ata ACTION
Telehealth Policy to Transform Healthcare

July 1, 2026

The Honorable Brian L. Schwalb
Attorney General, District of Columbia
400 6th Street, NW
Washington, DC 20001

RE: ATA ACTION CONCERN REGARDING BOARD OF MEDICINCE ACTIONS ON ASYNCHRONOUS TELEHEALTH AND PHYSICIAN-PATIENT RELATIONSHIP FORMATION

Dear Attorney General Schwalb,

On behalf of ATA Action, I am writing regarding the District of Columbia Board of Medicine's (the "Board") current enforcement posture and recent disciplinary actions premised on the assertion that 17 DCMR § 4618 (2017) remains in effect and requires physicians utilizing telehealth to establish a physician-patient relationship exclusively through real-time, synchronous modalities. This position is deeply concerning because it directly undermines the District's 2024 telehealth statute (DC Act 25-0479), which was specifically intended to supersede 17 DCMR § 4618 and explicitly permits physicians to use synchronous *or* asynchronous technologies to form a patient relationship. The Board's continued enforcement of the prior regulation—without issuing any guidance to address its clear conflicts with DC Act 25-0479—is creating significant confusion and concern across the telehealth community.

ATA Action is the policy and legislative advocacy arm of the American Telemedicine Association and the leading organization dedicated to advancing telehealth policy. Working collaboratively with federal and state legislators and policymakers, we drive patient access to care by influencing legislative and regulatory developments across telehealth, virtual care, remote patient monitoring, artificial intelligence in healthcare, health data privacy, and more. Our membership spans hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

Last month, ATA Action respectfully requested that the Board clarify that, consistent with the 2024 Act, physicians may use either synchronous or asynchronous technologies to form a relationship with a patient, provided doing so meets the standard of care for the patient's circumstances and condition. The Board disagreed, maintaining without explanation that "there is no conflict between the telehealth law and the telehealth regulation." Below is a summary of our concerns with the Board's continued reliance on this outdated regulatory regime, which are set forth in detail in our attached letter to the Board. We are providing that letter and the Board's response for the awareness of your office, and we hope your office may be able to help bring resolution to this matter.

I. The 2024 Act Expressly Permits Asynchronous Telehealth for Relationship Establishment

In July 2024, the District enacted the Health Occupation Revisions General Amendment Act (the "Act"), DC Act 25-0479, which introduced the "first-ever general guidelines for telehealth services provided by licensed health professionals in the District," with the stated goal of "encouraging consistent and high-

quality telehealth services."[1] The Act's telehealth provisions were drawn directly from the Uniform Telehealth Act of 2023, introduced at the request of the Uniform Law Commission.

The Act is intentionally technology-neutral and provides that "a practitioner-patient or practitioner-client relationship may be established through telehealth in accordance with the appropriate standard of care and the practitioner's competence and scope of practice." The Act defines "telehealth" to mean "the use of synchronous or asynchronous telecommunication technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." Taken together, these provisions make clear that a physician may use asynchronous technologies to form a patient relationship where clinically appropriate, and that real-time interaction is not required in all cases.

ATA Action, along with many other stakeholders, testified in strong support of both the Act and the Uniform Telehealth Act of 2023 precisely because of this technology-neutral approach. As we stated in our testimony at multiple hearings, 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 those technologies are appropriate to meet the standard of care for the condition presented by the patient. Asynchronous telehealth modalities are not novel—across the country, telehealth providers, including major health systems, use asynchronous modalities to evaluate patients and identify underlying conditions prior to prescribing medication, for both new and established patients, in fields including primary care, dermatology, ophthalmology and sexual health.

The Act also reflects the approach taken by the vast majority of states, which permit asynchronous technologies to be used in patient care and relationship formation when appropriate to meet the standard of care. The Federation of State Medical Boards (FSMB) *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (2022) confirms 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."[2] The technology-neutral framework in the Act reflects this national consensus and it was the foundation of ATA Action's strong support for the legislation.

