CENTER FOR CONNECTED HEALTH POLICY (CCHP) is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.
Disclaimers & Friendly Reminders

- Any information provided in today’s webinar is not to be regarded as legal advice. Today’s talk is purely for informational and educational purposes.
- Always consult with your organization’s legal counsel.
- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.
- Today’s webinar will be recorded and slides presented here will be made publicly available as resources at cchpca.org.
- Closed captioning is available.
- Please refrain from political statements or advertising commercial products or services during this webinar.
ABOUT CCHP

- Established in 2009 as a program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
- Work with a variety of funders and partners on the state and federal levels
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition
Today’s Speakers

Lisa A. Robin
Chief Advocacy Officer
Federation of State Medical Boards

Janet P. Orwig, MBA, CAE
Executive Director
PSYPACT

Brian Hasselfeld, MD
Medical Director, Digital Health and Telemedicine, Office of Johns Hopkins Physicians
Primary Care Physician, Internal Medicine and Pediatrics
Johns Hopkins Community Physicians

Heidi Ross
Vice President, Policy and Regulatory Affairs
National Organization for Rare Disorders
Federation of State Medical Boards (FSMB)

- Founded in 1912, we are the national, non-profit organization that represents all 70 of the state medical and osteopathic boards across the United States.
- State medical boards **protect the public** through the licensing, disciplining and regulation of 1 million+ physicians, PAs, and other health care professionals.
- FSMB **supports state medical boards** through education, assessment, research and advocacy and promotes regulatory best practices across states.
Achieving License Portability through Interstate Compacts

• A contract between compact states
• Constitutionally authorized
• Retains state sovereignty on issues traditionally reserved to state jurisdictions
• Commission established to coordinate cooperation
Interstate Medical Licensure Compact

Member States

- Active – SPL and issuing licenses
  - AL, AZ, CO, GA, GU, IA, ID, IL, KS, KY, LA, MD, ME, MI, MN, MS, MT, ND, NE, NH, NV, SD, TN, TX, UT, WA, WI, WV, WY
- Active – Issuing licenses only
  - OK, VT
- On boarding
  - CT, DC, IN, NJ, OH, PA

Copyright 2022 Federation of State Medical Boards
IMLC Eligibility

• Graduate of an accredited medical school
• Passed USMLE or COMLEX within 3 attempts
• Completed approved GME
• Holds ABMS or AOA specialty certification or a time-unlimited specialty certificate
• Possesses a full and unrestricted license to practice medicine in a IMLC Member state
• Has no criminal history
• Has no disciplinary action by a licensing agency
• Has never had a controlled substance registration suspended or revoked by the DEA
• Is not under active investigation by a licensing agency or law enforcement authority
Processing Information – Cumulative Numbers

April 1, 2017 to May 31, 2022

- Applications Processed = >23,000
- Licenses Issued = >35,000
PA Licensure Compact

• Partners:
  – Supported by a grant from HRSA’s License Portability Grant Program
  – FSMB, American Association of Physician Associates (AAPA), National Commission for Certification of Physician Assistants (NCCPA) and Council of State Governments National Center for Interstate Compacts (CSG NCIC)
  – Model Legislation developed, distributed and comments reviewed
  – Final version expected by the end of June
Other Licensure Models Addressing Portability

• Universal Licensure
• Regional Licensure
States with Permanent Interstate Telemedicine
The Appropriate Use of Telemedicine Technologies in the Practice of Medicine (adopted 4/30/22)

- Supersedes FSMB 2014 policy.

