

# Rating the States on Telehealth Best Practices:

**A Toolkit for a Pro-Patient  
and Provider Landscape**

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# Rating the States on Telehealth Best Practices:

## + A TOOLKIT FOR A PRO-PATIENT AND PROVIDER LANDSCAPE +

Millions of Americans tried telehealth for the first time during the COVID-19 pandemic. Federal officials made select changes to the Medicare program and governors advanced health access with flexible provider licensure for new uses of telehealth by waiving certain barriers by executive order. All of these changes garnered numerous headlines, and many state legislatures followed suit by updating their laws.

But once the public health emergency declarations started to end or executive orders were withdrawn, overnight or shortly after, many of the new flexibilities were lost. Furthermore, even though many states passed new laws related to telehealth, many of them made incremental changes because policymakers lacked a best practices roadmap for success.

While they cannot and should not replace all in-person medical appointments, virtual visits can save patients time and help them avoid germ-filled waiting rooms. Providers can also cut down on their risk of exposure and take some pressure off overburdened systems as they can see patients from an office or home. To experience the full potential of telehealth, states should follow these best practices.

 <b>DO Support "Modality Neutral" Options</b> Allow all kinds of telehealth (i.e., live video, remote monitoring, or recorded messages) to be used to establish a patient-provider relationship, and on whatever device is best for the patient and provider.	 <b>DO Support Access to Care</b> Allow all kinds of providers to utilize telehealth to allow for more team-based care and prohibit facility fees from being charged for services that can be delivered from anywhere.	 <b>DO Support Provider Access to Telehealth</b> Allow across-state-line telehealth with a simple registration for those holding a license or registration in good standing to help with the continuation of care and increase access in rural communities.
 <b>Don't Arbitrarily Limit Provider Tools</b> Requiring in-person visits before using telehealth or requiring certain technology methods (e.g., real-time video) when the clinical situation does not necessitate limits patient care.	 <b>Don't Mandate Coverage for Everything</b> Passing insurance coverage parity mandates that require paying for all services, since research has shown mixed outcomes for certain services over telehealth, can lead to wasteful spending. A mandate also inhibits innovation in care delivery.	 <b>Don't Mandate Payment Rates in Law</b> Passing a payment parity mandate that requires all telehealth visits to cost as much as an in-person visit hurts vulnerable patients as they pay more, and small businesses as large companies are not subject to these mandates.

This toolkit aims to help policymakers take the next step toward a more quality-oriented, affordable, and innovative health system by ensuring that their state laws on telehealth remove deleterious barriers that have historically discriminated against those in certain geographies, such as those living in rural communities or in underserved urban areas. This report explains policy best practices for ensuring that providers and patients can fully realize the benefits of using telehealth services when appropriate and provides a simple-to-read stoplight rating for each state on how closely their policies align with those best practices. The state profiles point state lawmakers to specific sections of law and regulation that need to change to improve their ranking.

States need to act now to ensure the physical and economic needs of their state are met with a more quality and future-oriented health system.

# Rating the States on Telehealth Best Practices

State	No In-Person Requirement	Modality Neutral	Start Telehealth by Any Mode	No Barriers to Across State Line Telehealth	All Providers Can Use Telehealth	Independent Practice	No Coverage Mandate	No Payment Mandate	Compacts
AL	●	●	●	●	●	●	●	●	●
AK	●	●	●	●	●	●	●	●	●
AZ	●	●	●	●	●	●	●	●	●
AR	●	●	●	●	●	●	●	●	●
CA	●	●	●	●	●	●	●	●	●
CO	●	●	●	●	●	●	●	●	●
CT	●	●	●	●	●	●	●	●	●
DE	●	●	●	●	●	●	●	●	●
FL	●	●	●	●	●	●	●	●	●
GA	●	●	●	●	●	●	●	●	●
HI	●	●	●	●	●	●	●	●	●
ID	●	●	●	●	●	●	●	●	●
IL	●	●	●	●	●	●	●	●	●
IN	●	●	●	●	●	●	●	●	●
IA	●	●	●	●	●	●	●	●	●
KS	●	●	●	●	●	●	●	●	●
KY	●	●	●	●	●	●	●	●	●
LA	●	●	●	●	●	●	●	●	●
ME	●	●	●	●	●	●	●	●	●
MD	●	●	●	●	●	●	●	●	●
MA	●	●	●	●	●	●	●	●	●
MI	●	●	●	●	●	●	●	●	●
MN	●	●	●	●	●	●	●	●	●
MS	●	●	●	●	●	●	●	●	●
MO	●	●	●	●	●	●	●	●	●
MT	●	●	●	●	●	●	●	●	●
NE	●	●	●	●	●	●	●	●	●
NV	●	●	●	●	●	●	●	●	●
NH	●	●	●	●	●	●	●	●	●
NJ	●	●	●	●	●	●	●	●	●
NM	●	●	●	●	●	●	●	●	●
NY	●	●	●	●	●	●	●	●	●
NC	●	N/A	●	●	N/A	●	●	●	●
ND	●	●	●	●	●	●	●	●	●
OH	●	●	●	●	●	●	●	●	●
OK	●	●	●	●	●	●	●	●	●
OR	●	●	●	●	●	●	●	●	●
PA	●	N/A	●	●	N/A	●	●	●	●
RI	●	●	●	●	●	●	●	●	●
SC	●	●	●	●	●	●	●	●	●
SD	●	●	●	●	●	●	●	●	●
TN	●	●	●	●	●	●	●	●	●
TX	●	●	●	●	●	●	●	●	●
UT	●	●	●	●	●	●	●	●	●
VT	●	●	●	●	●	●	●	●	●
VA	●	●	●	●	●	●	●	●	●
WA	●	●	●	●	●	●	●	●	●
WV	●	●	●	●	●	●	●	●	●
WI	●	●	●	●	●	●	●	●	●
WY	●	●	●	●	●	●	●	●	●

# Methodology and Best Practices Explained

To construct this report state laws in all 50 states were reviewed as well as evaluations by the Center for Connected Health Policy and the National Conference of State Legislatures.<sup>1</sup> In addition, the report reflects more recent state legislative changes that were not reflected in the NCSL report, for example, in Massachusetts.

Different states define telehealth and telemedicine in different ways, and some often use additional references such as teledentistry, telepsychiatry, or telepractice. For the sake of simplicity, the report will use telehealth as an all-encompassing term in this report.

This report did not examine state Medicaid telehealth policies.

Some states do not have current laws on telehealth related to commercial insurance. This silence in state laws means that there are fewer explicit barriers to accessing telehealth, but this silence also can lead to legal uncertainty over what is or is not allowed and may prevent providers from fully embracing the use of telehealth.

## Best Practices

It is important to provide some context for how the report defines best practices.

### NO IN-PERSON REQUIREMENT

Before the pandemic, many states required an in-person visit before being able to see a provider over telehealth to establish a patient-provider relationship. This can be a barrier to accessing care given many communities have an acute provider shortage to begin with,<sup>2</sup> and transportation remains a challenge for many low-income to middle-class patients.<sup>3</sup> In many cases, it would make more sense for a patient and provider to meet via telehealth to determine if an in-person encounter is necessary. In such cases, requiring an in-person visit prior to the provision of telehealth services is both unnecessary and inefficient. In-person requirements also force sick patients into an in-person environment when a virtual visit could help reduce the chance of transmission for both the patient and provider.

Removing this barrier helps give providers the flexibility to determine, with their patients, the best first step of care. Telehealth cannot and should not replace all in-person visits. But in some instances, if you require an in-person appointment first, some patients will choose to or be forced to receive no care at all.

The stoplight chart does not consider in-person requirements for prescriptions but notes in the state profiles how state laws treat that requirement, especially if they don't allow a patient-provider relationship to be established using asynchronous methods.

- **Green:** No in-person requirement to establish a provider-patient relationship before being able to use telehealth.
- **Yellow:** Certain specialty providers require an in-person requirement, or state administrative regulations have an in-person requirement.
- **Red:** Requires an in-person visit ahead of using telehealth.

## MODALITY NEUTRAL

Allowing for a quality-oriented, provider and patient-centered health system means allowing for many kinds of telehealth, not just live video as most people think of telehealth. For this category, the report will largely follow the term as defined by the American Telemedicine Association (ATA) which points to a “modality-neutral” definition of telehealth including various methods whether asynchronous or synchronous and various technologies whether by audio-video, store and forward, or remote patient monitoring.

“Telehealth” means a mode of delivering health care services using telecommunications technologies, including but not limited to asynchronous and synchronous technology, and remote patient monitoring technology, by a health care practitioner to a patient or a practitioner at a different physical location than the health care practitioner.

Remote patient monitoring refers to the transmission and monitoring of personal health data (including vital signs, weight, blood pressure, blood sugar, blood oxygen levels, heart rate, and electrocardiograms) via electronic communication technologies. Remote patient monitoring allows providers to track a patient’s health data outside of a health care facility. This is beneficial for preventing readmissions and allowing elderly and individuals with disabilities to live at home and avoid admission into a skilled nursing facility.

Store-and-forward refers to the electronic transmission of digital medical information including pre-recorded video or images (such as X-rays, MRIs, or photos of skin conditions). Store-and-forward transfers are particularly useful for consultations with specialists who can review medical information after it has been collected and uploaded. This provides patients access to specialty care in a timely manner without the need for coordinating schedules and lengthy travel.

- **Green:** Allows synchronous and asynchronous explicitly or has a broad enough definition for their use. The state law also mentions store-and-forward and remote patient monitoring.
- **Yellow:** Allows synchronous and asynchronous explicitly or has a broad enough definition to allow its use.
- **Red:** Limits the use of at least one kind of modality.

## START TELEHEALTH BY ANY MODE

Every patient has a different preference for how to interact with a telehealth provider. As a result, allowing for the patient-provider relationship to be initiated through the patient’s preferred modality is imperative. Imagine someone experiencing a behavioral health crisis in the middle of the night. They might strongly prefer to start communication by text or in an asynchronous manner before being comfortable switching to a video call or in-person visit. Or imagine a busy patient who just needs to follow up on an already-prescribed drug. Getting it refilled can be much more efficiently handled through an asynchronous interaction which prevents them from having to miss work and doesn’t waste the time of a provider so they can see a sick patient. If the health system is going to be more patient-centered, accessible, and avoid wasting money-- then state laws need to ensure these better methods to deliver care are available. Laws and board regulations should remove any barriers that get in the way of jump-starting a telehealth relationship.

- **Green:** Patients can start a telehealth relationship using the modality of their choice.
- **Yellow:** Law or regulations suggest a standard of care that would not allow starting a telehealth relationship over an asynchronous mode.
- **Red:** Law or regulations specifically restrict a certain modality for starting a telehealth relationship over an asynchronous mode.



## NO BARRIERS TO ACROSS STATE LINE TELEHEALTH

Allowing patients to access providers outside their community is imperative as most cities and towns simply lack certain kinds of providers.<sup>4</sup> Telehealth may be their only option for seeing a specialist, to get a second opinion or access team-based care. Allowing across-state-line telehealth ends geographic and economic discrimination for many patients and allows access to providers who would not otherwise be accessible, or who they could not afford to travel to see.<sup>5</sup>

Too many states and medical boards have made it time-consuming, expensive, and too difficult for providers to see patients outside their home state. Pilots don't lose their skills when they cross a state line, and neither do health care professionals. As more Americans are mobile, being able to stay in touch with providers who know the patient's history and have their trust is imperative to better health outcomes, and far better than the status quo that forces patients to start over with a brand-new provider.

For this category, the report was looking for states that clearly allow providers in good standing to see patients in another state without jumping through expensive time-consuming hoops—and not just for a consultation to another provider or during an emergency. States that earned a green often allowed providers to register to see new patients. Anything over and above these requirements are barriers to the provider and patient relationship.

Imagine that a family member gets sick and the nation's leading expert on treating coronavirus works at the Cleveland Clinic in Ohio. You could not see the specialist unless the provider went through the time and expense of obtaining a full medical license in your state. If you are wealthy, you could travel to Ohio and pay out of pocket for the services. Middle-class and low-income residents have no such option. This is discrimination by geography and economic status. Telehealth reform is a market-based equalizer.

- **Green:** Clear, straightforward, predictable registration or licensing process for all out-of-state health care providers to see patients across state lines.
- **Yellow:** Has a clear, straightforward, predictable registration or licensing process but it only applies to physicians, or certain kinds of providers, or only for surrounding states.
- **Red:** There are clear barriers to across-state-line telehealth, or there is not an option for a clear pathway to do so.