II. The 2024 Act Supersedes the Real-Time Mandate in 17 DCMR § 4618

We understand the Board is grounding its enforcement position in 17 DCMR § 4618 (the 2017 regulation) providing that "the physician may use real-time telemedicine to establish the physician-patient relationship" where no prior in-person interaction has occurred. The Act's text and legislative history make clear that it overrides 17 DCMR § 4618 generally, and the real-time mandate specifically.

First, the Act's sponsor and the Mayor's Office repeatedly acknowledged during the legislative process that the Board of Medicine had an existing policy in 17 DCMR § 4618 and that the Act sought to replace it with a "uniform" statutory approach applicable to all practitioners seeing District patients. The committee record reflects the Act's intent to align all professions under a single set of standards:

[1]B25-0545 - Health Occupations Revision General Amendment Act of 2023.
[2]Federation of State Medical Boards, The Appropriate Use of Telemedicine Technologies in the Practice of Medicine, April 2022. https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf

> *"The bill proposes the first-ever uniform guidelines for telehealth services in the District. Currently, each Board is responsible for responding to questions from professionals about the use of telehealth, and only the Board of Medicine has developed written telehealth guidance."*[3]

The District's Council Office of Racial Equity Impact Assessment likewise emphasized that the Act would "establish uniform standards of care between telehealth services and comparable in-person services," ensuring "residents receive the same quality care regardless of the avenue they take."[4] There is no legislative support for the notion that the Council intended all regulatory boards except the Board of Medicine to be governed by the Act, while the Board retained authority to rely on prior rules with different definitions and requirements. The legislative history reflects a clear intent to supplant—not supplement—the Board's existing regulatory guidance.

Second, the Act's licensure provisions further confirm it was intended to supersede the Board's prior telehealth rules. Under 17 DCMR § 4618.1, a physician seeking to use telehealth with a District resident must hold a District license or qualify for a limited exemption under DC Code 3–1205.02. The 2024 Act goes considerably further, permitting out-of-state practitioners in any field to see existing patients in the District for up to 120 days without a District-issued license. The Committee report explains this provision was added in response to physician testimony from Johns Hopkins, because the existing pathways for out-of-state practitioners—including those under 17 DCMR § 4618.1—were "too cumbersome" to operationalize.[5] It defies logic to argue the Council intended the Act to apply to every out-of-state practitioner except physicians while leaving 17 DCMR in force for the Board.

Finally, even if the Council had intended to preserve portions of 17 DCMR § 4618, the Act was clearly intended to override the real-time mandate specifically, as that mandate was recognized as an outdated approach that failed to reflect current telehealth practice. James McKay, Chair of the Uniform Law Commission for the District, directly addressed the deficiencies of 17 DCMR § 4618 in his legislative testimony:

> *"Moreover, this regulation [17 DCMR § 4618] is overly restrictive compared to the rest of the country because it mandates that only 'real-time'—i.e., 'synchronous'—telemedicine technologies can be used to form a patient relationship. This precludes the use of asynchronous visits to communicate and treat patients, although that approach is recommended by the Federation of Medical Boards and has been taken by a majority of states. The Uniform Act would permit both synchronous and asynchronous telehealth visits, so long as the standard of care is met."*[6]

ATA Action and other commentators who testified in support of the Act similarly cited the technology-neutral approach and ability to use asynchronous care as central reasons for their support.[7]

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[3]Council of the District of Columbia Committee on Health Committee Report ("Comm. Report"), Mar. 21, 2024, p. 2, https://tinyurl.com/4vyeah3f.
[4]Testimony of District Council Office of Racial Equity, Mar. 21, 2024, p. 491 ("The parameters established by the bill will create uniformity").
[5]Comm. Report, p. 8.
[6]Statement of James C. McKay Before the Comm. on Health on Bill 25-125, July 6, 2023, p. 13, https://lims.dccouncil.gov/downloads/LIMS/52325/Hearing_Record/B25-0125-Hearing_Record1.pdf?Id=196655.
[7]ATA Action letter in support of HORA, Dec. 5, 2023, Comm. Report p. 361; Letter of Support from Technet, Comm. Report p. 440; ATA Action Testimony on B25-125, Comm. Hearing on Bill 25-125, p. 7.