- Recognizes that when utilized and deployed effectively as a seamlessly integrated part of healthcare delivery, telemedicine can improve access and reduce inequities in the delivery of healthcare. To be effective, certain barriers must be eliminated or reduced, such as literacy gaps, access to broadband internet, and coverage and payment of telemedicine services.
The Appropriate Use of Telemedicine Technologies in the Practice of Medicine (adopted 4/30/22)

• Telemedicine is only one component of the practice of medicine;

• Certain exceptions may permit the telemedicine across state lines without the need for licensure in the states where the patient is located;

• The same standard of care and professional ethics apply. Failure to follow appropriate standard of care or professional ethics while using telemedicine may subject the practitioner to discipline by the medical board.
Thank You!

www.fsmb.org

Lrobin@fsmb.org

(202) 463-4006
Telepsychology & State Licensure: PSYPACT

CCHP State Telehealth Policy Webinar Series: Summer 2022
Janet Orwig, MBA, CAE
6/10/2022
What is ASPPB

- Association of State and Provincial Psychology Boards
- State/provincial/territorial psychology regulatory boards/colleges in the United States and Canada
- 65 member jurisdictions
- Services to licensing boards, applicants for licensure/registration, licensed psychologists
- The international source of information and resources for the regulation and licensure/registration of psychologists
<table>
<thead>
<tr>
<th>A Map of ASPPB’s History with Licensure Portability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement of Reciprocity</td>
</tr>
<tr>
<td>Credentials Bank</td>
</tr>
<tr>
<td>Certificate of Professional Qualification in Psychology (CPQ)</td>
</tr>
</tbody>
</table>
Interstate Compact
Compacts for Mental Health Professionals

- PSYPACT – Licensed Psychologists – 33 jurisdictions
- Counseling Compact – Licensed Professional Counselors -10 jurisdictions
- Social Work – Under Development (expected 2023)
Psychology Interjurisdictional Compact (PSYPACT)
ASPPB Telepsychology Task Force is charged with addressing telepsychology regulation.

ASPPB approves work on possible usage of interstate compact.

First State (Arizona) enacts PSYPACT.

ASPPB Board of Directors approves PSYPACT.

Seventh state (Georgia) enacts PSYPACT.

First PSYPACT Commission meeting held.

E.Passport Certificate requirements released for public comment.

May 2016

Apr. 2013

Dec. 2013

Feb. 2015

May 2016

Apr. 2019

July 2019

6 July 2020

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

2011–2015

History of PSYPACT
Why a Compact

- Address variations in laws among jurisdictions
- Address disciplinary processes across jurisdiction lines
- Address inconsistencies in licensure requirements for telepsychotherapy
Designed to regulate:

- The day-to-day practice of **telepsychology across state boundaries** and/or
- The **temporary in-person, face-to-face** practice of psychology for up to 30 days annually
Benefits of PSYPACT

- Increases client/patient access to care
- Facilitates continuity of care when client/patient relocates, etc.
- Ability to readily know legal requirements
- Promotes cooperation across PSYPACT states in the area of licensure and regulation
- Offers a higher degree of consumer protection across state lines
PSYPACT became operational when seven states enacted PSYPACT into law.

The Commission, the governing body of PSYPACT, was formed.

As new states enact they join the Commission.

Each PSYPACT participating state has one representative.

Bylaws and Rules need to be created by Commission.

PSYPACT states communicate and exchange information including verification of licensure and disciplinary sanctions.
Work of the Commission

- Adopted Bylaws
- Promulgated Rules
- Policies and Procedures
- Approved Annual Budget
- Elect Executive Board
- Establish standing committees
Important PSYPACT Terms to Know

- Telepsychology: the provision of psychological services using telecommunication
- Home State: the state where the psychologist is licensed
- Receiving State: the state where the client/patient is physically located when the services are delivered
- Authority to Practice Interjurisdictional Telepsychology: a licensed psychologist’s authority to practice telepsychology within the limits authorized under PSYPACT
A psychologist practicing into a Receiving State under the authority of PSYPACT will be subject to the Receiving State’s scope of practice.