## ALL PROVIDERS CAN USE TELEHEALTH

Pre-pandemic, some states only allowed doctors to use telehealth. The pandemic reopened the conversation about the need to give additional providers access to telehealth, and the acute shortage of providers in many counties adds to the need for more kinds of providers to be able to use it. In addition, innovations in care delivery like team-based care are only possible in many communities when all providers are allowed to use telehealth. As an example, for diabetes care, everyone from the primary care doctor to a nutritionist to an endocrinologist to an ophthalmologist or optometrist all need to be able to use telehealth to best coordinate care.

Many states tie telehealth use to only those providers who are currently licensed in state code, but in the future, care innovation may involve new kinds of providers that are not in state code. To be considered a best practice and achieve a green ranking in this category a state must have telehealth practitioner or provider definitions that are broad enough to allow for future innovation and not be limited to only certain codes of state law. If they are tied to a certain section of law, the state would receive a yellow ranking.

- **Green:** Definition for the kinds of providers is broad enough to allow any provider to use telehealth.
- **Yellow:** Definition for the kinds of providers that can use telehealth is limited to specific occupations listed in code.
- **Red:** Use of telehealth is limited to only some, or a very narrow set of providers.

## INDEPENDENT PRACTICE

For this category, the report ranks based on whether nurse practitioners (NPs) are allowed to practice in the way they have been trained, or if the state still requires a doctor to provide oversight or co-sign their work.

The country has an acute shortage of doctors that is projected to grow to up to 124,000 by 2034.<sup>6</sup> Expanding the supply of health care professionals with high-quality nurse practitioners (NPs) is not only a nice option to have for patients during a pandemic, but a necessity. It also allows doctors to focus on the most complex and sick patients. Ample research has shown that expanding NPs' scope of practice increases access to care and reduces costs without compromising on quality.<sup>7</sup> Absent reform, many patients may be forced to go without care.

It is important to acknowledge that expanding the scope of practice for pharmacists, physician assistants, dentists, and other medical providers can also be important as well. Yet, because of the impact of NPs being allowed to practice independently on patient access, the choice was made to focus on this for the report.

- **Green:** NPs can practice fully independently without a collaborative practice agreement or supervision from a physician to provide medical services.
- **Yellow:** NPs can practice independently after a certain period of time, or they have some collaboration or supervision requirement for at least one or more medical services, not including for prescribing.
- **Red:** An NP can never practice independently without a collaborative practice agreement or supervision.

## NO COVERAGE MANDATE

Coverage parity often mandates that all services that can be made available over telehealth must be covered. Yet a blanket coverage mandate ignores that not all telehealth is created equally.

A comprehensive research review by MedPAC in 2018 found that telehealth can be a game changer for post-stroke care, and for treatments for physically disabling and treatment-intensive conditions. Yet for other services, the evidence of better outcomes is far less certain.<sup>8</sup> Most state laws need to protect flexibility so that new innovative models can emerge, and best practices for telehealth can be data-driven as our country has more experience using the technology.

It should be noted that states typically require that telehealth services be provided at the same standard of care as in-person visits, but that is often left to the discretion of the provider. As a result, the data are often insufficient to determine outcomes. In five years, it may be determined by research that certain services cannot be delivered over telehealth at the same standard of care, but yet insurers will still be mandated by state law to cover them if the provider deems it otherwise. The goal in state law should instead be to preserve flexibility between the insurer and provider to pay for what works and stop paying for what doesn't.

- **Green:** No mandate for insurers to cover all services offered through telehealth.
- **Yellow:** There is a mandate for certain services.
- **Red:** Mandate for all services.

## NO PAYMENT MANDATE

Payment parity mandates that telehealth services are paid at the same rate as in-person office visits, often including facility fees. These mandates are intended to promote the use of telehealth but have unintended consequences that "perpetuate the worst features of our nation's health care system."<sup>9</sup> Mandating coverage of all services at a higher rate even if some provide no value has been shown to increase spending and hurt vulnerable patients and small businesses as patients put off needed care over cost concerns.<sup>10</sup>



One of the advantages of telehealth is that services can be rendered from any setting. This includes the provider. For providers offering tele-services from a home office or any office setting, there are significant savings on administrative costs and overhead, and there is no cross-subsidizing other facility-based services (emergency room, research and development, office costs, etc.). So, it makes little sense that policy should mandate the same payment rate, including in many cases a facility fee, even if the service is delivered from a home office.

- **Green:** No mandate for insurers to pay the same rate for telehealth services as an in-person visit.
- **Yellow:** Payment mandate for some services, or cost-sharing requirements that are mandated at the same level for the patient as an in-person visit.
- **Red:** Payment mandate for all services to pay the same rate for telehealth as an in-person visit.

## COMPACTS

Compacts are an attempt to make it easier for certain providers to provide services in more than one state. Compacts are a positive step forward but do have limitations, as they are time-consuming, expensive, limited to only member states, and are a barrier to a more flexible patient-centered health system.

Compacts don't remove a barrier to out-of-state providers—fees. For example, the Interstate Medical Licensure Compact (IMLC) for physicians still requires them to have a license in every state. As such, physicians are deterred from securing and maintaining licenses in multiple states due to the costs of the initial licensing and renewal fees. This is such a significant problem that the IMLC, the Federation of State Medical Boards, and some state boards have received federal taxpayer dollars to reduce barriers to telehealth through the IMLC. But this problem is not going away.

Additionally, associations and boards support compacts because it protects their control and revenue. The American Medical Association, the largest association and lobby group of physicians, stated the IMLC was not designed to facilitate telehealth across state lines. Instead, “The compact is the first line of defense against troubling federal proposals to create a federal telemedicine license, or to change the site of practice from where the patient is located to where the physician is located for purposes of telemedicine...The compact is intended to prevent just that.”<sup>11</sup>

That is why the ranking also examined states that have set up an easier pathway to deliver services. The impact of compacts is limited to only member states, so registrations are far more flexible. States should pass compacts if the political environment does not allow for these easier pathways, but only as a plan B.

- **Green:** Member of at least both the Nurse Licensure Compact and Interstate Medical Licensure Compact (IMLC).
- **Yellow:** Member of at least one of the Nurse Licensure Compact or IMLC.
- **Red:** Not a member of either.

## NO FACILITY FEE

Facility fees have been used as a way for health systems to add an additional charge over and above the charge for medical services provided. Given that telehealth can be delivered from almost any setting, states should not require or allow a facility fee to be charged for telehealth as such care can be delivered from almost anywhere. The cost to deliver the care should be all inclusive and part of any negotiation with the insurer or patient. The report does not provide a full breakdown on this topic but still highlights it as a best practice to avoid making telehealth visits more expensive for patients.



# ALABAMA

The state currently has no telehealth statute for commercial insurance. This silence in state laws means that there are fewer explicit barriers to accessing telehealth, hence many of the green ratings given on the stoplight chart. But this silence also can lead to legal uncertainty over what is or is not allowed, open the door for inconsistent regulatory interpretation, and, ultimately, may prevent providers from fully embracing the use of telehealth.

State law silence also ensures inconsistency of insurance policies on telehealth that underutilize the service, as insurers still pay mainly for in-person visits in a facility. It also means that there is not an easy path for patients to see the provider of their choice, even if they are located across a state line, hence the red ranking. It should be noted that there is a very small window of opportunity for doctors to obtain a special purpose license ([AL Admin Code 540-X-16](#) and [Code of AL Sec. 34-24-502 - 507](#)) for cross-state licensing, but it is unclear if and how they can use telehealth. Regardless, this is far from an easy process, is at the complete discretion of the Board of Medical Examiners, and only applies to doctors.

Without a state law, individual boards have promulgated some reference FAQs and rules around telehealth. For example, the [Board of Medical Examiners and Medical Licensure Commission confirms that no statutes or regulations specifically regulate telehealth, thus “physicians are held to the same standard of care irrespective of the modality of treatment.”](#) Also, several other individual boards have adopted applicable regulations, including [Board of Nursing \(AL Admin Code 610-X-6\)](#), [Board of Optometry \(AL Admin Code 630-X-13\)](#), and the [Board of Social Work \(AL Admin Code 850-x-2\)](#). Yet, these rules often include extra barriers to accessing care including additional requirements on providers or patients before using telehealth, or administrative records requirements. For example, for optometry ([Code of AL 34-22-83](#)), they have added an in-person requirement for distant site providers.

Alabama is a member of the Interstate Medical Licensure Compact for doctors. The state also participates in the Nurse Licensure Compact, Psychology Interjurisdictional Compact, Physical Therapy Licensure Compact, and Audiology and Speech-Language Pathology Interstate Compact.





# ALASKA

Alaska’s definition of telehealth is modality neutral in that it does not specify whether services are required to be synchronous or asynchronous ([Alaska Statutes Sec. 47.05.270\(e\)](#); [Alaska Stat. Ann Sec. 44.33.381](#)). State law does not explicitly mention remote patient monitoring or store-and-forward technologies. Alaska regulations prohibit treatment, diagnosis, or the prescription of medications based “solely on a patient-supplied history” received by “telephone, facsimile, or electronic format” ([Alaska Admin Code tit.12,Sec. 40.967\(27\)](#)). In other words, a patient-provider relationship may not be established through asynchronous modalities. Alaska requires coverage parity for mental health services ([Alaska Statutes Sec. 21.42.422](#) as amended by [HB 29 \(2020\)](#)). The state does not require payment parity.

Alaska state law does not specify which providers are authorized to practice telehealth. The state does have a telemedicine business registry ([Alaska Statutes Sec. 44.33.381](#)) and the application is limited to certain provider types that must get an Alaska business license as part of that process. ([Registry form](#)) Ideally, this would be open to any provider and not require a separate business license. Providers are generally required to hold an Alaska license to practice telehealth in the state. Alaska is not a member of any interstate licensure compacts. Nurse practitioners are permitted to practice independently in Alaska ([Alaska Admin. Code 12-44.400](#)).







# ARIZONA

The Arizona Legislature passed sweeping telehealth reforms in 2021 ([HB 2454 \(2021\)](#)). Arizona’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities, allowing for “audio-only” if audio-visual telehealth is not reasonably available ([AZ Revised Statutes Sec. 36-3601](#)). However, the medical practice act restricts prescribing to providers with an established doctor-patient relationship or those who conduct an examination “during a real-time telemedicine encounter with audio and video capability.” ([AZ Revised Statutes Sec. 32-1401\(27\)\(tt\)](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies ([AZ Revised Statutes Sec. 36-3601](#)). Arizona has payment and coverage parity requirements for private insurance providers (AZ Revised Statutes Sec. 20-841.09). Payment parity is not required for services provided through a telehealth platform provided or sponsored by the insurer

State law specifies which providers may practice telehealth ([AZ Revised Statutes Sec. 36-3601](#)). While the state’s definition of “health care provider” is broad, it may exclude some providers and limit future innovation. The state provides a registration process for out-of-state providers to practice telehealth in Arizona without obtaining a separate Arizona license. Arizona is also a member of the Nurse Licensure Compact, Physical Therapy Compact, and Psychology Interjurisdictional Compact. Nurse practitioners are permitted to practice independently in Arizona ([AZ Revised Statutes Sec. 32-1601](#))





## ARKANSAS

Arkansas's definition of telehealth is broad and includes synchronous and asynchronous modalities. State law explicitly mentions remote patient monitoring and store-and-forward technologies. State law requires a provider to have a "professional relationship" with a patient in order to provide telehealth services. Medical Board regulations state that a proper patient-provider relationship can be started without an in-person visit but require, "a face-to-face examination using real-time audio and visual telemedicine technology..." ([State Medical Board Regulation 2.8, Rule No. 060.00.16-003](#)). In addition, "A patient completing a medical history online and forwarding it to a Provider is not sufficient to establish the [patient practitioner] relationship, nor does it qualify as store-and-forward technology." ([State Medical Board Regulation](#) No 38.1) These rules limit patient choice to start a relationship in an asynchronous manner and should be removed. Arkansas requires both payment and coverage parity (Code of AR Sec. 23-79-1602).

State law allows all health care providers to practice telehealth. The state's definition of health care provider includes any person "who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession" (Code of AR Sec. 17-80-402). This broad definition ensures that no potential telehealth practitioner is excluded and provides flexibility for future innovation. However, out-of-state providers must have an Arkansas license to practice telehealth in the state. Arkansas is a member of the Nurse Licensure Compact ([NLC](#)), Psychology Interjurisdictional Compact ([PSYPACT](#)), and Physical Therapy Licensure Compact ([PT Compact](#)). However, Arkansas has not joined the Interstate Medical Licensure Compact ([IMLC](#)) or Advance Practice Nurse Compact ([APRN Compact](#)). Nurse practitioners are permitted to practice independently after working under a collaborative practice agreement physician for 6,240 hours ([HB 1258 \(2021\)](#)).







