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What Eliminating Barriers to Interstate Telehealth Taught Us During the Pandemic

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STAFF

Julia Harris
Senior Policy Analyst, Health Project

Tara Hartnett
Project Coordinator, Health Project

G. William Hoagland
Senior Vice President

Dena McDonough, PA-C
Associate Director, Health Project

Marilyn Serafini
Director, Health Project

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Introduction

Early in the COVID-19 pandemic, nearly all states and the federal government approved unprecedented flexibilities in licensing rules to allow more interstate mobility for health care professionals. The lifting of restrictions on out-of-state practitioners significantly aided the response to the crisis by expanding telehealth, bolstering care in underserved areas, increasing access to mental health services, and importantly, providing some relief for overstressed hospitals and health systems losing health care workers. Now, as temporary waivers in most states are expiring, there are opportunities to improve interstate licensure requirements so that lessons learned during the pandemic can bring long-term benefits to the health care system.

The Centers for Medicare and Medicaid Services (CMS), as well as almost every state in the country, temporarily waived the requirement that physicians be licensed in the state where their patients are located.^{1,2} In a matter of months, a famously territorial and complicated area of health policy unwound, creating new opportunities for patients to access care. Patients could suddenly receive care from providers practicing anywhere in the country. This was especially important for patients living in remote or medically underserved areas, as well as those with rare medical conditions. The loosened requirements also greatly expanded access to behavioral health professionals during a time of growing anxiety, depression, and substance abuse.

The temporary suspension of occupational licensing laws during state emergencies, such as natural disasters, is not new. States typically lift licensing laws for relief workers, including health care workers, to practice on a volunteer basis during disaster recovery. But the COVID-19 pandemic has impacted all states simultaneously and continues to linger almost two years later. Unfortunately, the aftershocks on the American health care workforce will be evident long after the pandemic ends.

Over the past year, states' temporary COVID-19 flexibilities for out-of-state licensure began expiring, despite the federal public health emergency due to COVID-19 remaining in effect.^{3,4} By the end of 2021, only about a dozen state emergency waivers for licensure requirements are expected to continue.⁵ A handful of states, such as Arizona, West Virginia, and Florida, passed permanent legislation allowing physicians not licensed in the state to register and provide telehealth services to in-state patients.⁶

Policymakers are now faced with important decisions that will affect provider licensure and patient access to care across state lines — beyond the current pandemic.

Background

States have always maintained the authority to license and regulate health care providers. State licensing boards ensure providers practicing within their purview meet a minimum set of professional qualifications, maintain ethical standards of care, and are disciplined if necessary. This long-standing function of state licensing boards serves to protect patients from unqualified or unprofessional behavior.

Critics argue that other stakeholders, such as managed care organizations and hospitals, monitor providers' quality of care more closely than state boards. Moreover, many health economists see limits on cross-state licensure as roadblocks to healthy provider competition and innovation in health care. In certain cases, state medical boards have demonstrated a focus on limiting the supply of providers to stifle competition and further their own financial interests. In 2014, the Federal Trade Commission (FTC) sued the North Carolina State Board of Dental Examiners, arguing that the board's arbitrary prohibitions on non-dentists providing teeth-whitening services violated antitrust laws.⁷ This case ultimately went to the Supreme Court, which decided in favor of the FTC. The case was later referenced in Teladoc's challenge to Texas' licensure regulations that limited the use of telehealth in the state.⁸

One of the first major expansions of provider licensure occurred when Congress passed the Veterans E-Health and Telemedicine Support (VETS) Act of 2017, removing state licensure requirements for U.S. Department of Veterans Affairs physicians. VA policies allow a federal employee to hold a license in one state and practice in any jurisdiction. In the first year under VETS, more than 900,000 veterans used telehealth to access services, a 17% increase.⁹ Two-thirds of services were for tele-mental health visits.¹⁰ In November 2020, the VA issued an [interim final rule](#) further confirming its authority to allow VA health care professionals to practice their professions "consistent with the scope and requirements of their VA employment, notwithstanding any state license, registration, certification, or other requirements that unduly interfere with their practice."¹¹ The VA's approach effectively bypasses state licensing boards and asserts federal control over its providers.