For the purpose of regulating telepsychology through PSYPACT, the practice of psychology takes place where the practitioner psychologist is located and licensed.
Away We Go: How PSYPACT Works

States Enact PSYPACT
PSYPACT Commission is Established
Licensed Psychologists can practice under the authority of PSYPACT by applying for and meeting criteria established by the Commission:

Authority to Practice Interjurisdictional Telepsychology (APIT)
Which requires the ASPPB E.PASSPORT
To practice telepsychology
Into a receiving state

Temporary Authorization to Practice (TAP)
Which requires the ASPPB IPC
To conduct temporary in-person face-to-face practice
In a distant state
PSYPACT & Commission Requirements for APIT

- Acceptable Graduate Degree in Psychology
- Current Full and Unrestricted License in a Compact State
- No History of Adverse Action
- Provide Current, Active E.Passport
- Meet Other Criteria Established by Commission
E. Passport is an ASPPB Certificate

Commission will have an agreement with ASPPB to provide services regarding the vetting of the E. Passport.

E. Passport Requirements
• Meet educational standards-doctoral degree from an APA/CPA or Joint Designated program
• Possess a current, full and unrestricted license to practice psychology in a Home State which is a Compact State
• Passing score on the EPPP
• No history of adverse action
• Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification
• Meet other criteria as defined by the Rules of the Commission
• Be held to Guidelines for the Practice of Telepsychology
Current Status:
**ENACTED, NOT YET EFFECTIVE**

Washington - WA H 1286 (Enacted 3/4/2022; Effective Date to TBD by Washington Department of Health)
Indiana - IN S 365 (Enacted 3/10/2022; Effective July 1, 2022)
Idaho - ID S 1305 (Enacted 3/23/2022, Effective July 1, 2022)
Connecticut - CT S 2 (Enacted 5/24/2022, Effective October 1, 2022)

**ENACTED, UNDER FURTHER REVIEW** (* indicates PSYPACT legislation has been enacted in a state but has not been formally adopted by the PSYPACT Commission. PSYPACT authorizations are not yet valid in this state.)

South Carolina - SC H 3833
ACTIVE PSYPACT LEGISLATION (*Please note the following states have introduced PSYPACT legislation but have not yet enacted PSYPACT and therefore are not considered PSYPACT participating states.)

Massachusetts - MA S 2542
Michigan - MI H 5489
Rhode Island - RI H 7501/RI S 2605
Commonwealth of the Northern Mariana Islands - CNMI HB 22-80
New York - NY S 9234
Legislation by Year
PSYPACT: 2020 Compared to 2021
Visit our Website: www.psypact.org
Compact Law, Bylaws, Rules and Policies

Introduction

The Psychology Interjurisdictional Compact Commission is a quasi-governmental agency and is the sole entity permitted to administer the Compact. In doing its administrative work, the Commission must not only follow the language of the Compact, but also the rules and policies created by the Commission to govern itself.

The Commission’s governance materials can be found on this page. Please see each section below for a brief description and its pertinent governance materials.
Verification of PSYPACT Authorizations

PSYPACT is an interstate compact that allows psychologists licensed in PSYPACT to practice telepsychology and/or practice temporarily in other PSYPACT participating states. In order to practice telepsychology under the authority of PSYPACT, a psychologist must have an active Authority to Practice Interjurisdictional Telepsychology (APIT) granted from the PSYPACT Commission. In order to practice temporarily under the authority of PSYPACT, a psychology must have an active Temporary Authorization to Practice (TAP) granted from the PSYPACT Commission. The PSYPACT Commission provides online primary source verification of these authorizations. To view all psychologists holding a current APIT or TAP, use the search by method below to get started. If you have any questions or need any additional information for PSYPACT verifications, contact us at info@psypact.org.

Search by:
Select Method

Show 10 entries

<table>
<thead>
<tr>
<th>Psychologist Name</th>
<th>States where Licensed*</th>
<th>EPassport Issue Date</th>
<th>APIT Issue Date</th>
<th>EPassport Renewal Date</th>
<th>IPC Issue Date</th>
<th>TAP Issue Date</th>
<th>IPC Renewal Date</th>
<th>Mobility Number</th>
</tr>
</thead>
</table>

PSYPACT Directory: verifypsypact.org
Thank you!