# CALIFORNIA

California’s definition of telehealth includes synchronous and asynchronous modalities, but does not explicitly mention remote patient monitoring ([CA Business and Professions Code 2290.5](#)). State law prohibits insurance providers from requiring “in-person contact occur between a health care provider and a patient before payment is made for...services appropriately provided through telehealth” ([CA Insurance Code 10123.85](#)).

State law specifies which providers may practice telehealth [CA Business and Professions Code 2290.5](#). While the state’s definition of “health care provider” is broad, it may exclude some providers and limit future innovation. Out-of-state health care providers must have a California license to practice telehealth in the state. California is not part of any multi-state licensure compacts. Nurse practitioners are permitted to practice independently after three full-time equivalent years of practice or 4,600 hours ([AB 890 \(2020\)](#)).







# COLORADO

Colorado's definition of telehealth is broad and modality neutral, mentioning both remote patient monitoring and store-and-forward (CO Revised Statutes Sec. 10-16-123, note all Colorado references need to be looked up individually using the state website [link](#)). State law prohibits health insurance providers from requiring "in-person contact between a provider and a covered person for services appropriately provided through telehealth" (CO Revised Statutes Sec. 10-16-123). The state requires both coverage and payment parity (CO Revised Statutes Sec. 10-16-123).

Colorado does not have a registration process for out-of-state telehealth providers, but is a member of several interstate licensing compacts including the Interstate Medical Licensure Compact, Nurse Licensure Compact, Interjurisdictional Psychology Compact, Physical Therapy Compact, EMS Compact, Occupational Therapy Interstate Compact, and Audiology and Speech-Language Interstate Compact. Nurse practitioners are permitted to practice independently in Colorado (CO Revised Statutes Sec. 12-255-111)





## CONNECTICUT

In May 2021, Connecticut lawmakers enacted [HB 5590](#) which alters several of the state’s telehealth policies until June 30, 2023. The definition of telehealth included in the legislation is modality neutral and includes synchronous and asynchronous modalities. The definition explicitly mentions remote patient monitoring and store-and-forward technologies. There is no requirement that telehealth provider must have a prior in-person interaction with a patient, but providers must have “access to, or knowledge of, the patient’s medical history, as provided by the patient, and the patient’s health record, including the name and address of the patient’s primary care provider, if any” ([HB 5590 \(2021\)](#)). Connecticut requires both payment and coverage parity for services provided via telehealth ([CT General Statute Sec. 38a-499a](#); [Sec. 38a-526a](#); and [HB 5596 \(2021\)](#)).

HB 5590 authorizes a wide variety of health care providers to practice telehealth, but limits potential providers to those licensed under sections referenced in the legislation. Providers are also generally required to have a Connecticut license in order to practice telehealth in the state. Connecticut is not a member of any interstate licensing compacts. Nurse practitioners are permitted to practice independently in Connecticut, but must first work under the supervision of a physician for a period of three years after their initial licensure ([CT General Statute 20-87a\(2\)](#)).







# DELAWARE

In June 2021, Delaware lawmakers enacted [HB 160](#) which consolidates the state's telehealth laws under a single chapter and makes permanent several flexibilities that were initially enacted in response to the COVID-19 pandemic. HB 160 maintains separate definitions of telehealth and telemedicine. These definitions are modality neutral and specifically include the use of remote patient monitoring and store-and-forward technologies. In-person contact is not required prior to the provision of telehealth services ([HB 160 \(2021\)](#)). However, the medical practice act requires a real-time modality unless the physician previously examined the patient in-person, another provider is available with the patient for the telehealth encounter, or the physician is acting consistent with major medical specialty society developed evidence-based clinical practice guidelines. ([Delaware Chapter 52, Sec. 6004\(a\)](#)) Delaware requires both coverage and payment parity ([Delaware Code Title 18 Sec. 3370](#) and [Sec. 3571R](#)).

State law authorizes a wide variety of health care providers to practice telehealth, but limits potential providers to those licensed by professional boards listed in statute ([Delaware Code Title 24 Sec. 6002](#)). This may limit potential innovation in the future. Telehealth providers are also required to be licensed in Delaware or have a multi-state licensed Practice Registered Nurse Compact, Physical Therapy Licensure Compact, Psychology Interjurisdictional Compact, Interstate Medical Licensure Compact, and Emergency Medical Services Compact. Nurse practitioners in Delaware may practice independently ([Delaware Code Title 24 Sec. 1935](#)).





# FLORIDA

Florida’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities. State law explicitly mentions remote patient monitoring and store-and-forward technologies ([Florida Statutes Sec. 456.47](#)). Florida does not require either payment or coverage parity. State law only requires that payment rates and methodologies be mutually agreed upon between insurers and providers ([Florida Statutes Sec. 641.31\(45\)](#)).

While the state’s definition of “health care provider” is broad, it may exclude some providers and limit future innovation ([Florida Statutes Sec. 456.47](#)). Florida is only a member of the Nurse Licensure Compact. However, the state has a registration process that allows out-of-state providers to practice telehealth in the state without obtaining a Florida license ([Florida Statutes Sec. 459.013\(1\)\(a\)](#)). Florida also allows nurse practitioners to practice independently ([Florida Statutes Sec. 464.0123](#)).







# GEORGIA

Georgia’s definition of telemedicine explicitly mentions remote patient monitoring and store-and-forward technologies ([Code of Georgia 33-24-56.4.\(b\)](#)). State law prohibits insurers from requiring “an in-person consultation or contact before a patient may receive telemedicine services from a health care provider, except for the purposes of initial installation, setup, or delivery of in-home telehealth devices or services, or as otherwise required by state or federal law, rule, or regulation” ([Code of Georgia Sec. 33-24-56.4.\(f\)](#)). The state also requires both coverage and payment parity ([Code of Georgia Sec. 33-24-56.4.\(e\)](#) and [Sec. 33-24-56.4.\(g\)](#)).

Georgia’s telehealth laws do not define the term “health care provider.” In theory, this silence in state law may lend flexibility and allow for future innovation in the delivery of telehealth services. However, silence may also lead to a lack of clarity for prospective providers. Georgia provides a special “telemedicine license” that allows physicians licensed in other states to practice telehealth in Georgia without obtaining a full Georgia license ([Code of Georgia Sec. 43-34-31.1](#)). This provides an easy pathway for physicians to practice across state lines, but does not apply to other health care providers. However, Georgia is a member of several interstate licensure compacts including the Interstate Medical Licensure Compact and the Nurse Licensure Compact. Nurse practitioners are not allowed to practice independently and must establish a “written nurse protocol agreement” with a delegating physician ([Georgia Rules and Regulations Rule 410-11-.14](#)).





# HAWAII

Hawaii’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities. State law explicitly mentions remote patient monitoring and store-and-forward technologies ([Hawaii Revised Statutes Sec. 431:10A116.3; 432D-23.5; 432:1601.5](#)). Hawaii requires both payment and coverage parity ([Hawaii Revised Statutes Sec. 431:10A116.3; 432D-23.5; 432:1601.5](#)). State law prohibits insurers from requiring “face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth” ([Hawaii Revised Statutes Sec. 431:10A116.3; 432D-23.5; 432:1601.5](#)).

State law authorizes all health care providers to practice telehealth ([Hawaii Revised Statutes Sec. 431:10A116.3; 432D-23.5; 432:1601.5](#)). This broad authorization will allow for future innovation in the delivery of telehealth services. Health care providers are generally required to hold a Hawaii license to practice telehealth in the state. Hawaii is not part of any interstate licensing compacts. Nurse practitioners are allowed to practice independently ([Hawaii Administrative Rules 16-89-2](#)).







## IDAHO

Idaho's definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities. State law explicitly mentions remote patient monitoring and store-and-forward technologies ([Idaho Statutes Sec. 54-5703](#)). Idaho does not have any laws related to insurance coverage or payment for telehealth services. State law does not require in-person contact before providers and patients engage in telehealth. Providers may establish a "provider-patient relationship" via two-way audio or audio-visual interaction, but not through asynchronous modalities ([Idaho Statutes Sec. 54-5705](#)).

Idaho allows all health care providers to practice telehealth. State law defines a "provider" as "any health care provider who is licensed, required to be licensed, or, if located outside of Idaho, would be required to be licensed if located in Idaho, pursuant to title 54, Idaho Code, to deliver health care consistent with his or her license" ([Idaho Statutes Sec. 54-5703](#)). This definition is very broad, but does make reference to specific statutes. Consequently, the definition could potentially hamper future innovation in the delivery of telehealth services. Providers are required to be licensed in Idaho to practice telehealth in the state. Idaho is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, and EMS Compact. Nurse practitioners are allowed to practice independently in Idaho ([Idaho Administrative Code 24.34.01](#)).





# ILLINOIS

Illinois's definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities. State law explicitly mentions remote patient monitoring and store-and-forward technologies ([225 ILCS 150/5](#) and [HB 3308 \(2021\)](#)). Illinois does not require in-person contact before telehealth services may be provided, but does require that telehealth patients be “established patients.” State law defines an “established patient” as “a patient with a relationship with a health care professional in which there has been an exchange of an individual’s protected health information for the purpose of providing patient care, treatment, or services” ([HB 3308 \(2021\)](#)). Insurance providers are prohibited from requiring in-person contact before the provision of telehealth services ([215 ILCS 5/3562.22](#)). Illinois state law requires both payment and coverage parity for services provided by in-network providers. However, state laws specify that insurers and providers are not prohibited from negotiating alternate reimbursement rates for telehealth services ([215 ILCS 5/3562.22](#) and [HB 3308 \(2021\)](#)).

Illinois allows all health care providers to practice telehealth. The state’s definition of “health care professional” lists specific occupations, but specifies that the definition is not limited to those listed ([225 ILCS 150/5](#)). Health care providers are required to be licensed in Illinois to provide telehealth services in the state. Illinois is a member of the Interstate Medical Licensure Compact and Psychology Interjurisdictional Compact. The state is not a member of the Nurse Licensure Compact, but is currently considering legislation to join the NLC. Nurse practitioners are not permitted to practice independently in Illinois and must maintain a collaborative practice agreement with a physician ([225 ILCS 65/65-35](#)).





# INDIANA

Indiana’s definition of telehealth explicitly mentions remote patient monitoring and store-and-forward technologies ([Indiana Code Sec. 25-1-9.5-6](#)). In-person contact is not required prior to the provision of telehealth services, even for prescriptions. State law requires that insurers “provide coverage for telehealth services in accordance with the same clinical criteria as the policy provides coverage for the same health care services delivered in person” ([Indiana Code Sec. 27-8-34-6](#)). Moreover, coverage for telehealth services “may not be subject to a dollar limit, deductible, or coinsurance requirement that is less favorable to a covered individual” than those applied to the same services delivered in person ([Indiana Code Sec. 27-8-34-6](#)). These provisions require coverage parity, but do not explicitly require payment parity.

Indiana allows a broad range of health care providers to practice telehealth, but the state’s definition of “practitioner” is limited to those listed in statute ([Indiana Code 25-1-9.5-3.5](#)). Indiana has a telehealth certification process that allows out-of-state providers to practice telehealth without obtaining a full Indiana license ([Indiana Code 25-1-9.5-9](#)). The state is a member of the Nurse Licensure Compact and EMS Compact, but is not a member of the Interstate Medical Licensure Compact. Nurse practitioners are not permitted to practice independently in Indiana ([848 IAC 5-1-1\(7\)](#)).







## IOWA

Iowa’s definition of telehealth is limited to “the delivery of health care services through the use of interactive audio and video” ([Iowa Code 514C.34](#)). State law does not mention remote patient monitoring or store-and-forward technologies. However, some licensing boards—including the Iowa Board of Medicine and Board of Physician Assistants—have promulgated rules with alternative definitions that are modality neutral. These definitions do explicitly mention remote patient monitoring and store-and-forward technologies. Iowa requires both coverage and payment parity ([Iowa Code 514C.34](#) and [SF 619 \(2021\)](#)).

