Summary of Cross-State Telehealth Advocacy Framework

Informed by Discussion at Removing Licensure Barriers to Interstate Telehealth: A Policy Summit

May 20th, 2025 at the Johns Hopkins Bloomberg Center in Washington, DC

(See List of Organizations Represented in Appendix)

Introduction

This document summarizes two actionable proposals emerging as top priorities from the event "Removing Licensure Barriers to Interstate Telehealth," held at the Hopkins Bloomberg Center on May 20, 2025. This event was attended by over 60 experts across health systems, advocates, as well as policy and legal experts from across the country. These physician licensure proposals—1) **a Continuity of Care Model** and 2) **a National Telehealth Registry**—offer specific pathways to increase flexibility in cross-state telehealth and expand access to care across state lines. While this document focuses on physician licensure, these approaches could be adopted by other health professions. Together, they provide a practical and balanced approach to modernizing the telehealth landscape.

Rationale

State-specific licensure rules remain a significant barrier to telehealth, preventing patients from accessing essential healthcare services—especially specialized care—and creating unnecessary obstacles to cross-state collaboration. These restrictions cause unnecessary suffering for patients across the country (Video 1 and Video 2). Many have worked hard to address these barriers over the past decade (*Table 1*), but state-based solutions have fallen short of meeting the needs of most clinicians and patients. Despite guidance from the Federation of State Medical Boards (FSMB) and the Uniform Law Commission, only a handful of states have adopted common-sense exceptions to licensure requirements for cross-state telehealth.

The time has come for a unified federal strategy. National solutions to interstate telehealth barriers are essential for improving patient outcomes, reducing provider challenges, optimizing the efficiency of government resources, and enabling seamless healthcare delivery across state lines. The development of common-sense national solutions for interstate telehealth, combined with investments in interoperable health systems, would enable the creation of centralized, nationwide care models. For instance, a national center of excellence for rare cancers could deliver cutting-edge treatments to patients across the country by partnering with local clinicians and leveraging comprehensive health data from local care sites to provide timely, effective, and coordinated care.

Federal precedent, including the VETS Act, the Military Spouses Licensure Relief Act, and the Sports Medicine Licensure Clarity Act, demonstrates the feasibility of targeted carve-outs to address licensure challenges. By leveraging the interstate commerce clause of the U.S. Constitution, federal oversight can establish a cohesive strategy for telehealth access nationwide, ensuring seamless collaboration across states while respecting local governance structures.

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Table 1. 2014-2024 - Solid Progress at State Level, But Not Enough				
	Interstate Medical Licensure Compact 2014/2015	**FSMB Telemedicine Practice Statement Adopted 2022**	**Uniform Telehealth Act 2022**	**Individual State Actions (e.g. VA established patients, CA end of life)**
Strengths	✓ Path to licensures ✓ Maintains state authority	✓ Outlines common sense exceptions ✓ Unanimously adopted by FSMB	✓ Outlines common sense exceptions ✓ Multiple provider types ✓ Provides model language	✓ Many changes are automatic and do not require additional provider work or cost
Gaps	X Not true portability X Not feasible for infrequent or unexpected care - $100s-1,000s fees, hours of provider time, weeks of processing	X Requires individual states to draft language and have champions	X 2 states have passed X Not passed in 2 states X Registration only works if uniform adoption	X Heterogeneity X Difficult to track X Difficult to implement (e.g. EHR scheduling)

Note: Although the primary focus of this document is on physician licensure, a similar model could be applied across health professions.

1. Continuity of Care Model (Established Care Model):

A continuity of care model allows more flexibility in interstate telehealth in the context of an ongoing patient-physician relationship. With this approach, if a licensed healthcare provider has an established provider-patient relationship with an individual in a state where the provider holds an active and valid license, the provider may continue to deliver healthcare services to the patient for up to three (3) years from the initial establishment of the relationship, regardless of the patient's location, provided that:

1. The provider complies with all applicable laws, regulations, and standards of care in the state where the patient is physically located at the time of delivering care.
2. The provider maintains all necessary licensure or certifications in at least one U.S. state or jurisdiction.

Allowing for a continued relationship across state lines is reflective of the current practice habits of many providers who speak with patients through telephone and MyChart to ensure continuity of care once a relationship is established.

We propose that this model could be federally clarified through congressional action. Congress could pass legislation that establishes this model nationwide, creating cross-state uniformity and alleviating geographic care barriers. To do so, such legislation would:

A. Amend the existing licensure framework to allow physicians licensed in their home state to render care across state lines for patients who have previously established care.
B. Define clear conditions under which this law would apply, such as requiring documentation of the initial in-person visit and establishing time limits (e.g., 3 years).