For further information please contact:

• Janet Orwig ([jorwig@asppb.org](mailto:jorwig@asppb.org))
Telehealth: Patient-Centered Data Review

June 10th, 2022

Brian Hasselfeld, MD – Medical Director, Digital Health and Telemedicine
Telemedicine Visit Volume Trends

Monthly Comparison

Total March 2020+ Volume: 1,403,204
Telemedicine Visit Volume Trends

In-Person vs. Telemedicine Comparison

- Telemedicine has generally been substitutive care during pandemic
- Trailing 10 day daily average visits (yellow) tracking to pre-COVID daily average in 2021 (gray)
Telemedicine vs. In-Person Visits
Ambulatory Volume

- When excluding “telemedicine insensitive” areas (i.e., Lab, Radiology), telemedicine visits have been approximately 20% of “telemedicine sensitive” ambulatory care in CY’21
- Care remains distributed across multiple primary care and subspecialty verticals
- High percentage users of telemedicine: mental / behavioral health, but also advanced specialties like genetics, anesthesia / pre-operative medicine, neurology, and neurosurgery

*Note: Excludes “telemedicine insensitive” visits, such as lab, radiology.
Patient Satisfaction with Telemedicine

Testimonials

“Telemedicine has been the most transformational way to access health care - it is efficient, and personal - seems that the provider is more focused on speaking with you and determining the plan of care. I would prefer all visits to be virtual and then come in if necessary (e.g. removal of a mole, etc).”

✓ Personal and efficient
✓ Preference for most visits, only in-person when necessary

✓ Safer for those at risk of infection
✓ Decreased fear of exposure

“I think that telemedicine and or video visits offer patients and practitioners the maximum flexibility to deal with various situations not only COVID-19 but code red air quality, inclement weather, etc. As well for sick children and elderly people for whom going to medical office might be an additional hassle or pain.”

✓ Not just for the pandemic
✓ Benefits for many patient populations and circumstances

“Telemedicine has been a lifesaver, especially for me who is immunocompromised, affording me the opportunity to receive medical care without the fear of exposure.”

Source: Select quotes from JHM patient surveys
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Patient Satisfaction with Telemedicine (cont’d)

Testimonials

“Getting into my online video visit was easy, but unfortunately I was in Virginia at the time, so I had to drive 20 minutes into Maryland, which was tedious and seemed unnecessary”

“I live in Virginia. To have virtual visit with a doctor they said I have to be in Maryland. That is absurd and extremely inconvenient for out of state patients”

“I am grateful for this and find telehealth liberating for people with disabilities. I live in another state and don’t drive. This is an amazing way for me to get to Hopkins for the care that I need... people who have had my illnesses probably are grateful not to have the added travel cost and time, lodging cost and time, time away from work. Thank you for making telehealth so awesome... Let me know if I can reach out to the state of Virginia so that this service continues as appropriate for people who cannot be treated in my state as they can be treated at Hopkins”

- Patients, their medical relationships, and their medical needs are dynamic
- There is little ability to fully predict when and where a patient may be when a new or established patient issue arises, and patients expect (demand) flexibility in accessing care – rightfully so

Source: Select quotes from JHM patient surveys

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Telehealth and Health Equity
COMMENTARY

A Process for Developing a Telehealth Equity Dashboard at a Large Academic Health System Serving Diverse Populations

Helen K. Hughes, MD, MPH
Brian W. Hasselfeld, MD
Lisa A. Cooper, MD, MPH
Rachel L. J. Thornton, MD, PhD
Yvonne Commodore-Mensah, PhD, MHS, RN

Abstract: Johns Hopkins Medicine (JHM) rapidly implemented telehealth system-wide as part of its COVID-19 pandemic response. In a four-month period (January–May, 2020), video visits across the system increased more than 1,000-fold (from approximately 80 to 80,000 per month). For vulnerable populations, telehealth may reduce or exacerbate disparities in access to and quality of care. To enhance equity in telehealth access, we must assess,
### Telemedicine Modality – Video vs Phone

**July 2020 – April 2022**

#### Telemedicine Equity | Percent Total of Encounters

<table>
<thead>
<tr>
<th></th>
<th>Video</th>
<th>Phone</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>84%</strong></td>
<td>910,368</td>
<td>16%</td>
<td>167,360</td>
</tr>
<tr>
<td><strong>16%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>100%</strong></td>
<td>1,077,728</td>
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#### Preferred Language