Iowa authorizes all health care providers to practice telehealth. The state defines of “health care professional” as “physicians and other health care practitioners who are licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care services in the ordinary course of business or in the practice of a profession, whether paid or unpaid, including persons engaged in telemedicine or telehealth” ([Iowa Code 686D.2](#)). This definition will allow for future innovation in the delivery of telehealth services. Health care providers are required to hold an Iowa license to practice telehealth in the state. However, Iowa is a member of several interstate licensing compacts including the Interstate Medical licensure Compact and the Nurse Licensure Compact. Nurse practitioners are permitted to practice independently in Iowa ([655 IAC 7.1](#)).





## KANSAS

Kansas’s definition of telemedicine refers to real-time interactive communications that “includes” store-and-forward technology suggesting some real-time component may be required to use telemedicine. Although store-and-forward may be an element of such telemedicine offering primarily utilizing real-time modalities for establishing a provider patient relationship and delivering diagnostic or prescription services using telemedicine, it could be interpreted that a store-and-forward “only” service is not captured in the telemedicine definition. Removing the reference to real-time would bring clarity. State law does not mention remote patient monitoring ([Kansas Statute 4-2,211\(5\)](#)). In-person contact is not required prior to the provision of telehealth services. Kansas requires coverage parity but does not require payment parity ([Kansas Statute 40-2,213](#)).

Kansas limits the practice of telehealth to a relatively small number of health care occupations. The state’s definition of “health care provider” is limited to physicians, physician assistants, advanced practice registered nurses, and providers authorized to practice by the Kansas Behavioral Sciences Regulatory Board ([Kansas Statute 4-2,211\(2\)](#)). In 2021, Kansas lawmakers enacted [HB 2208](#) which created a “telemedicine waiver” to allow out-of-state health care providers to practice telehealth in Kansas without obtaining a full Kansas license. However, these waivers are limited only to occupations regulated by the Kansas Board of Healing Arts. Kansas is also part of several interstate licensing compacts including the Interstate Medical Licensing Compact and Nurse Licensure Compact. Nurse practitioners are not permitted to practice independently in Kansas ([Kansas Administrative Regulations 60-11-101](#)).







## KENTUCKY

Kentucky's definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities. State law explicitly mentions remote patient monitoring, but does not mention store-and-forward technologies ([Kentucky Revised Statutes 304.17A-005](#) and [HB 140 \(2021\)](#)). However, the relevant statute notes that the definition of telehealth is not limited to the modalities and technologies listed. Kentucky state law does not require in-person contact prior to the provision of telehealth services. The state requires both payment and coverage parity ([Kentucky Revised Statutes 304.17A-138](#); [304.17A-005](#); and [HB 140 \(2021\)](#)). However, providers and insurers may contractually agree to lower reimbursement rates for telehealth services.

Kentucky does not explicitly state which health care providers are authorized to practice telehealth. However, state law does list which regulatory boards are authorized to promulgate rules related to telehealth ([Kentucky Revised Statutes 211.332](#) and [HB 140 \(2021\)](#)). Health care providers are generally required to hold a Kentucky license to practice telehealth in the state. However, Kentucky is a member of several interstate compacts including the Interstate Medical Licensing Compact and the Nurse Licensure Compact. Nurse practitioners are not permitted to practice independently in Kentucky ([Kentucky Revised Statutes 314.042](#)).







# LOUISIANA

Louisiana distinguishes between the terms telemedicine and telehealth. The practice of telemedicine is limited to physicians ([Louisiana Revised Statutes 37:1262](#) and [HB 270 \(2021\)](#)). Meanwhile, laws pertaining to telehealth apply to non-physician providers including physician assistants and nurse practitioners ([Louisiana Revised Statutes 40:1223.3](#) and [HB 270 \(2021\)](#)). The state's definitions of telehealth and telemedicine are essentially equivalent and both can be considered modality neutral in that they both include synchronous and asynchronous technologies. Both definitions also explicitly mention remote patient monitoring and store-and-forward technologies. State law does not require in-person contact before the provision of telehealth/telemedicine services. However, significant rulemaking authority delegated to the professional boards in the state could result in the imposition of in-person requirements for some health care providers. The Board of Medical Examiners, for example, has promulgated rules stating that online, electronic, or written mail messages do not satisfy the standards of appropriate care required for the practice of medicine ([Louisiana Admin. Code 46:XLV-7505\(B\)](#)). This may prevent a patient-provider relationship from being initiated through asynchronous modalities and should be changed. Louisiana does not have any requirements related to coverage parity between telehealth/telemedicine and in-person services. Moreover, Louisiana does not generally require payment parity between telehealth/telemedicine services and in-person services. The only exception is for a physician in the same location as the patient who facilitates a telemedicine visit. In that circumstance, the facilitating physician must be reimbursed at least 75 percent of the standard rate for the same care provided in face-to-face settings ([Louisiana Revised Statutes 22:1821](#)).

Louisiana authorizes a broad range of health care providers to practice telehealth. However, the state's definition of "health care provider" is limited to those listed in statute ([Louisiana Revised Statutes 40:1223.3\(6\)\(a\)](#)). State law requires the Board of Medical Examiners to issue special telemedicine licenses to out-of-state physicians. State law authorizes other professional boards to issue similar licenses for out-of-state telehealth providers, but the boards are not required to do so. At present, the only non-physician providers with cross-state licensing pathways are speech-language pathologists and audiologists ([Louisiana Administrative Code 46:LXXV Sec.111](#)). However, Louisiana is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, EMS Compact, Audiology and Speech-Language Pathology Interstate Compact, and Physical Therapy Compact. Nurse practitioners are not permitted to practice independently in Louisiana ([Louisiana Administrative Code 46:XLVII Sec. 4513](#)).





## MAINE

Maine’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([Maine Revised Statutes Title 24-A Sec. 4316](#) and [LD 791 \(2021\)](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies. In-person contact is not required before the provision of telehealth services. Maine requires coverage parity between telehealth and in-person services ([Maine Revised Statutes Title 24-A Sec. 4316](#)). Deductible, copayment, and coinsurance requirements for telehealth services may not exceed those for comparable services provided in person ([Maine Revised Statutes Title 24-A Sec. 4316](#)). These provisions require coverage parity, but do not explicitly require payment parity.

Maine authorizes a wide variety of health care providers to practice telehealth. In 2021, the Maine legislature passed legislation that delegates rulemaking authority to several professional boards regarding telehealth practice ([LD 791 \(2021\)](#)). This approach restricts the practice of telehealth to occupations under the jurisdictions of the referenced boards and may limit future innovation in the delivery of telehealth services. Maine has a telehealth registration process that allows out-of-state physicians to practice telehealth in the state without a full Maine license ([Maine Revised Statutes Title 32 Sec. 3300-D](#)). However, the practice of registered out-of-state physicians are limited to providing “consultative services as requested by a physician, advanced practice registered nurse or physician assistant” licensed in Maine. Moreover, the in-state physician, advanced practice registered nurse or physician assistant must retain “ultimate authority over the diagnosis, care and treatment of the patient.” Such consultative services are generally permitted in most other states without requiring registration. Therefore, this registration process does not constitute an easy pathway to practicing across state lines and, in some ways, is actually an additional barrier relative to requirements in other states. Maine is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Occupational Therapy Licensure Compact, and Interstate Psychology Compact. Nurse Practitioners are permitted to practice independently in Maine after working at least 24 months under the supervision of a licensed physician ([Maine Revised Statutes Title 32 Sec. 2102](#)).





## MARYLAND

Maryland’s Insurance and Health Occupations statutes have differing definitions of telehealth. The definition provided in the Health Occupations code is clearly modality neutral in that it includes synchronous and asynchronous modalities ([Maryland Health Occupations Code Sec. 1-1001](#)). The definition provided in Maryland’s Insurance code references “interactive audio, video, or other telecommunications or electronic technology” ([Maryland Insurance Code Sec. 15-139](#)). The inclusion of the word “interactive” may limit the use of some modalities. In-person contact is not required prior to the provision of telehealth services.

In 2021, Maryland lawmakers enacted legislation that temporarily requires both payment and coverage parity ([HB 448 \(2021\)](#)). These parity requirements are set to expire after June 30, 2023. Maryland’s Insurance code has permanent provisions that prohibit insurers from denying coverage for a health care service “solely because it is provided through telehealth and is not provided through an in-person consultation or contact between a health care provider and a patient” ([Maryland Insurance Code Sec. 15-139](#)).

Maryland authorizes a broad range of health care providers to practice telehealth. However, the state’s definition of “health care practitioner” is limited to those regulated under Maryland’s Health Occupations code ([Maryland Health Occupations Code Sec. 1-1001](#)). This definition may limit future innovation in the delivery of telehealth services. In general, telehealth providers are required to be licensed in Maryland. There are some exceptions to this licensure requirement, but only for physicians practicing under a narrow set of circumstances ([Maryland Health Occupations Code Sec. 14-302](#)). These exceptions do not constitute an easy path to the practice of telehealth across state lines. However, Maryland is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Physical Therapy Compact, Interstate Professional Counselors Compact, Interstate Occupational Therapy Licensure Compact, Audiology and Speech-Language Pathology Interstate Compact, and Psychology Interjurisdictional Compact. Nurse practitioners are permitted to practice independently in Maryland after working under the supervision of a physician or independent nurse practitioner for 18 months ([Maryland Health Occupations Code Sec. 8-302.1](#)).







# MASSACHUSETTS

Massachusetts' definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([Massachusetts Senate No. 2984](#)). In-person contact is not required before the provision of telehealth services. Massachusetts requires both coverage and has payment parity for behavioral health ([Massachusetts Senate No. 2984](#)).

Massachusetts authorizes all health care providers to practice telehealth. Out-of-state telehealth providers are required to obtain a Massachusetts license to practice telehealth in the state. Massachusetts is not a member of any interstate licensure compacts. Nurse practitioners are permitted to practice independently in Massachusetts ([Bill S.2984 \(2020\)](#)).





## MICHIGAN

Michigan's Public Health Code and Insurance Code provide differing definitions of telehealth and telemedicine. The state's Insurance Code defines telemedicine as "the use of an electronic media to link patients with health care professionals in different locations" ([Michigan Public Health Code Sec. 333.16283](#)). However, "the health care professional must be able to examine the patient via a ... secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging" ([Michigan Public Health Code Sec. 333.16283](#)). This definition does not clearly include remote patient monitoring. Michigan's Public Health Code defines telehealth as "the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration" ([Michigan Insurance Code Sec. 500.3476](#)). Moreover, the definition provided in Michigan's Public Health Code clarifies that telehealth includes, but is not limited to, telemedicine as defined in the state's Insurance Code ([Michigan Insurance Code Sec. 500.3476](#)). In-person contact is not required before the provision of telehealth services. Michigan does not explicitly require coverage or parity.

Michigan authorizes all health care providers to practice telehealth. State law defines a "health professional" as "an individual who is engaging in the practice of a health profession" ([Michigan Public Health Code Sec. 333.16283](#)). Health care providers are required to obtain a Michigan license to practice telehealth in the state. Michigan is only a member of the Interstate Medical Licensure Compact. Nurse practitioners are required to enter collaborative practice agreements with physicians to perform some duties delegated to them by a physician ([Michigan Public Health Code Sec. 333.16215](#)).







# MINNESOTA

Minnesota’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous technologies ([Minnesota Statutes 62A.673\(2\)\(h\)](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies. However, the state excludes remote patient monitoring from its definition of telehealth ([Minnesota Statutes 62A.673\(2\)\(h\)](#)), and includes audio-only through July 1, 2023. Separate provisions regulate the use and coverage of what state law refers to as “telemonitoring” services ([Minnesota Statutes 62A.673\(7\)](#)). In-person contact is not required before the provision of telehealth services, although there are some in-person requirements pertaining to the prescription of some medications ([Minnesota Statutes 151.37\(2\)\(d\)](#)). Minnesota requires both coverage and payment parity ([Minnesota Statutes 62A.673\(4\)](#) and [Minnesota Statutes 62A.673\(5\)](#)).

Minnesota authorizes all health care providers to practice telehealth. The state defines a “health care provider” as “a health care professional who is licensed or registered by the state to perform health care services within the provider’s scope of practice and in accordance with state law” ([Minnesota Statutes 62A.673\(2\)\(c\)](#)). Minnesota provides a telehealth registration process that allows out-of-state physicians to practice telehealth in the state without a Minnesota license ([Minnesota Statutes 147.032](#)). This registration process is only available to physicians and is not available to other health care providers. Minnesota is a member of the Interstate Medical Licensure Compact and Psychology Interjurisdictional Compact. Nurse practitioners are permitted to practice independently after working for at least 2,080 hours “within the context of a collaborative practice agreement” with a physician ([Minnesota Statutes 148.211\(1c\)](#)).