Another approach to increasing provider licensure flexibilities has been through the expansion of [licensure compacts](#), which are formal, binding, legislatively-enacted agreements between two or more states.¹² Licensure compacts are currently available for physicians, nurses, emergency medical service professionals, physical therapists, psychologists, and audiology and speech language pathologists. While each compact has its own unique structure, participation can promote mutual recognition models and licensure

reciprocity. Despite increased interest in licensure compacts since the start of the pandemic, gaps in state participation remain; most notably, California and New York, two of the most heavily populated states, are nonparticipants in all existing health professional compacts (see Appendix A for a complete listing of states' participation in major licensure compacts). The first licensure compact was created for nurses and, as of 2021, it holds the highest level of state participation, with 37 states plus Guam.¹³ Providers benefiting the most from state participation in compacts are those who deliver telehealth services, move frequently (for example, military spouses), or work or live across a state border.

Lessons from the Pandemic

The pandemic allowed for near-total policy alignment between all states and the federal government. The country's complicated patchwork of state licensure processes was suspended, allowing providers to seamlessly practice across state lines. The short-term flexibilities afforded during the pandemic provided some important clues about possible future policy directions.

Here is what provider licensure flexibilities during the pandemic demonstrated:

- ***Licensure flexibilities have the potential to improve patient access to services.*** Based on early evidence, provider licensure flexibilities played a role in helping people access health care services via telehealth during the pandemic. In general, telehealth was an important tool for keeping access to care available, with nearly half (43.5%) of Medicare primary care visits provided via telehealth in April 2020, compared with less than 1% before the pandemic.¹⁴ States' reinstatement of pre-pandemic state licensure policies in 2021 caused genuine care disruptions, often with patients receiving little warning or explanation for why their access to care would change. The Johns Hopkins health system in Baltimore, Maryland, estimated that about 10% of its 330,000 patients who accessed telehealth during the pandemic were from out-of-state.¹⁵ When neighboring Virginia's waiver expired, Johns Hopkins canceled more than 1,000 virtual care appointments for patients in the state.¹⁶

Access to services can be especially hard to come by in rural areas or other underserved communities with provider shortages.¹⁷ Marshfield Clinic, a rural health system in Wisconsin, found that access to telehealth saved their patients an estimated 1.4 million driven miles from September 2019 to August 2020.¹⁸ Patients not only save travel time and money with telehealth appointments, but also have significantly lower rates of no-show

appointments and patient cancellations.¹⁹ Telehealth access coupled with provider licensure flexibility gives providers the ability to export their services to underserved areas while continuing to live where they desire.

- ***The trend of behavioral health providers moving to virtual care has increased access to mental health and substance use services.*** During the pandemic, behavioral health providers made a massive shift to delivering services via telehealth — vastly overshadowing telehealth utilization rates for other health care professionals.^{20,21} A McKinsey analysis found that in February 2021, 50% of outpatient claims for psychiatrists were delivered via telehealth, followed by 30% of claims for substance use treatment.²²

In 2020, more than half of adults with mental health conditions went untreated, and the percentage was even higher in Black and Latino communities.²³ Rates of mental illness and substance abuse have risen markedly since the pandemic started — symptoms of anxiety and/or depression in adults nearly quadrupled and drug overdose deaths continue to outpace all previous records.^{24,25} The U.S. is experiencing a mental health crisis, paired with a [severe shortage](#) of psychiatrists, psychologists, and other behavioral health specialists in remote and underserved communities.²⁶

Evidence demonstrates that the quality of tele-behavioral health services are generally equivalent to in-person care and can increase access to services.^{27,28} The [Consolidated Appropriations Act](#) of 2021 gave Medicare beneficiaries permanent access to tele-mental health services from home;²⁹ prior to that, the [SUPPORT for Patients and Communities Act](#) of 2018 authorized Medicare coverage of services via telehealth for the treatment of substance use disorders and co-occurring mental health disorders.³⁰

State officials report they are seeing more behavioral health providers moving to fully virtual practices — simultaneously enjoying the increased appointment compliance telehealth affords as well as the payment parity.³¹ Medicare continues to pay for telehealth services at parity through the federal public health emergency; however, a permanent reimbursement approach for Medicare has yet to be finalized. While the debate continues at the federal level, payment parity requirements are becoming more prevalent at the state level. Laws requiring the reimbursement rate be the same for in-person and telehealth services are now required for commercial plans across 21 states, for at least some subset of services.³²

This shift in the behavioral health delivery system to virtual care presents new opportunities to increase patients' access to mental health and substance use treatment services. Without cross-state recognition of licensure, CMS cannot take full advantage of this opportunity to increase patient access to behavioral health services and address the growing crisis.