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We recognize the Act explicitly permits the Mayor to *prospectively* "add additional requirements through rulemaking" for specific health professionals regarding provider-client relationship formation:"A practitioner-patient or practitioner-client relationship may be established through telehealth in accordance with the appropriate standard of care and the practitioner's competence and scope of practice; provided, that the Mayor may through rulemaking issue additional requirements for specific health professionals to establish a practitioner-client relationship, including an initial in-person physical examination." This provision was added specifically to address concerns raised by veterinarians and to preserve "the discretion to issue regulations requiring an initial in-person examination."[8] The plain language on the statute makes clear that rulemaking around the patient-relationship must occur following the Act; it does not give Board license to reach back to prior regulations that conflict with the underlying statute and were drafted before this authority in the Act. While the Board may—at the Mayor's direction—issue future regulations imposing additional requirements, no such rulemaking has occurred in the nearly two years since the Act's enactment. Therefore, the real-time mandate in 17 DCMR § 4618 has no continuing legal force.[9]

III. Continued Enforcement of 17 DCMR § 4618 Is Causing Significant Confusion in the Telehealth Community

When ATA Action shared the foregoing analysis with the Board, it responded cursorily, concluding there is "no conflict" on the grounds that the Board had independent authority to issue regulations:

> *"The existing regulations are valid as there is no conflict with the statute and they are within the statutory authority of DC Health. ATA Action's objections appear to stem from the mistaken belief that because the regulations were issued prior to the telehealth law, they are rendered null and void unless and until they are reissued. However, this objection is incorrect as DC Health already had the authority to issue such regulations prior to the passage of the Health Occupations Revision General Amendment Act of 2023."*

ATA Action does not question the Board's authority to conduct rulemaking prior to the Act's enactment. We do, however, maintain that the Board lacks authority to enforce rules that conflict with a subsequently enacted statute that supersedes them. If the Board wishes to impose additional requirements or update its rules to be consistent with the Act, it should do so through notice-and-comment rulemaking open to public participation.

As explained above, the conflict between the statute and regulation on relationship formation is not the only area of misalignment between the 2024 Act and 17 DCMR § 4618. The broader inconsistency is generating substantial confusion among our members, who cannot determine whether the Board is selectively enforcing portions of the outdated regulation or disregarding the updated statute altogether. Given the Board's continued discipline under 17 DCMR § 4618, many members are reluctant to provide statutorily permissible care to District patients without a District license, even where the Act expressly authorizes them to do so.

[8]Comm. Report, Mar. 21, 2024, p. 8.
[9]The Council subsequently passed the Certificate of Need Improvement Amendment Act of 2025, DC Act 26-44, which exempted telehealth providers from the certificate of need process. This further reflects the District's policy intent to expand telehealth access and is additional evidence that the District has consistently acted to make it easier for DC residents to access telehealth services.

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We believe it is essential that the Board rescind 17 DCMR § 4618 and promptly issue guidance confirming that the District imposes no specific modality requirement for forming a physician-patient relationship, and that physicians may establish such a relationship via asynchronous or synchronous technologies where clinically appropriate and consistent with the applicable standard of care.

Without such action, continued inconsistent Board interpretations will perpetuate exactly the confusion the Act was designed to eliminate, and the unwarranted fear of discipline will deter practitioners from using lawful and clinically appropriate telehealth modalities. Should the Board determine that a synchronous interaction should be required for all new patients going forward, that substantive policy change must occur only pursuant to the Mayor's directive, through notice-and-comment rulemaking as the Act expressly contemplates.

We appreciate your prompt attention to this matter and would welcome the opportunity to meet with your office to help bring resolution to this issue. If you have any questions or would like to discuss further, please contact me at hyoung@ataaction.org.

Kind regards,

Hunter Young

Hunter Young
Head of State Government Relations
ATA Action