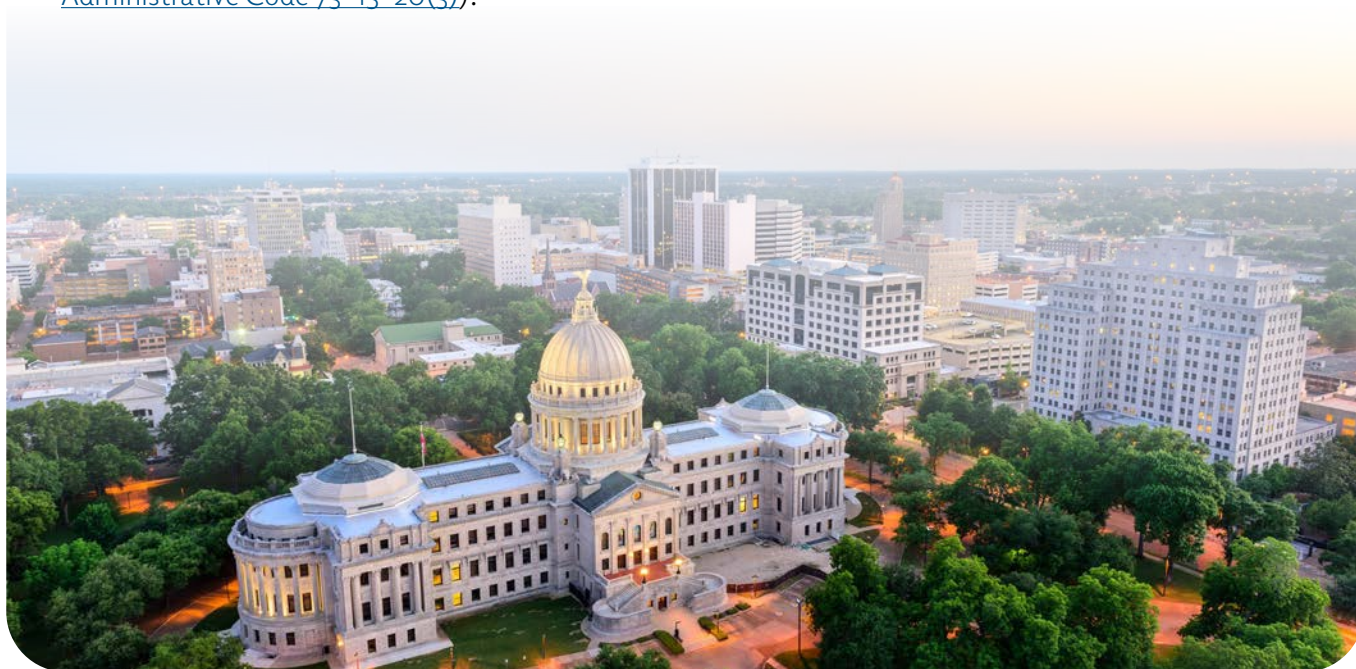




# MISSISSIPPI

Mississippi’s definition of telehealth is not explicitly modality neutral, but the state’s laws do recognize both synchronous and asynchronous modalities. State law limits definition of telehealth to services provided via “interactive audio, video, or other electronic media” and further stipulates that telehealth “must be ‘real-time’ consultation” ([Mississippi Code Sec. 83-9-351\(1\)\(d\)](#)). Mississippi’s insurance code maintains separate definitions and rules regarding “store-and-forward telemedicine services” and remote patient monitoring services” ([Mississippi Code Sec. 83-9-353](#)). In-person contact is not required prior to the provision of telehealth services. However, rules promulgated by the Mississippi Board of Medical Licensure require telemedicine to be “capable of replicating the interaction of a traditional encounter in-person between a provider and a patient” ([Mississippi Administrative Code 30-17-2635.5.1](#)) This requirement prevents a patient-provider relationship from being established through asynchronous modalities. Mississippi requires coverage parity between telehealth and in-person services ([Mississippi Code Sec. 83-9-351\(2\)](#)). The state does not explicitly require payment parity, but does stipulate that deductibles, co-payments, and coinsurance for telehealth services may not exceed those applicable to in-person services ([Mississippi Code Sec. 83-9-351\(3\)](#)). State law also establishes minimum reimbursement rates for remote patient monitoring services ([Mississippi Code Sec. 83-9-353\(13\)](#)).

Mississippi authorizes all health care providers licensed in the state to practice telehealth. The state does not provide any registration process as an alternative to licensure. However, Mississippi is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Physical Therapy Compact, and EMS Compact. Nurse practitioners are not permitted to practice independently in Mississippi ([Mississippi Administrative Code 73-15-20\(3\)](#)).





# MISSOURI

Missouri’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities. State law explicitly mentions store-and-forward technologies, but not remote patient monitoring ([Missouri Statutes Sec. 191.1145](#)). In-person contact is not required before the provision of telehealth services. However, state law requirements for physicians establishing a physician-patient relationship through telemedicine must include an “interview” and “sufficient dialogue” that may present practical limitations for certain asynchronous modalities. ([Missouri Statutes Sec. 191.1146, 334.108\(1\)](#)). Moreover, pharmacy regulations also prohibit the dispensing of a prescription drug “if the pharmacist has knowledge, or reasonably should know under the circumstances, that the prescription order for such drug was issued on the basis of an internet-based questionnaire or without a valid pre-existing patient-provider relationship” ([Missouri Code of State Reg. 20-2220-2.020\(11\)](#)). This rule does not prevent the initiation of a patient-provider relationship through asynchronous online questionnaires but does explicitly prohibit the fulfillment of prescriptions based on such questionnaires. In-person contact is not required before the provision of telehealth services. Missouri requires coverage parity between in-person and telehealth services. The state does not explicitly require payment parity, but does stipulate that deductibles, co-payments, and coinsurance for telehealth services may not exceed those applicable to in-person services ([Missouri Statutes Sec. 376.1900](#)).

Missouri authorizes all health care providers licensed in the state to practice telehealth. State law defines a “health care professional” as “a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law” ([Missouri Statutes Sec. 376.1350\(19\)](#)). The state does not provide any registration process as an alternative to licensure. However, Missouri is a member of the Nurse Licensure Compact, Physical Therapy Compact, Psychology Interjurisdictional Compact, EMS Compact, and Occupational Therapy Licensure Compact. Nurse practitioners must practice under a written collaborative agreement with a physician in Missouri ([Missouri Code of State Reg. 20-2200-4.200](#)).





# MONTANA

Montana’s definition of telehealth is modality neutral in that it does not specify whether services are required to be synchronous or asynchronous ([Montana Code Annotated Sec. 33-22-138](#)). The state’s insurance code does not explicitly mention store-and-forward or remote patient monitoring technologies. In-person contact is not required prior to the provision of telehealth services. Montana requires coverage parity between in-person and telehealth services ([Montana Code Annotated Sec. 33-22-138](#)). The state does not explicitly require payment parity.

Montana authorizes a wide range of health care providers to practice telehealth. However, the state’s definition of “health care provider” is limited to individuals licensed under specified sections of the state code ([Montana Code Annotated Sec. 33-22-138\(8\)\(b\)](#)). This definition may exclude some potential telehealth providers and may limit future innovation in the delivery of telehealth services. Health care providers are generally required to hold a Montana license in order to practice telehealth in the state. However, Montana is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, and Physical Therapy Compact. Nurse Practitioners can practice independently or with collaborative management in Montana ([Montana Admin. Rules 24.159.1470](#)).







# NEBRASKA

Nebraska’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([Nebraska Revised Statute 44-312 \(a\)\(i\)](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies ([Nebraska Revised Statute 44-312 \(a\)\(i-iii\)](#)). In-person contact is not required before the provision of telehealth services ([Nebraska Revised Statute 38-1,143\(1\)](#)). Nebraska requires coverage parity for mental health and dermatology services ([Nebraska Revised Statute 44-793](#) and [44-7,107](#)). Payment parity is required for mental health services ([Nebraska Revised Statute 44-793](#)).

Nebraska authorizes a wide variety of health providers to practice telehealth. However, state law explicitly precludes some potential providers from providing telehealth services ([Nebraska Revised Statute 38-1,143\(4\)](#)). Providers are generally required to hold a Nebraska license to practice telehealth in the state. However, Nebraska is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Psychology Interjurisdictional Compact, Physical Therapy Compact, EMS Compact, and Audiology and Speech-Language Pathology Interstate Compact). Nurse practitioners must have 2,000 hours of supervised practice before being able to practice independently in Nebraska ([Nebraska Rev. Stat. 38-2322](#)).





## NEVADA

Nevada state law provides multiple differing definitions of telehealth. The definition applicable to health insurance policies is modality neutral in that it includes synchronous and asynchronous modalities ([Nevada Revised Statutes Sec. 689A.0463](#) and [Sec. 629.515](#) as amended by [SB5 \(2021\)](#)). The relevant section of state law explicitly mentions store-and-forward technologies, but not remote patient monitoring. In-person contact is not required prior to the provision of telehealth services ([Nevada Revised Statutes Sec. 629.515](#) as amended by [SB5 \(2021\)](#)). Nevada requires both coverage and payment parity ([Nevada Revised Statutes Sec. 689A.0463](#) as amended by [SB5 \(2021\)](#)). However, payment parity is not required for audio-only telehealth services.

Nevada authorizes all health care providers to practice telehealth. State law defines a “provider of health care” as “a person who is licensed, certified or otherwise authorized by the laws of this state to administer health care in the ordinary course of the business or practice of a profession” ([Nevada Revised Statutes Sec. 439.820](#)). In general, health care providers are required to obtain a Nevada license to practice telehealth in the state. The Nevada Board of Medical Examiners may issue special purpose licenses to out-of-state physicians under limited circumstances ([Nevada Revised Statutes Sec. 630.261\(1\)](#)). Nevada is a member of the Interstate Medical Licensure Compact and Psychology Interjurisdictional Compact. Nurse practitioners are permitted to practice independently, but must have two years or 2,000 hours of experience before engaging in full independent practice for controlled substances in Nevada ([Nevada Rev. Stat. 632.237\(3\)](#)).







## NEW HAMPSHIRE

New Hampshire's definition of telehealth is modality neutral in that it does not specify whether services are required to be synchronous or asynchronous ([New Hampshire Revised Statutes Sec. 415-J:2](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies. In-person contact is not required before the provision of telehealth services. However, statute authorizing establishing a physician-patient relationship through telemedicine requires "an in-person or face-to-face 2-way real-time interactive communication exam" ([New Hampshire Revised Statutes Sec. 329:1-c; 318:1\(XV-a\)](#)). This would prohibit a physician-patient relationship from being established through asynchronous modalities. New Hampshire requires both coverage and payment parity ([New Hampshire Revised statutes Sec. 415-J:3](#)).

New Hampshire authorizes a wide variety of health care providers to practice telehealth. However, state law explicitly limits the practice of telehealth to specific providers listed in statute ([New Hampshire Revised statutes Sec. 415-J:3\(XII\)\(a-k\)](#)). Providers are generally required to hold a New Hampshire license to practice telehealth in the state. However, New Hampshire is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, EMS Compact, Physical Therapy Compact, Psychology Interjurisdictional Compact, Audiology and Speech Language Pathology Compact, and Occupational Therapy Compact. Nurse practitioners are permitted to practice independently in New Hampshire ([New Hampshire Rev. Stat. 326-B:2.I](#)).







## NEW JERSEY

New Jersey’s definition of telehealth is modality neutral in that it does not specify whether services are required to be synchronous or asynchronous ([New Jersey Statutes Sec. 26:2S-29](#)). However, state medical board rules not yet modified given recent statutory modification may limit certain asynchronous and audio-only modalities. (New Jersey Admin Code Sec. 13:35-6B.5). State laws explicitly mentions remote patient monitoring and store-and-forward technologies. In-person contact is not required prior to the provision of telehealth services ([New Jersey Statutes Sec. 45:1-63](#)). New Jersey requires both coverage and payment parity ([New Jersey Statutes Sec. 26:2S-29](#)).

New Jersey authorizes all health care providers to practice telehealth. The state’s definition of “health care provider” lists specific occupations. However, the relevant statute specifies that the definition is not limited to those listed ([New Jersey Statutes Sec. 45:1-61](#)). Providers are generally required to hold a New Jersey license to practice telehealth in the state. However, New Jersey is a member of the Nurse Licensure Compact, Physical Therapy Compact, and Psychology Interjurisdictional Compact. Nurse practitioners are permitted to practice independently, but are required to work under a collaborative agreement with a physician when prescribing medications (New Jersey State Board of Medical Examiners Laws 45:11-49(b)).

