included in a licensure compact system. The Department also does not explain why the Uniform Telehealth Act’s registration provisions are uniquely exposed to such fraud schemes, unlike PSYPACT, the Interstate Medical Licensure

¹² DC Health, Psychology Interjurisdictional Compact (PSYPACT), <https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Psychology%20Interjurisdictional%20Compact.pdf>.

¹³ For more information, see U.S. Department of Health and Human Services, *2023 Operation Nightingale Enforcement Action*, <https://oig.hhs.gov/newsroom/media-materials/nightingale/>.



Compact (“IMLC”), and the DMV Reciprocity Pathway programs of which the District is already a member.¹⁴ Ultimately, the Department’s inferences regarding Operation Nightingale are unsound.

Thank you for your support for telehealth. We encourage you and your colleagues to support B25-0125 to ensure easy and efficient access to high-quality health care services in the District of Columbia. After recently experiencing a global pandemic, we have all witnessed the need for government leadership and the health care industry to continue to find ways to expand access to health care as much as reasonably possible for the benefit of the residents of the District. Please do not hesitate to let us know how we can be helpful to your efforts to advance common-sense telehealth policy. If you have any questions or would like to discuss the telehealth industry’s perspective further, please contact me at kzebley@ataaction.org.

Kind regards,

A handwritten signature in black ink, appearing to read "Kyle Zebley", is written over a light gray rectangular background.

Kyle Zebley
Executive Director
ATA Action

¹⁴ See DC Health Board of Medicine, <https://dchealth.dc.gov/bomed>.