<table>
<thead>
<tr>
<th>Language</th>
<th>Video</th>
<th>Phone</th>
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<tbody>
<tr>
<td>English</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>Spanish</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Chinese (Mandarin)</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Korean</td>
<td>19%</td>
<td>81%</td>
</tr>
<tr>
<td>Arabic</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>Sign Language – ASL (American Sign Language)</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Russian</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Urdu Pakistani</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Nepali</td>
<td>39%</td>
<td>62%</td>
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#### Ethnicity

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<th>Video</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Not Hispanic or Latino</td>
<td>16%</td>
<td>84%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Unknown</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>Choose Not to Disclose</td>
<td>13%</td>
<td>87%</td>
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<tr>
<td>Unknown</td>
<td>11%</td>
<td>89%</td>
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<tr>
<td>Other</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Asian</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Unknown</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>30%</td>
<td>70%</td>
</tr>
</tbody>
</table>

#### Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Video</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>White or Caucasian</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Asian</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>American Indian or Alaska</td>
<td>20%</td>
<td>72%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
<td>86%</td>
</tr>
</tbody>
</table>

#### Encounters by Age Range

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Video</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Less Than 1 Year</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Under 13 Years</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Age 13 - 17</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td>Age 18 - 30</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Age 31 - 50</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Age 51 - 64</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Age 65 - 74</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Age 75+</td>
<td>77%</td>
<td>77%</td>
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</tbody>
</table>
Telemedicine Modality – Video vs Phone
July 2020 – April 2022

<table>
<thead>
<tr>
<th>Payor Financial Class</th>
<th>Video</th>
<th>Phone</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>27%</td>
<td>73%</td>
<td>222,502</td>
</tr>
<tr>
<td>Medicare</td>
<td>25%</td>
<td>75%</td>
<td>256,572</td>
</tr>
<tr>
<td>Other Payor</td>
<td>26%</td>
<td>74%</td>
<td>4,272</td>
</tr>
<tr>
<td>Private</td>
<td>7%</td>
<td>93%</td>
<td>579,861</td>
</tr>
<tr>
<td>Self Pay</td>
<td>33%</td>
<td>67%</td>
<td>14,499</td>
</tr>
<tr>
<td>TBD</td>
<td></td>
<td>100%</td>
<td>22</td>
</tr>
</tbody>
</table>
Telemedicine Equity Dashboard
How Patients Access Telemedicine

- % phone
  - # phone encounters
  - # telemedicine encounters

- % video
  - # video encounters
  - # telemedicine encounters

In-Person vs Telemedicine Dashboard
How Patients Access Outpatient Care

- % telemedicine visit
  - # telemedicine encounters
  - # total encounters

- % in person visit
  - # in person encounters
  - # total encounters

*Note: Excludes "telemedicine insensitive" visits, such as lab, radiology.
# Telemedicine Utilization Overall

**July 2020 – April 2022**

## All Outpatient Encounters

<table>
<thead>
<tr>
<th>In-Person Visit</th>
<th>Video Visit</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>83%</td>
<td>5,185,601</td>
<td>17%</td>
</tr>
</tbody>
</table>

## Telemedicine Encounters

<table>
<thead>
<tr>
<th>Video and Phone Encounters</th>
<th>Video</th>
<th>Phone</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video</td>
<td>85%</td>
<td>902,470</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>15%</td>
<td>163,442</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>100%</td>
<td>1,065,912</td>
<td></td>
</tr>
</tbody>
</table>
Patients with Medicaid have used higher rates of telemedicine than those insured by Medicare or Commercial / Private payors.