The Governor in New Jersey just recently signed a new telehealth bill. While the new law locks in the some of the COVID-19 flexibilities, it does not change its rating in this report as they left in payment parity until 2023, which had been a subject of concern for the Governor. With recently passed reform, the medical board regulations will need to be updated to remove the requirement that telehealth must be real-time and must include video, to now allow for asynchronous telehealth. ([New Jersey Admin. Code 13:35-6B.5](#))





## NEW MEXICO

New Mexico’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([New Mexico Statutes Sec. 59A-22-49.3](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies. In-person contact is not required prior to the provision of telehealth services. However, regulations of professional boards restrict prescribing or dispensing drugs or supplies unless the telehealth offering includes a face-to-face telehealth encounter. (New Mexico Code Sec. 16.10.8.8(L)(6); 16.19.4.9(C)(18), (19)). New Mexico requires both coverage and payment parity ([New Mexico Statutes Sec. 59A-22-49.3](#)).

New Mexico authorizes all health care providers to practice telehealth. State law defines a “health care provider” as “a person licensed to provide health care to patients in New Mexico” and lists several occupations that are included in that definition ([New Mexico Statutes Sec. 24-25-3](#)). However, the definition is not limited to those listed. Providers are generally required to hold a New Mexico license to practice telehealth in the state. However, the New Mexico Medical Board issues special “telemedicine licenses” to out-of-state physicians ([New Mexico Statutes Sec. 61-6-11.1](#)). Non-physician providers may not obtain telemedicine licenses. However, New Mexico is a member of the Nurse Licensure Compact. Nurse practitioners are permitted to practice independently in New Mexico ([New Mexico Nursing Practice Act 61-3-23.2\(B\)\(2\)](#)). Medical board regulations, [New Mexico Code R. 16.10.8.8\(L\)\(6\)](#), consider it unprofessional conduct for a physician to establish a relationship with a patient without a face-to-face telehealth encounter, and a physical exam that is recorded or waived if not part of the normal standard of care. This should be updated or removed to allow for a patient-provider relationship to be established by asynchronous modes if that is the patient preference.







## NEW YORK

New York’s definition of telehealth is modality neutral in that it does not specify whether services must be synchronous or asynchronous ([Laws of New York Article 32 Sec. 3217-H](#)). State law does not explicitly mention remote patient monitoring and store-and-forward technologies. In-person contact is not required prior to the provision of telehealth services. New York requires coverage parity between in-person and telehealth services ([Laws of New York Article 32 Sec. 3217-H](#)). The state does not explicitly require payment parity, but does stipulate that deductibles, co-payments, and coinsurance for telehealth services must be “at least as favorable to the insured” as those applicable to in-person services ([Laws of New York Article 32 Sec. 3217-H](#)).

New York authorizes a wide variety of health care providers to practice telehealth. However, the state’s definition of “telehealth provider” is limited to specific occupations listed in statute ([Laws of New York Article 29-G Sec. 2999-CC](#)). Providers are generally required to hold a New York license to practice telehealth in the state. Moreover, New York is not a member of any interstate licensure compacts. Nurse practitioners must practice under collaboration with a physician in New York ([New York Edu. Law 6902.3](#)).







# NORTH CAROLINA

North Carolina does not currently have a telehealth statute for commercial insurance. In-person contact is not required before the provision of telehealth services.

Providers are generally required to hold a North Carolina license to practice telehealth in the state. However, North Carolina is a member of the Nurse Licensure Compact, Physical Therapy Compact, Psychology Interjurisdictional Compact, Audiology and Speech-Language Pathology Interstate Compact, and Occupational Therapy Interstate Compact. Nurse practitioners must practice under a collaborative agreement with a supervising physician in North Carolina ([North Carolina Admin. Code 21-36.0810](#)).





## NORTH DAKOTA

North Dakota’s definition of telehealth is modality neutral in that it does not specify whether services are required to be synchronous or asynchronous ([North Dakota Century Code Sec. 26.1-36-09.15](#)). State law explicitly mentions store-and-forward technology but does not mention remote patient monitoring. In-person contact is not required prior to the provision of telehealth services. North Dakota requires coverage parity but does not require payment parity ([North Dakota Century Code Sec. 26.1-36-09.15](#)).

North Dakota authorizes all health care providers to practice telehealth. The state’s definition of “health care provider” references occupations licensed under specific chapters of the state code ([North Dakota Century Code Sec. 26.1-36-09.15](#)). Providers are generally required to obtain a North Dakota License to practice telehealth in the state. However, North Dakota is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Physical Therapy Compact, and EMS Compact. Nurse practitioners can practice independently in North Dakota ([North Dakota Admin. Code 54-05-03.1-01](#)). The [North Dakota Food, Drug and Cosmetic Act](#) defines that for a valid prescription for a specified drug a practitioner must conduct “...an in-person medical evaluation of the patient,” then the provider can prescribe certain drugs such as muscle relaxants and those to treat erectile dysfunction. The in-person requirement should be removed at least for certain drugs that are safely being prescribed in almost all other states over telehealth.





## OHIO

Ohio's definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([Ohio Revised Code Sec. 3902.30](#)). State law does not explicitly mention remote patient monitoring or store-and-forward technologies. In-person contact is not required prior to the provision of telehealth services. Ohio requires coverage parity but does not require payment parity ([Ohio Revised Code Sec. 3902.30](#)).

Ohio authorizes a wide range of providers to practice telehealth. However, the state's definition of "health care professional" is limited to specific occupations listed in the relevant section of the state code ([Ohio Revised Code Sec. 3902.30](#)). Providers are generally required to obtain an Ohio license in order to practice telehealth in the state. However, Ohio is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Physical Therapy Compact, Occupational Therapy Licensure Compact, Psychology Interjurisdictional Compact, and Audiology and Speech Language Pathology Interstate Compact. Nurse practitioners must practice in collaboration with one or more physicians or podiatrists in Ohio ([Ohio Revised Code 4723.43\(C\)](#)).

The Governor of Ohio recently signed [HB 122](#). The new state law would allow more providers to use telehealth, but would still limit providers to those named in the bill. The law explicitly leaves out dentists. The state should update it to allow any provider to use telehealth. It does include a version of coverage parity, but states that this does not include asynchronous telehealth if it differs from the coverage described in the health benefit plan.

The bill permits licensing boards to require an initial in-person visit before using telehealth before prescribing a schedule II controlled substance to a new patient. The bill does lay out three exceptions from any in-person requirement if the patient is receiving hospice or palliative care, is receiving medication-assisted treatment or other medication for opioid-use disorder, a patient has a mental health condition, or if the provider believes it is an emergency situation.

The bill would allow Ohio providers to see patients in other states, but does not allow for the same access for Ohio patients. Proposed regulations by the State Medical Board of Ohio are considering adding an in-person requirement before being able to prescribe certain drugs. This should be removed.







# OKLAHOMA

Oklahoma’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([Oklahoma Statutes Citationized Sec. 6802](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies.

In-person contact is not required prior to the provision of telehealth services. Oklahoma requires both coverage and payment parity ([Oklahoma Statutes Citationized Sec. 6803](#)).

Oklahoma authorizes all health care providers to practice telehealth. State law defines a “health care professional” as “a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law” ([Oklahoma Statutes Citationized Sec. 6802](#)). This definition is broad and allows for future innovation in the delivery of telehealth services. Providers are generally required to obtain an Oklahoma license to practice telehealth in the state. However, the State Board of Osteopathic Examiners may issue special “telemedicine licenses” ([Oklahoma Statutes Citationized Sec. 633](#)). Oklahoma is also a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Physical Therapy Compact, Psychology Interjurisdictional Compact, and Audiology and Speech Language Pathology Interstate Compact. Nurse practitioners must have a supervising physician to prescribe drugs and some medical supplies, and a collaborative agreement with a physician in Oklahoma ([Oklahoma Nurse Practice Act 567.3a\(6\)](#)).





## OREGON

Oregon's definition of telehealth is modality neutral in that it does not specify whether services are required to be synchronous or asynchronous ([Oregon Revised Statutes Sec. 743A.058](#) and [HB 2508 \(2021\)](#)). State law explicitly mentions remote patient monitoring, but not store-and forward technologies. In-person contact is not required prior to the provision of telehealth services. However, dated regulations of the medical board and pharmacy board may limit comfort regarding prescribing medication resulting “only from sale or consultation over the Internet” or “an internet-based relationship” given the vague nature of such provisions. (Oregon Admin. Rules [847-025-0000](#); [855-019-0210](#)). Oregon requires both coverage and payment parity ([Oregon Revised Statutes Sec. 743A.058](#) and [HB 2508 \(2021\)](#)).

Oregon authorizes all health care providers to practice telehealth. State law defines a “health professional” as “a person licensed, certified or registered in this state to provide health care services or supplies” ([Oregon Revised Statutes Sec. 743A.058](#)). This definition is broad and allows for future innovation in the delivery of telehealth services. Providers are generally required to hold an Oregon license to practice telehealth in the state. However, the Oregon Medical Board may “issue to an out-of-state physician a license for the practice of medicine across state lines” ([Oregon Revised Statutes Sec. 677.139](#)). Oregon is only a member of the Physical Therapy Compact. Nurse practitioners are permitted to practice independently in Oregon ([Oregon Admin. Rules 851-050-0005](#)).

The medical board in Oregon has regulations that prohibit a physician from “...writing prescriptions for medication resulting only from a sale or consultation over the Internet.” ([Oregon Admin. Rule 847-025-0000](#)) This should be updated to allow asynchronous telehealth to be used if that is the preference of the patient.





# PENNSYLVANIA

Pennsylvania has no telehealth statute for commercial insurance. The state also lacks any laws related to the practice of telehealth by health care providers. In-person contact is not explicitly required to establish a patient-provider relationship.

Providers are generally required to hold a Pennsylvania license in order to practice in the state. However, Pennsylvania may grant limited “extraterritorial licenses” to physicians “residing in or maintaining the office of practice in any adjoining state” near the border. The Board may exercise broad discretion in granting such licenses, depending on the availability of medical services in the area and whether the adjoining state provides similar flexibility to Pennsylvania physicians. These restrictions and the degree of discretion allowed to the Board prevent this from representing an easy pathway to the practice of telehealth across state lines. However, Pennsylvania is a member of the Interstate Medical Licensure Compact, Nurse Licensure Compact, Physical Therapy Compact, and Interjurisdictional Psychology Compact. In Pennsylvania, nurse practitioners must have a written collaboration agreement with a physician ([Pennsylvania Code 49.21.251](#)).







## RHODE ISLAND

Rhode Island’s definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities ([Rhode Island General Law Sec. 27-81-3](#) and [SB 4 \(2021\)](#)). State law explicitly mentions remote patient monitoring and store-and-forward technologies. In-person contact is not required prior to the provision of telehealth services. Rhode Island requires both coverage and payment parity ([Rhode Island General Law Sec. 27-81-4](#) and [SB 4 \(2021\)](#)).

Rhode Island authorizes all health care providers to practice telehealth. State law defines “health care provider” as “a health care professional or a health care facility” ([Rhode Island General Law Sec. 27-81-3](#)). This definition is broad and allows for future innovation in the delivery of telehealth services. Providers are generally required to obtain a Rhode Island license to practice telehealth. Rhode Island is not a member of any interstate licensure compacts. Nurse practitioners are permitted to practice independently in Rhode Island ([Rhode Island General Laws 5-34-3\(2\)](#)).

In board notes in Rhode Island, there is a preference expressed for interactive, real-time interactions. “Evaluating a patient via Telemedicine or in-person is a dynamic, interactive experience which should conclude with a customized care plan for the patient-relevant to the chief complaint.” In as much as this serves as a deterrent to asynchronous modes, the board should make it clear that patients can establish a relationship in the method they prefer. (Rhode Island Board of Medical Licensure and Discipline, [Guidelines for the Appropriate Use of Telemedicine and the Internet in Medical Practice](#)).





## SOUTH CAROLINA

The state currently has no telehealth statute for commercial insurance. This silence in state laws means that there are fewer explicit barriers to accessing telehealth, but it likely ensures inconsistency of insurance policies on telehealth that underutilize the service, as they still pay mainly for in-person visits in a facility. But there is a definition of telemedicine for providers which broadly states that it is, “using electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening practitioner.” ([South Carolina Code Annotated Sec. 40-47-20\(52\)](#)). The definition does not mention remote patient monitoring or store-and-forward. The state only requires an in-person visit for prescribing medication when a physical examination is needed ([South Carolina Code Annotated Sec. 40-47-37\(A\)](#)).