C. Direct the Department of Health and Human Services (HHS) to oversee implementation, develop rules, and monitor compliance.
D. Provide funding incentives or grants through agencies like HHS to assist states with any necessary technical and procedural integration.

The Commerce Clause (Article I, Section 8, Clause 3) provides a constitutional foundation for federal intervention. As telehealth services often involve interstate commerce, federal regulation could ensure that patients can access providers across state lines without facing licensure barriers. Congress could argue that the model addresses the "effects on interstate commerce" by reducing geographic barriers to care for a mobile population that includes college students, seasonal workers, and patients with chronic illnesses who may require continuity of care. Legislative language could be adapted from existing federal laws that define permissible cross-state telehealth practices, such as the VETS Act (which addresses telehealth for veterans) and the Sports Medicine Licensure Clarity Act (which ensures malpractice insurance coverage for sports medicine providers traveling with teams).

2. A National Telehealth Registry

A national registry is a mechanism by which physicians in good standing in a home state could efficiently obtain national licensure portability with appropriate guardrails and oversight. A national telehealth registry would ensure the ability for patients to establish a new relationship with a physician across state lines for complex specialty care and other impactful use cases.

One option would be to establish a national telehealth registry through a cooperative federalism model in which federal funding is tied to each state passing a law to participate in the registry. Supported by the Commerce Clause, another pathway could be for the federal government to establish and fund a national registry without additional state laws. Regardless of approach, a registry could be operationalized in partnership with the Federation of State Medical Boards (FSMB) and the Department of Health and Human Services (HHS).

If a cooperative federalism model is used, the federal government could encourage state alignment through funding or resource allocation, like the Health Resources and Services Administration's (HRSA) past support of the Interstate Medical Licensure Compact (IMLC). This approach bears resemblance to the driver's license model, where states mutually recognize each other's standards under federal guidance. For states already participating in the IMLC, this registry could be implemented as an addendum, reducing the legislative burden of adoption. For the smaller number of non-IMLC states, advocacy campaigns and federal incentives would be necessary to encourage participation.

A Targeted Approach

In 2022, the FSMB house of delegates unanimously adopted a document outlining the types of cross-state telemedicine that should be allowed to occur across state lines in the absence of additional licensure (FSMB 2022). The Uniform Law Commission has developed a Uniform Telehealth Act (2024) with model language for more flexible cross-state care.

Building on these frameworks, a broad systemic national registry could allow for cross-state telemedicine for common-sense use cases in the situation where a physician or other healthcare provider has no previous disciplinary action against them. Providers who pay a fee and register with the national registry would be able to provide the following via telehealth across state lines in the following situations:

Targeted use cases could include:

1. **Rare and Life-Threatening Conditions:** Clinicians can deliver care to new patients with rare and life-threatening conditions across state lines by enrolling in the national registry. This would include rare diseases (as defined by the FDA), cancer care, transplant medicine, and palliative care.
2. **Clinical Trials:** Providers delivering care through clinical trials can deliver care to out-of-state patients using telemedicine technologies if they participate in the national registry.

Additional situations to consider:

3. **Out-Of-State Consultations Requested by Local Clinicians:** Out-of-state physicians consulting at the request of a locally licensed provider. Consulting clinicians can interact directly with the patient so they can provide the best possible advice to the requesting clinician.
4. **Patient Screening for Complex Referrals:** Out-of-state specialty centers can screen patients to assess whether the patient is a candidate for ongoing care without obtaining local licensure. The consulting clinician can interact directly with the patient to ensure they have the appropriate information to make a high-quality recommendation.
5. Follow-up care for established patients was also a part of the FSMB proposal and Uniform Telehealth Act, but would be better addressed by a broad exemption that does not involve the additional step of a registry. If a separate continuity of care exemption was not feasible, continuity of care across state lines could be incorporated into the types of care delivered under a registry.

Note: Adding additional use cases to a national telehealth registry could expand access to care but may lead to operational challenges as the scope and number of providers in the registry expands.