However, they have also required meaningfully higher rates of audio-only care.
# Telemedicine Utilization by Race

**July 2020 – April 2022**

## All Outpatient Encounters

<table>
<thead>
<tr>
<th>Race</th>
<th>In-Person Visits, % of Total</th>
<th>Telemedicine Encounters, % of Total</th>
<th>Total Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>White or Caucasian</td>
<td>17%</td>
<td>83%</td>
<td>3,688,722</td>
</tr>
<tr>
<td>Black or African American</td>
<td>19%</td>
<td>81%</td>
<td>1,547,828</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td>85%</td>
<td>403,594</td>
</tr>
<tr>
<td>Asian</td>
<td>14%</td>
<td>86%</td>
<td>314,319</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>18%</td>
<td>82%</td>
<td>151,397</td>
</tr>
<tr>
<td>*Unspecified/Unknown</td>
<td>92%</td>
<td>8%</td>
<td>100,241</td>
</tr>
<tr>
<td>Choose Not to Disclose</td>
<td>17%</td>
<td>83%</td>
<td>30,062</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>22%</td>
<td>78%</td>
<td>12,435</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>17%</td>
<td>83%</td>
<td>4,535</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>20%</td>
<td>80%</td>
<td>793</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>14%</td>
<td>86%</td>
<td>648</td>
</tr>
<tr>
<td>Hispanic</td>
<td>99%</td>
<td>1%</td>
<td>531</td>
</tr>
<tr>
<td>Unable to Obtain</td>
<td>95%</td>
<td>5%</td>
<td>257</td>
</tr>
</tbody>
</table>

## Telemedicine Encounters

<table>
<thead>
<tr>
<th>Race</th>
<th>Video</th>
<th>Phone</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White or Caucasian</td>
<td>13%</td>
<td>87%</td>
<td>619,879</td>
</tr>
<tr>
<td>Black or African American</td>
<td>23%</td>
<td>77%</td>
<td>297,803</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
<td>86%</td>
<td>60,554</td>
</tr>
<tr>
<td>Asian</td>
<td>93%</td>
<td>7%</td>
<td>44,674</td>
</tr>
<tr>
<td>Multi-Racial</td>
<td>90%</td>
<td>10%</td>
<td>26,599</td>
</tr>
<tr>
<td>Unknown</td>
<td>89%</td>
<td>11%</td>
<td>7,592</td>
</tr>
<tr>
<td>Choose Not to Disclose</td>
<td>15%</td>
<td>85%</td>
<td>5,084</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>23%</td>
<td>72%</td>
<td>2,721</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>13%</td>
<td>87%</td>
<td>1,003</td>
</tr>
<tr>
<td>Unable to Obtain</td>
<td>100%</td>
<td>0%</td>
<td>13</td>
</tr>
</tbody>
</table>

© Johns Hopkins Medicine – Not for Distribution
Income: $102,885
9% Black
5% Hispanic

Income: $39,648
87% Black
2% Hispanic

Income: $31,949
64% Black
17% Hispanic

Income: $48,358
11% Black,
4% Hispanic

*Note: Excludes “telemedicine insensitive” visits, such as lab, radiology.

July 2020 – April 2022
All Ages

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>% TM/All</th>
<th>%Phone/TM</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>21213</td>
<td>21%</td>
<td>41%</td>
</tr>
<tr>
<td>21205</td>
<td>23%</td>
<td>37%</td>
</tr>
<tr>
<td>21222</td>
<td>22%</td>
<td>36%</td>
</tr>
<tr>
<td>21210</td>
<td>17%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th><strong>April to October 2021</strong></th>
<th><strong>July 2020 to February 2022</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person-level</strong></td>
<td><strong>Encounter-level</strong></td>
</tr>
<tr>
<td>Telehealth use increased dramatically, access was not equitable</td>
<td>Telehealth use increased dramatically, access was not equitable</td>
</tr>
<tr>
<td>23% of respondents used telehealth</td>
<td>21% of encounters were conducted by telehealth</td>
</tr>
<tr>
<td>Telehealth use rates were similar (21.1-26.8%) among most demographic subgroups but were much lower among those who were uninsured (9.4%) and young adults ages 18 to 24 (17.6%).</td>
<td>Of total encounters, 20-27% were by telehealth for most groups. Rates were &lt;15% in patients under 13, over 75, and in some non-English speaking groups.</td>
</tr>
<tr>
<td>The highest rates of telehealth visits were among those with Medicaid (29.3%) and Medicare (27.4%) and Black individuals (26.8%).</td>
<td>The highest rates of telehealth visits were among those with Medicaid (25%), Black individuals (23%), and those with preferred language of English (21%).</td>
</tr>
<tr>
<td>There were significant disparities among subgroups in terms of audio versus video telehealth use.</td>
<td>There were significant disparities among subgroups in terms of audio versus video telehealth use.</td>
</tr>
</tbody>
</table>
Telehealth, Out of State Volume, and Licensure Complexity
Out of State Video Visits
March 2020 – June 2021