There is no easy pathway for across-state-line telehealth, but a physician licensed in the state doesn't have to reside in the state. ([South Carolina Code Annotated Sec. 40-47-37\(C\)\(9\)](#)) And advisory notices from boards and commissions highlight some exemptions. For example, interns and students have an exemption, and any government employee providing psychological services. In other words there is a carveout for some across-state-line telehealth, it is just for students and government employees, and not available to the rest of the patients in the state ([South Carolina Board of Examiners in Psychology Telehealth Statement, March 11th, 2019](#)).

In South Carolina, nurse practitioners must have a written protocol with a physician to practice ([South Carolina Code 40-33-34\(D\)](#)).

South Carolina is a member of the Physical Therapy Compact, Nurse Licensure Compact, and the Emergency Medical Services Compact. In South Carolina law the state has placed a ban on telehealth being used to prescribe lifestyle drugs. ([South Carolina Code of Laws Section 40-47-37\(C\)\(6\)](#)) This barrier is out of date and so-called lifestyle drugs such as those for erectile dysfunction have been safely delivered over telehealth for years. The state should remove this barrier to increase patient access to services.





## SOUTH DAKOTA

One definition of telehealth is for only interactive audio-video that is Health Insurance Portability and Accessibility Act (HIPAA) compliant. ([South Dakota Codified Laws Sec. 58-17-167](#)) The definition for providers is broad enough to allow both synchronous and asynchronous modalities and mentions store-and-forward and remote patient monitoring ([South Dakota Codified Laws Sec. 34-52-1](#)). It might be helpful for the state to update the definition in Section 58-17-167 to be more in line with the one in Section 34-52-1.

The definition of health care professional is broad enough to all providers to use telehealth ([South Dakota Codified Laws Sec. 58-17F-1](#)).

The laws and rules around across-state-line telehealth leave some uncertainty for providers. Current laws requires that “any health care professional treating a patient in the state through telehealth shall be fully licensed to practice in the state or employed by a licensed health care facility, an accredited prevention or treatment facility, a community support provider, a nonprofit mental health center, or a licensed child welfare agency,” and they are subject to any rules adopted by the applicable licensing board ([South Dakota Codified Laws Sec. 34-52-2](#)). Yet regulation for physicians ([South Dakota Regulation 20:78:03:12](#)) point to current law that allows the Board of Medical and Osteopathic Examiners to grant a license to practice in the state without exam as long as they are in good standing in their home state or in Canada as long as the applicant pays a fee, but does allow the board to require an oral or written exam ([South Dakota Codified Laws Sec. 36-4-19](#)).

In South Dakota, nurse practitioners must complete 1,040 hours under physician supervision before they are able to practice independently ([South Dakota Codified Laws 36-9A-1](#)). The state is a member of the Physical Therapy Compact, Interstate Medical Licensure Compact, Nurse Licensure Compact, and the Emergency Medical Services Compact.







## TENNESSEE

The definition of telehealth is for multiple modes of communication, including store-and-forward, between a provider at a limited set of locations to a school setting. The definition of a qualified site is limited to a “office of a health care services provider, a hospital licensed under title 68, a facility recognized as a rural health clinic under federal Medicare regulations, a federally qualified health center, any facility licensed under title 33, or any other location deemed acceptable by the health insurance entity,” which does not maximize the flexibility for how to provide telehealth. The state has a telehealth coverage mandate, and mandates that insurers must pay an originating site a site fee for hosting the patient ([Tennessee Code Annotated, Sec. 56-7-1002](#), note all Tennessee references need to be looked up individually using the LexisNexis link).

Provider-based telemedicine is defined with multiple modes of communication with HIPAA-compliant technology only for patients that have seen them in the last 16 months. There is also a coverage mandate and does place limits on the qualified sites from where telemedicine can be delivered ([Tennessee Code Annotated, Sec. 56-7-1003](#)). It also excludes remote patient monitoring. Yet in [Tennessee Code Annotated, Sec. 56-7-1011](#) it says that “A health insurance entity may consider any remote patient monitoring service a covered medical service if the same service is covered by Medicare. The appropriate parties may negotiate the rate for these services in the manner in which is deemed appropriate by the parties.” But goes on to say that the rates should be set “in the same manner as the health insurance entity establishes reimbursement of expenses for covered health care services that are delivered by in-person means,” which could be interpreted to mean payment parity is required, or that the negotiations just need to follow a similar pathway when being agreed on. This is enough to result in a yellow ranking.

The state limits the use of telehealth to those currently licensed under title 63 or offering care as a state-contracted crisis service provider employed by a facility licensed under title 33 ([Tennessee Code Annotated, Sec. 56-7-1002\(3\)](#)). Or to an alcohol and drug abuse counselor licensed under title 68, or a graduate or student in training under title 68. But this definition is set to be repealed on April 1, 2022 ([Tennessee Code Annotated, Sec. 63-1-155\(D\)](#)).

In Tennessee, nurse practitioners must practice under physician supervision ([Tennessee Code Annotated, Sec. 63-7-123](#)).

Providers from another state are only permitted to practice across-state-line telehealth on a volunteer basis through a free clinic ([Tennessee Code Annotated, Sec. 63-1-155\(\(g\)\(3\)\)](#)). Tennessee law does allow the board to grant a pathway for out-of-state board-certified physicians to be issued a telemedicine license ([Tennessee Code Annotated Sec. 63-6-209\(b\)](#)), these licenses are granted subjectively. Furthermore, some board rules around granting telemedicine licenses should be removed as they add uncertainty to across-state-line services, for example the Tennessee Osteopathic Board telehealth licenses ([Tennessee Rule Annotated, Rule 1050.02.17.\(2\)](#)).

Tennessee is a member of the Interstate Medical Licensure Compact, Nurses Licensure Compact, Physical Therapy Compact, Emergency Medical Services Compact, and Psychology Interjurisdictional Compact.



## TEXAS

Texas's definition for telehealth and telemedicine are broad, but only reference the use of "telecommunications or information technology." The definitions also appear to allow any provider to use teleservices, but doesn't mention remote patient monitoring or store-and-forward ([Texas Insurance Code 1455.001](#)). There is an exception for small employer health benefit plans written under Chapter 1501 ([Texas Insurance Code 1501.001](#)). In the occupation code for health professions, the state does allow synchronous audiovisual or asynchronous when clinical information from relevant photographic, records, labs is available. ([Texas Occupation Code Sec. 111.005 \(3\)\(A\) and \(B\)](#))

As of January 1, 2022, there will be a coverage mandate in the state ([Texas Insurance Code Sec. 1455.004\(a\)](#)).

The definition of telehealth or occupational therapists requires patients to be in Texas at the time of services ([Texas Admin. Code, Title 40 Sec. 362.1\(39\)](#)). And the state places limits on the locations at which a licensed dyslexia practitioner can see a patient at, which includes an "educational setting, including a school, learning center, or clinic" ([Texas Occupations Code 403.15](#)).

SB 992 would have allowed across-state-line telehealth services but did not pass in 2021. Current state laws have different standards for different kinds of providers. Current law allows for doctors to get an across-state-line license if they are 21, in good standing, have passed the Texas Medical Jurisprudence Examination, fill out a full application, pay a fee, and may only be for "the interpretation of diagnostic testing and reporting results to a physician fully licensed and located in Texas or for the follow-up of patients where the majority of patient care was rendered in another state." The final limitation is that the doctor may not see patients in Texas in person ([Texas Admin. Code, Title 22, Sec. 172.12](#)). Mental health providers in Texas can see patients in other states, but it does not appear that a Texas patient could see a mental health provider from another state ([Texas Occupations Code 113.002](#)). Texas does not allow across-state-line teledentistry ([Texas Occupations Code 251.003\(10\)\(d\)](#)).

In Texas, nurse practitioners must have a written agreement with a supervising physician ([Texas Admin Code 22-11-21.13](#)). Texas is a member of the Nurses Licensure Compact, Physical Therapy Compact, Psychology Interjurisdictional Compact, EMS Personnel Licensure Interstate Compact and the Interstate Medical Licensure Compact.





## UTAH

The definition for telehealth in the state allows for both synchronous and asynchronous interactions, ([Utah Code, 26-60-102](#)). However, does require them to be both Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act, which may limit what forms of equipment or telehealth platforms can be used and raise the price of services in the process. ([Utah Code, 31A-22-649\(2\)\(b\)](#)). The definitions do include both remote patient monitoring and store-and-forward.

Utah allows for across-state-line telehealth for physicians that are in good standing in their home state and have 10 years of experience. They also allow this for those providing free care, or care where they only charge enough to pay for malpractice insurance ([Utah Code Annotated Sec. 58-67-305\(7\)](#)). They also allow for exemptions for mental health therapists to continue to see clients for up to 45 days after their patient has moved to Utah ([Utah Code, 58-61-307\(k\)](#)).

Utah has a partial coverage parity mandate for telehealth services covered by Medicare, and mental health conditions ([Utah Code, 31A-22-649.5\(2\)](#)). Furthermore, for telepsychiatric consultations, they require insurers to cover both in- and out-of-network options if seven days pass from the initial request, minus any cost-sharing. The state law states that payment rates just have to be at a negotiated commercially reasonable rate ([Utah Code, 31A-22-649.5\(2\)\(b\)](#)).

The definition of provider does link to only currently licensed providers, so a more broad definition might be important to allow for future innovation ([Utah Code, 26-60-102\(6\)](#)). Utah is a member of the Interstate Medical Licensure Compact, Psychology Interjurisdictional Compact, Nurse Licensure Compact, Physical Therapy Licensure Compact, Audiology and Speech-language Pathology Interstate Compact, and the Emergency Medical Services Compact. In Utah, nurse practitioners can practice independently ([Utah Code 58-31b-102](#)).

Utah's rarely used Online Prescribing Act may complicate and create potential limitations for asynchronous telehealth services, especially for smoking cessation, skin medication, hair loss, and erectile dysfunction conditions covered by such statute, while benefiting only one or two organizations licensed under such statute. Utah Code Ann Sec. [58-83-102](#), [306](#); Utah Admin. Code [R156-83-306](#)).







## VERMONT

The definition for telemedicine in the state only includes live interactive audio and video ([Vermont Statutes Annotated, Title 8 Sec. 4100k\(h\)\(7\)](#)). But the law mandates reimbursement for store-and-forward services ([Vermont Statutes Annotated, Title 8 Sec. 4100k\(e\)\(1\)](#)).

The state mandates coverage of telehealth, including for audio-only ([Vermont Statutes Annotated, Title 8 Sec. 4100k\(a\)\(1\)](#)) and ([Vermont Statutes Annotated, Title 8 Sec. 41001\(b\)\(1\)](#)). Vermont also has a payment parity mandate but does not apply it if an insurer contracts with a third-party vendor to provide the services, or the insurer and provider have entered into a value-based contract ([Vermont Statutes Annotated, Title 8 Sec. 4100k\(B\)](#)). This payment mandate is set to expire on January 1, 2026.

There is no requirement for an existing relationship for audio-only ([Vermont Statutes Annotated, Title 8 Sec. 41001\(3\)](#)). The state set up a working group to look at across-state-line telehealth which must report findings by December 15, 2021.

In Vermont, nurse practitioners are allowed to practice independently after 2,400 hours or two years under a collaborative practice agreement. ([Vermont Statutes 26-28-1613](#)) Vermont is a member of the Interstate Medical Licensure Compact and Nurse Licensure Compact. In [Vermont Statute Ann. 18-9361\(a\)](#) they cite a definition from [Vermont Statutes Ann. 8-4100k](#) which states that telemedicine is conducted by “through the use of live interactive audio and video” and store and forward requires an image. The state should update these definitions to clarify that a relationship can be started by asynchronous modes.





# VIRGINIA

Virginia's definitions of telemedicine and telehealth are inclusive of both synchronous and asynchronous forms but do not use those terms ([Virginia Code Annotated Sec. 38.2-3418.16 \(B\)](#)) and [Virginia Statute 32.1-122.03:1 \(A\)](#)). The statewide telehealth plan definition does mention remote patient monitoring and store-and-forward. However, there are separate definitions for teledentistry and store and forward technologies for dentists ([Virginia Code Annotated Sec. 54.1-2700](#)).

The state has a “consultant exemption” for out-of-state providers, but a patient must be seeing an in-state provider first, therefore the state does not have an easy pathway for across-state-line telehealth ([Virginia Code Annotated Sec. 54.1-2901 \(A\)\(15\)](#)).