Operationalizing a National Registry

A national registry would involve a national database of provider information, which could be established through collaboration with existing databases such as NPI and Provider Bridge. A process would be outlined for cross-jurisdictional data sharing, cross-jurisdictional reporting, and disciplinary action. Providers would need to follow any specific laws in the states where patients are located. In clinical areas where there is significant cross-state variability (e.g., reproductive healthcare), providers would receive education as part of the registration process, and up-to-date resources would be kept on the registry's website so that providers would not have to seek information from multiple sources to stay up to date. If a provider had a disciplinary action against them, they are no longer eligible to be on the

national registry. In this situation, they could practice in other states through seeking full licensure (e.g., through IMLC).

It is not clear whether a national registry could be passed and operationalized at the federal level, or if state laws would be needed in each individual state. A state-by-state approach would be challenging, but the IMLC provides many lessons learned and a pre-existing framework. Since 2014, 43 states have adopted the IMLC. As an addendum to these states' existing IMLC legislation, the national registry could leverage the infrastructure and agreements already in place. The states already participating in the IMLC can modify their agreements to include the registry without requiring entirely new legislation, making adoption more efficient. For the remaining 7+ states and jurisdictions that have not passed the IMLC, a narrower standalone bill focused specifically on telehealth practitioner licensure could be proposed. Adoption in these states would require significant state-level advocacy efforts to overcome individual barriers to participation, but the precedent of the IMLC provides a productive pathway for legislative drafting and adoption.

To support these efforts, targeted funds from the federal government could be allocated. Funding would need to overcome historical insufficiencies, with budget projections informed by historical needs (e.g., IMLC). For instance, HRSA provided approximately $2 million toward the implementation of the IMLC Compact Commission infrastructure. Developing a broader advocacy program for the national telehealth registry, including state campaign support, technology infrastructure, and operational expenses, may require a significantly larger allocation. Also, ongoing federal funding to state medical licensing boards could be a mechanism to ensure participation, given that an anticipated decrease in physician license fees has historically been a barrier to state board acceptance of streamlining licensure pathways.

Next Steps for Cross-State Telehealth Advocacy

What We Have After Two Convening Events:

1. **Advocates**: A strong base of over 150 advocates engaged in this effort over the past year across academic medical centers, advocacy organizations, professional societies, legal experts, and many others.

2. **Patient Stories**: Three impactful advocacy videos highlighting real stories to illustrate the importance of cross-state telehealth. (Video 1, Video 2, and Video 3)

3. **Action Plans**: Six detailed action plans informed by leading health system and patient advocacy organizations aimed at addressing barriers to interstate telehealth, focused on urgent, high-impact clinical conditions (Cancer Care, Clinic Trials, Mental Health, Rare Diseases, and Transplant).

4. **Policy Approaches**: Comprehensive policy proposals, including the Continuity of Care Model and the National Telehealth Registry.

What We Need:

1. **Connections**: Engage policymakers, state medical boards, and regulators to build momentum for policy changes. Partner with organizations and stakeholders who can amplify the message.

2. **Advocacy Support**: Strengthen the network of advocates by expanding outreach efforts and providing resources to equip individuals and organizations to champion policy changes. Mobilize grassroots advocacy and expand educational efforts for the public and healthcare providers.

3. **Funding**: Secure financial backing to continue campaign efforts, such as producing advocacy materials, hosting events, and meeting with lawmakers. We estimate approximately $900,000 is needed to fuel the next stage of this important effort.

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Appendix

Organizations in attendance at:
Removing Licensure Barriers to Interstate Telehealth: A Policy Summit
May 20th, 2025, at the Johns Hopkins Bloomberg Center in Washington, DC

American Medical Association
American Telemedicine Association
Association of American Medical Colleges
ATA Action
Bipartisan Policy Center
Boston Children's Hospital
Boston University
Brown University School of Public Health
Center for Connected Health Policy
Cystic Fibrosis Foundation
DC Council, Committee on Health
Federation of Podiatric Member Boards
Federation of State Medical Boards
George Washington University
Harvard Law's Center for Health Law Policy & Innovation
Harvard Medical School/Massachusetts General Hospital
HHS, HRSA, Office for the Advancement of Telehealth
Intermountain Health
Interstate Medical Licensure Compact Commission
Johns Hopkins Health System
Johns Hopkins University and Medicine
Kennedy Krieger Institute
Meadows Mental Health Policy Institute
Meeting Makers
Memorial Sloan Kettering Cancer Center
Mid-Atlantic Telehealth Resource Center
Pacific Legal Foundation
Peterson Center on Healthcare
The Ohio State University Wexner Medical Center
Uncommon Cures, Inc.
University of Arizona James E. Rogers College of Law
University of Virginia
Virginia Board of Medicine
Washington Medical Commission