- Video Visit encounters to states other than MD, DC, FL: **91,082**
- These encounters represented ~9% of total telemedicine volume during this timeframe
COVID Licensure Changes

Pre-COVID

- Power to license and regulate professionals delegated to the states, including all healthcare professionals
  - Limited Federal involvement

- Any healthcare professional that is licensed (i.e., physician, nurse, social worker, psychologist, physical therapist, etc) must have a license in the state where the patient is physically located

During COVID

- States issued waivers through various authorities (governors’ executive orders, medical board regulations, etc.) to permit flexibility

  - Waivers varied by:
    - New vs. established
    - Provider type (as each provider type regulated by a different board)
    - Patient status (inpatient, outpatient)
    - Expiration dates
    - Process (open waiver, emergency licensure, temporary licensure, etc)

Throughout 2021: Return to Pre-COVID

- Most states have expired waivers
Recent Published Literature

- Recent study published June 6th* in Health Affairs: “Interstate Telehealth Use By Medicare Beneficiaries Before And After COVID-19 Licensure Waivers, 2017–20”

- “We found that most out-of-state telehealth use was for established patient care and that a higher percentage of out-of-state telehealth users lived in rural areas compared with beneficiaries who did not receive care outside of their state”

- “…findings suggest that the elimination of pandemic licensure flexibilities will affect different states to varying degrees and will also affect the delivery of care for both established patients and rural patients”

*I live in Virginia. To have virtual visit with a doctor they said I have to be in Maryland. That is absurd and extremely inconvenient for out of state patients


Source: Select quote from JHM patient surveys
Impact of State-Based Licensing on Basic Scheduling Operations

- Reason for visit permitted for telemedicine (Dept. specific)
- Patient wants telemedicine visit
- Patient INTENDED LOCATION in same state, in state where provider is licensed, OR in select waiver state(s)

- Scheduling decision trees require a new input field (“Where WILL you be in the future?”)
- Complex logic behind the scenes to compare to provider licensure and any existing “waiver rules” based on up to date legal review

A couple of questions

* Select the state where the patient will be physically located during the Video Visit. Our provider must have a medical license where the patient is during the Video Visit.

Video Visits are not offered for patients who are located outside of the US and US territories during the visit.

If no appointment times are found for the state you select, please call the office.

[Choose]
Where can we go from here?

- The patient must remain at the center, and preventing care based on state by state geographic boundaries is not meeting the needs of our patients.

- Compacts that retain all of the financial burden of the existing licensing system are not addressing the issue, which is the “dynamic-ness” of patients: they may be anywhere at any time, and expect to be able to seek care on their terms (especially from established providers).
  - As an example, as of last night per the IMLC website, it would cost ~$14,000 per physician to get licensed in the 31 states with listed cost data.

- Working towards true state reciprocity (similar to broad nursing reciprocity) will help us meet our patients where they are in every sense of the word and retain the state-based practice of medicine rules, regulations, requirements, and discipline processes.

- Consider federal action (precedents exist: VA system and the Sports Medicine Licensure Clarity Act), and as a temporizing measure, Congress could pass the TREAT Act.
TELEHEALTH AND RARE DISEASE PATIENTS

Heidi Ross
Vice President, Policy and Regulatory Affairs
NORD, a 501(c)(3) organization, is a patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them. NORD, along with its more than 330 patient organization members, is committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.
WHAT IS A RARE DISEASE?