The state makes it clear that insurers are not compelled to cover “technical fees or costs for the provision of telemedicine services,” but does appear to have coverage and payment parity mandates. ([Virginia Code Annotated Sec. 38.2-3418.16 \(D\)](#))

The state also makes clear in law that providers can't be forced to use proprietary technology or applications for the telehealth services they offer. This grants the providers some flexibility to use whatever services are most cost-effective. ([Virginia Code Annotated Sec. 38.2-3418.16 \(D\)](#))

In Virginia, starting on July 1, 2022, nurse practitioners will be allowed to practice independently but only after five years of full-time practice under a practice agreement. ([Virginia Code 54.1-2957](#)) They can also prescribe Schedule II-VI controlled substances without a collaborative agreement if certain conditions are met ([Virginia Code 54.1-2957.01\(A\)](#)).

The state is a member of the Nurses Licensure Compact, but not the Interstate Medical Licensure Compact.

In [Virginia State Code 54.1-3303](#) for a prescription, the practitioner-patient relationship shall exist if the practitioner has “performed or caused to be performed...either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically.” Additionally in Virginia, while state law permits store-and-forward, in medical board guidance, in the context of a provider prescribing Schedule VI controlled substances, the guidance states that “telemedicine services” means “the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient.” It is unclear if patients can use asynchronous modes that don't include images. The guidance should be updated to make it clear that the patient can pick the mode that is best for them. ([Virginia Medical Board Guidance Document 85-12, revised October 28, 2018](#))





## WASHINGTON

The definition of telemedicine in Washington allows for both synchronous and asynchronous telehealth. But the law does not mention remote patient monitoring or store-and forward by name, but it would appear to be allowed. State administrative code for hospice care and physical and occupational therapy both have very broad definitions for telehealth that would appear to allow any kind of telehealth ([Washington Admin Code 246-33-610 \(20\)](#)) and ([Washington Admin Code 246-915-187\(3\(a\)\)](#)).

The state does set certain locations a patient can receive telehealth, but includes flexibility for the patient by allowing them to be at “home or any location determined by the individual receiving the service” ([Washington Rev. Code 48.43.735 3\(g\)](#)).

There is no easy pathway to across-state line telehealth outside of a consultation for a physician ([Washington Rev Code 18.71.030\(6\)](#)) and ([Washington Rev Code 18.57.040](#)).

The state mandates both coverage and payment parity ([Washington Rev. Code 48.43.735](#)). However, the services must be one that would have been provided in-person, and medically necessary. Store and forward telehealth must be listed in the negotiated agreement to be reimbursed ([Washington Rev. Code 48.43.735 2](#)). The state law also allows provider groups over eleven to negotiate a different rate ([Washington Rev. Code 48.43.735 1\(b\)ii](#)).

For audio-only, there must be a patient-provider relationship first that includes at least one in-person visit in the last 12 months starting in 2023 ([Washington Rev. Code 48.43.735 1\(a\(v\)\) and 9\(d\)](#)).

The state does also allow a facility fee to be layered on top of the medical care at certain facilities ([Washington Rev. Code 48.43.735 4](#)).

Washington is a member of the Interstate Medical Licensure Compact and Physical Therapy Compact.







## WEST VIRGINIA

West Virginia recently passed a major update to its telehealth laws. The state's definition of telehealth is modality neutral in that it includes synchronous and asynchronous modalities, and allows for patient monitoring, and store-and-forward. But the new law does call on boards to issue emergency rules for legislative approval on how to regulate across-state-line telehealth, but there appears to be a decently open pathway for across-state-line care with a registration ([West Virginia Statute 30-1-26b\(2\)](#)). However, where a physician does not have any existing provider-patient relationship, one may only be established through telemedicine if it incorporates "interactive audio using store and forward technology, real-time videoconference or similar secure video services, or audio-only calls in real time – all limiting for asynchronous-only methods. ([West Virginia Code Sec. 30-3-13a\(c\)\(2\)](#)). Further, the state did erect a barrier that prohibits a provider from another state from seeing a West Virginia patient in West Virginia in person. Long-term, these across-state-line rules do not appear to apply to physicians as physicians practicing telemedicine are required to be licensed in West Virginia ([West Virginia Statute 30-2-13a\(b\(2\)\)](#)).

Many of the boards have issued emergency rules many that last until 2027 or 2030 that are allowing for interstate telehealth, including for speech language pathology, audiologists, physicians (this temporary authority will expire in 2027), dentists, chiropractic examiners, social workers and nurses.

The law requires that patients must see a provider within 12 months of the initial telehealth visit, with a few exemptions. It does not appear to require the patient to see the telehealth provider, but any in person provider ([West Virginia Statute 30-1-26b\(4\)](#)). The state also does set some guardrails around how a patient-provider relationship is set when prescribing ([West Virginia Statute 30-1-26](#)).

West Virginia does have a different definition of telemedicine for physicians but is broad in nature ([West Virginia 30-3-13a\(4 and 5\)](#)).

The state has both a coverage and payment parity mandate. However the payment parity mandate is for an established patient or for patient care when they are in an acute facility for a consultation on their care, but there is no mandate for a new patient or follow-up care from acute care that is not for chronic care management or scheduled medications ([West Virginia Statute 5-16-7b](#)) and ([West Virginia Statute 33-57-1d](#)). The coverage mandate extends to remote patient monitoring. Nurse practitioners are not permitted to practice fully independently ([West Virginia Statute 30-7-15a](#)).

The definition of health care practitioner is only tied to those listed, which may prevent future innovation with a more broad definition ([West Virginia Statute 30-1-26a](#)). West Virginia is a member of the Interstate Medical Licensure Compact, Audiology & Speech-Language Pathology Interstate Compact, Physical Therapist Licensure Compact, Nurse Licensure Compact and the Psychology Interjurisdictional Compact.

[West Virginia Code 30-3-13a\(3\)\(b\)](#) states that practice of telemedicine "typically involves secure real-time audio/video conferencing or similar secure audio/video services, remote monitoring, interactive video and store and forward digital image or health data technology," this interpretation is unclear if a relationship can be started by asynchronous modes, so the state should update the law by removing this language to bring clarity."



## WISCONSIN

Wisconsin does not have a definition of telehealth for commercial insurers in law. But in administrative code there is a definition that applies to physicians and indirectly to physician assistants that references the use of “electronic communications,” which is broad, but does not consider audio only, email, text messages, fax, or mail to be a form of telehealth ([Wisconsin Admin Code MED Ch 24.02](#)). Physicians may establish a relationship through telemedicine ([Wisconsin Admin Code MED Ch 24.03](#)).

The silence for all other providers on telehealth means that there are fewer explicit barriers to accessing telehealth in theory, but this silence also means there is legal uncertainty of what is allowed or not. Given that physicians have some rules, most other providers likely read that to mean they are not allowed to use telehealth. There is no easy pathway to across-state-line telehealth, even though the governor allowed some during the COVID-19 pandemic, and it is very unclear if other providers feel like they can use telehealth at any time.

Nurse practitioners can not practice independently ([Wisconsin Admin Code Ch N8.10](#)).

Wisconsin is a member of the Nurse Licensure Compact, and the Physical Therapy Compact, but repealed being a member of the Interstate Medical Licensure Compact.





## WYOMING

Wyoming currently has no overall telehealth statute for commercial insurers in law. Instead, state laws kicked that responsibility to define telehealth to boards and commissions ([Wyoming Code 33-1-303a\(iv\)](#)), with the exceptions in law of definitions in the Medical Practice Act for physicians and surgeons that defines telehealth as using “electronic communication or other means” ([Wyoming Statutes 33-26-102\(a\)xxix](#)), for occupational therapists with the definition being “using telecommunications technology” ([Wyoming Statutes 33-40-102\(a\(v\)\)](#)), and audiologists which in the compact defines it as “the application of telecommunication technology” ([Wyoming Statutes 33-33-402\(2\(y\)\)](#)). The Board of Chiropractic Examiners ([Wyoming Admin Rules, Ch 1, Sec 3\(t\)\)](#)), physical therapy ([Wyoming Admin Rules, Ch 1, Sec 4\(d\)](#)) which only allows telehealth by consultation by telehealth between physical therapists not directly to patients, and speech pathologists ([Wyoming Admin Rules, Ch 13, Sec 2\(b\)](#)—all have their own definitions as well.

Overall all of the definitions in Wyoming are very broad, with the exemption of the physical therapists. This may seem like a good thing at first, but it can also lead to uncertainty on what technology is allowed or not. An improvement would be to state that synchronous, asynchronous, remote patient monitoring and store-and-forward are allowed.

With state law putting the responsibility on the boards to write definitions for telehealth, in practice, this means that every board will have a different set of rules, and those providers whose board has not written rules are not allowed to use telehealth.

Wyoming does not require an in-person visit, but for online prescribing state law does state that electronic prescribing of a controlled substance requires a “documented physician-patient relationship...” and will be subject to review, discipline and consequences if there is not ([Wyoming Statutes 33-26-402\(a\)\(xxxiii\)](#)).

Wyoming allowed additional [flexibility](#) for some across-state-line care during the pandemic, but those have since [expired](#).

Wyoming is a member of the Interstate Medical Licensure Compact, the Nurse Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and EMS Personnel Licensure Interstate Compact.

Nurse practitioners are permitted to practice independently, but since the Board of Nursing does not have rules around telehealth, they are unable to use such tools.









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## REFERENCES

1. Center for Connected Health Policy, “Policy Finder,” CCHP, (2021) <https://www.cchpca.org/all-telehealth-policies/>, and National Conference of State Legislatures, “Nurse Practitioners: Practice Authority,” NCSL, (2021) <https://scopeofpracticepolicy.org/practitioners/nurse-practitioners/sop/practice-authority>
2. See for example Health Professional Shortage Areas designated by the U.S. Department of Health and Human Services: “HPSA Find,” Health Resources and Services Administration, data.HRSA.gov, <https://data.hrsa.gov/tools/shortage-area/hpsa-find> (accessed 9 Dec. 2021).
3. Samina T. Syed, Ben S. Gerber, and Lisa K. Sharp, “Traveling Towards Disease: Transportation Barriers to Health Care Access,” *Journal of Community Health* 38 (2013). 976–993. <https://doi.org/10.1007/s10900-013-9681-1>
4. Jessica D. Bellinger, Rahnuma M Hassan, Patrick A. Rivers, Qiang Cheng, Edith Williams, and Saundra H. Glover, “Specialty Care Use in US Patients with Chronic Diseases,” *International Journal of Environmental Research and Public Health* 7 (2010). 975–990. <https://doi.org/10.3390/ijerph7030975>
5. See for example: James P. Marcin, Ulfat Shaikh, and Robin H. Steinhorn, “Addressing Health Disparities in Rural Communities Using Telehealth,” *Pediatric Research* 79 (2016). 169–176. <https://doi.org/10.1038/pr.2015.192>; and “Telehealth Models for Increasing Access to Specialty Care,” Rural Health Information Hub, <https://www.ruralhealthinfo.org/toolkits/telehealth/2/care-delivery/specialty-care> (accessed 9 Dec. 2021).
6. “The Complexities of Physician Supply and Demand: Projections From 2019 to 2034,” Association of American Medical Colleges, <https://www.aamc.org/media/54681/download?attachment>. (accessed 5 Dec. 2021).
7. Vittorio Nastasi “Removing Restrictions of Nurse Practitioners Could Expand Access to Health Care,” Reason Foundation, 8 Oct. 2020. <https://reason.org/commentary/removing-restrictions-of-nurse-practitioners-could-expand-access-to-health-care/>.
8. Medicare Payment Advisory Commission, “Mandated report: Telehealth services and the Medicare program,” MEDPAC, Chapter 16, Page 495, [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar18\\_medpac\\_ch16\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar18_medpac_ch16_sec.pdf)
9. Katherine Restrepo, “The Case Against Telemedicine Parity Laws,” The John Locke Foundation, 15 Jan. 2018. <https://www.johnlocke.org/research/telemedicine/>.
10. Josh Archambault, “Telehealth Mandates Hurt Vulnerable Patients and Small Business, Forbes, 7 Jul. 2020. <https://www.forbes.com/sites/theapothecary/2020/07/07/telehealth-mandates-hurt-vulnerable-patients-and-small-business/?sh=6b9696043994>
11. “Issue Brief: Interstate Medical Licensure Compact,” American Medical Association, April 2019. <https://www.ama-assn.org/system/files/2020-03/fsmb-interstate-medical-licensure-compact-issue-brief.pdf>.





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