

Licensure & Scope of Practice in Disaster Virtual Care

Disclaimer: This material is for **informational purposes only** to support disaster virtual care planning and operations. It **does not constitute legal advice** and should not be relied upon as a substitute for consultation with qualified counsel. Laws, waivers, and declarations **change rapidly**; clinicians and organizations should verify current requirements with their state authorities, payors, and legal advisors. Providers should verify current requirements with their **state licensing boards, activating entities, and legal counsel** before providing care.

Where Am I Legally Practicing?

In virtual care, the “place of practice” is **always the patient’s physical location**, not the clinician’s^{1,12}. Providers must be licensed, waived, or otherwise authorized in that state. During declared emergencies, states may activate temporary mechanisms - such as ESF-8 assignments, §1135-related waivers, or EMAC deployments - that allow cross-state practice^{2,3,5}. These differ from licensure compacts like IMLC or NLC, which still require advance registration or fees^{9,10}. Per CCHP’s Fall 2025 report, most states continue to apply the **host-state rule**, but 38 states plus DC and Puerto Rico now offer limited virtual care registration or cross-state options¹³. The Johns Hopkins / CCHP summit proposed a national virtual care registry and “established-patient allowance” to standardize cross-border care¹³. Until federal action occurs, each state retains independent authority. If no valid pathway applies, cross-state virtual care risks unlicensed practice and malpractice exposure^{1,12}. Confirm patient location and document the pathway authorizing care^{1-5,13}.

Who Authorizes Me and How Do I Prove It?

Disaster authority is **never** automatic^{1,2}. Clinicians **must** be formally activated or credentialed through:

- State ESF-8 activation – mission orders or roster letters⁵.
- EMAC deployment – Mission Order Authorization packet³.
- Hospital disaster privileging / credentialing-by-proxy – verified by medical staff office⁶.
- Temporary state waivers or executive orders – posted by boards or governors^{1,2,11}.
- Federal teams (NDMS, USPHS, VA) – orders define FTCA coverage⁸.

Maintain digital and paper copies of all activation and privileging documents^{1-3,6}.

What Scope Applies and Who Supervises?

The **patient’s state** controls scope of practice, prescribing, and supervision rules—even under cross-state activation^{1,12}. Emergency orders may loosen NP/PA/EMS supervision or allow “functional” remote oversight^{4,5}. When normal oversight is disrupted, authority can be reassigned to a disaster medical director under ESF-8⁵. Expanded scope flexibilities **end when the declaration ends** unless extended^{2,4}. Verify supervision rules, emergency modifications, and sunset dates for each jurisdiction¹⁻⁵.

Rapid Credentialing & Privileging Pathways

Hospitals may invoke **disaster privileging**, granting temporary privileges without full committee review if CMS criteria are met⁶. Credentialing-by-proxy allows one facility to accept another’s credentials under CMS Conditions of Participation with a written agreement⁶. Outside hospitals, rapid authority can come from **state licensure waivers, ESF-8 activation, or EMAC recognition**^{1,3,5}. All are time-limited and *must be documented*. Identify whether you’re hospital-privileged, state-activated, or EMAC-deployed and retain supporting proof²⁻⁶.

When the Disaster Ends

Once a governor’s order, ESF-8 activation, EMAC mission, or hospital privileging expires, normal licensure rules resume immediately^{1,2}. Continuing cross-state virtual care then requires a permanent license, compact privilege, or virtual care registration^{9-11,13}. CCHP notes some states allow short continuity windows for established patients, but they are inconsistent¹³. CMS’s 2026 Physician Fee Schedule requires FQHCs and RHCs to meet **in-person visit rules** for tele-mental-health as of **Oct 1, 2025**, ending pandemic-era flexibilities¹³. Track expiration dates and end or transition care promptly^{1,2,9-13}.

If No Disaster Is Declared

Without an emergency order, cross-state practice generally requires a full license, compact privilege, virtual care registration, hospital credentialing, or federal status^{1-3,9-11}. Good-Samaritan laws rarely apply - they cover **unscheduled emergency aid**, not ongoing virtual care, prescribing, or billing⁴. The **PREP Act** only shields countermeasure activities, not regular care⁷. Build “wind-down” plans that transition or end care once emergency authority expires^{1,9-11}.

Which Law Controls?

The **patient’s location** almost always determines both *licensure* and *malpractice law*^{1,2,12}. Exceptions may include:

- **EMAC:** responder treated as agent of the requesting state³.
- **FTCA:** federal jurisdiction for NDMS or USPHS responders⁸.
- **PREP Act:** limited preemption for covered countermeasures only⁷.

Verify the patient’s state and ensure the disaster mechanism remains active^{1-3,7-8,12-13}.

Virtual Care Across State Lines

This outline gives a quick decision process for confirming whether you’re authorized to provide virtual care across state lines during a disaster or emergency activation.

1. Identify patient location.

2. Does the provider hold an active license in the patient’s state?

If yes, proceed under standard virtual care rules/laws.

If no, continue below.

3. Has the patient’s state issued an emergency or disaster declaration?

If yes, temporary authorization is possible:

- a. Emergency licensure or disaster credentialing.
- b. EMAC Assignment (for deployed responders)
- c. Telemedicine credentialing by proxy (hospital based)

If no, cross-state care not authorized unless under a compact.

4. Is the provider practicing within the host-state scope of practice?

If yes, proceed, document authority and supervision.

If no, do not initiate patient care; contact your state board.

References

- (1) FSMB — *State Emergency Licensure & Cross-State Practice Policies* (2023). <https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensure-requirements-covid-19.pdf>
- (2) CMS — *§1135 Waiver & Disaster Billing/Licensure FAQ* (2024). <https://www.cms.gov/about-cms/agency-information/emergency/downloads/medicareffs-emergencyqas1135waiver.pdf>
- (3) EMAC Operations Manual (2023). <https://mil.wa.gov/asset/648892cb6fa00/EMAC%20Operations%20Manual%20May%2010%202023.pdf>
- (4) National Governors Association — *Emergency Licensure/Scope/Supervision Flexibilities* (2020). <https://www.nga.org/wp-content/uploads/2020/05/Memorandum-on-Overview-of-Federal-and-State-Liability-Protections-and-Immunities-4-6-Final-For-Checklist.pdf>
- (5) HHS ASPR — *ESF-8 / State Medical Coordination* (program guidance). <https://aspr.hhs.gov/HealthCareReadiness/Pages/default.aspx>
- (6) CMS — *Disaster Privileging & Credentialing-by-Proxy (CoPs)*. <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/disaster-privileging>
- (7) HHS ASPR — *PREP Act Overview & Limits*. <https://aspr.hhs.gov/legal/PREPAct/Pages/default.aspx>
- (8) U.S. DOJ — *Federal Tort Claims Act (FTCA) Overview*. <https://www.justice.gov/civil/ftca>
- (9) IMLC — *Interstate Medical Licensure Compact*. <https://www.imlc.org/>
- (10) NCSBN — *Nurse Licensure Compact (NLC) Overview*. <https://www.ncsbn.org/nurse-licensure-compact>
- (11) CCHP — *State Telehealth Laws & Reimbursement Policies* (Fall 2024). <https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2024/>
- (12) HHS — *Telehealth Legal Considerations (Licensure & Malpractice)*. <https://telehealth.hhs.gov/providers/legal-considerations>
- (13) CCHP / Johns Hopkins Telehealth Summit — *Policy Approaches Summary* (Oct 2025). <https://washingtondc.jhu.edu/wp-content/uploads/2025/10/October-2025-Telehealth-Summit-Policy-Approaches-Summary.pdf>