• Rare diseases are defined as a disease or condition that affects less than 200,000 Americans.

• According to the National Institutes of Health (NIH), there are more than 7,000 rare diseases, 2/3 of which have a genetic component to them.

• Approximately 90% of rare diseases do not have an FDA approved treatment.

• About half of those who have a rare disease are children.
IMPACT OF COVID-19 ON RARE DISEASE PATIENTS

• NORD has conducted two surveys on the impact of COVID-19 since the pandemic started.
  • 79% experienced canceled medical appointments
  • 32% had challenges accessing medical care and treatment
  • 14% have experienced issues accessing medication for their rare disease

88% offered a telehealth appointment during COVID-19 accepted it, 92% of whom said it was a positive experience

70% would like the option of telehealth for medical appointments in the future
A 2020 NORD survey found that 40% of rare disease patients travel more than 60 miles for their medical appointments.

- Significant travel costs
- Missed work and school
- Disruptions to family routine
Our three-year-old son has two rare diseases and is very medically complex. He has several hundred medical appointments a year. Telehealth is a necessity for him in order to get the care he needs, while also allowing him time to be at home and at school to develop.

Alexandra Mahady
Mother of rare disease patient

#TelehealthAdvocacy
NORD Telehealth Principles

1) All patients should have equal and effective access to telehealth services

2) Patients and their providers should be able to make a choice on the location and type of care they receive that is based on what is in the best interest of the patient

3) Transparency around privacy protections and patient cost-sharing must be established and preserved

4) Data should drive decisions on telehealth
PATIENT ACCESS TO OUT OF STATE PROVIDERS

Adjustments to state licensure requirements proved to be a lifeline for many rare disease patients.

- In March 2020, NORD sent letters to 20 Governors asking them to ensure patients could see their out-of-state health care providers via telehealth.
- All Governors did end up adjusting their state licensure requirements to some extent, which enabled broader telehealth access across state lines.
- Fragmented approaches = provider and patient confusion.
PATIENT ACCESS TO OUT OF STATE PROVIDERS

My daughter was diagnosed with occult tethered spinal cord, which is very rare. Because of telehealth, we were able to have a consultation with a leading neurosurgeon in Rhode Island during the pandemic, then follow up visits after surgery from our home in Las Vegas. This saved us thousands of dollars and allowed my daughter to have her spine surgery from an expert in that specific field.

Lara Allen
Mother of a patient with a rare disease

#TelehealthAdvocacy
LEGISLATIVE EFFORTS – SHORT TERM

Endorsed the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act

• Allows any health care professional in good standing with a valid practitioners’ license to render services—including telehealth—anywhere for the duration of the COVID-19 pandemic

Advocated for Governors and State Legislators

• Maintain and expand medical licensure flexibilities for the duration of the federal public health emergency

- OR -

• Reinstate licensure flexibilities if they have expired for the duration of the federal public health emergency

- AND -

• Implement new flexibilities to better address patient needs during and after the pandemic, ie joining the IMLC
Telehealth is here to stay (We hope!)

• Huge opportunity to effectively integrate telehealth into our health care system to help meet patient needs.

• NORD’s 31 designated Centers of Excellence
  • Telehealth working group

State:
• Licensure Compacts
• ACE Kids Act Implementation

Federal:
• Maintain robust telehealth access
• Accelerating Access to Kids Care Act
Thank you.

Heidi Ross
Vice President, Policy and Regulatory Affairs
HRoss@rarediseases.org
Panel Q&A

Please submit questions using the Q&A function.
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Next Webinar: June 17 – Private Payer Laws

Kevin P. Beagan
Deputy Commissioner
Massachusetts Division of Insurance

Representative David Bentz
Delaware House of Representatives
18th District

Chelsey Matter, RRT, MPH
Executive Director of Government Programs Health Integration
Blue Cross Blue Shield of North Dakota

Mike Rhoads
Deputy Commissioner of Health and Life Insurance
Oklahoma Department of Insurance
Please don’t forget to fill out your evaluation form!

Thank you and have a great day!