- ***Data sharing is foundational to protecting the public.*** State licensing boards bear the responsibility for screening, monitoring, and disciplining providers in their respective states. This makes states' willingness to adopt cross-state recognition of licensure highly dependent on their confidence in the data sharing and their authority to investigate and discipline providers working from out-of-state. With the tangle of executive actions issued early in the pandemic to loosen licensure requirements, there were instances of exemptions to licensure where providers were delivering services to patients in states based on a license they held in another state; therefore, those providers were outside any investigatory or disciplinary jurisdiction by the state of practice.³³ Maintaining clear accountability for providers, in all contexts in which they practice, is critical to increased licensure portability.

To promote patient safety, the U.S. Department of Health and Human Services (HHS) operates the [National Practitioner Data Bank \(NPDB\)](#), a web-based repository of reports concerning medical malpractice payments as well as certain adverse actions related to health care practitioners, providers, and suppliers. Registered entities such as hospitals, state licensing boards, and health plans can query the databank for information on final disciplinary actions.³⁴ Separately, all provider compacts maintain their respective databases to share critical information regarding disciplinary actions and investigations across state borders. While the NPDB is only populated with final actions, which can come long after an initial complaint is filed, the data available through compacts is more immediate — for example, as soon as a provider who presents an imminent threat to patient safety is brought under investigation.³⁵ Development of the technology platforms to enable secure communication among participating member boards is critical and additional investments in data infrastructure and secure data-sharing capabilities may be needed.

Additionally, federal law requires criminal background checks on all applicants within a compact.³⁶ FBI reviews the statutory language for each compact to ensure compliance with federal law before granting State Identification Bureaus the authority to perform the background checks. The FBI has recently withheld approval for a variety of reasons, including concerns regarding privacy and fingerprinting processes, resulting in administrative roadblocks to compact participation.

- ***New market entrants have the potential to lower prices.*** It is important for states to develop localized regulations, but not at the expense of robust provider competition. Reduced competition can lead to higher prices, restricted access to care, and negative impacts on quality of care.³⁷ State licensing boards impose administrative and financial requirements for providers to practice in each state. For example, a physician who wants to expand a practice across state lines could face hundreds of dollars in

licensing fees, depending on the state, as well as tedious paperwork. In 2018, the FTC released a [report](#) on the economic impacts of licensure, which included higher prices and less convenience for consumers, and recommended improving licensure portability.³⁸

In a possible signal to the potential of new provider types, 2021 delivered record-breaking venture capital investments for digital health companies, driven in large part by telehealth investment.³⁹ New providers like Firefly Health and Eleanor Health lean heavily into convenient, virtual care services and are building their footprints in new markets. Major insurers are also increasing their telehealth offerings. In 2021, UnitedHealth Group, the nation's largest insurance company, launched Optum Virtual Care in all 50 states and Cigna purchased MDLIVE — broadly increasing beneficiaries' access to virtual care appointments.⁴⁰ Reforms to state licensure laws can increase provider competition through new providers entering the fray, which can drive improved outcomes, efficiency, and reduce costs.

- ***Licensure flexibilities helped ease the burden on an already overtaxed health care workforce.*** The pandemic placed unprecedented stress on nurses, doctors, behavioral health providers, nursing home workers, and other support staff. The Office of the Inspector General at HHS reported that impacts of the pandemic were particularly traumatic for frontline nurses who faced loss of co-workers due to COVID-19, self-isolation from their families, and overwhelming loss of life. With patients' families unable to be present due to strict hospital protocols, a nurse was often the last person dying patients saw.^{41,42} Many staff retired early or left health care altogether — in August 2021 alone, over half a million individuals left the health care and social assistance workforce.⁴³ A survey of health care workers found that nearly 1 in 5 quit their jobs since COVID-19 hit the U.S. and, of those who stayed in the medical field, about 1 in 5 have considered leaving.⁴⁴

The strain on the health care workforce has been particularly dire in rural areas, which have long struggled to recruit and retain providers.⁴⁵ Hospital associations from some of the least populated states in the nation, such as Montana, South Dakota, Wyoming, and Iowa, describe crisis-level staffing issues and fierce competition over recruiting and retaining staff.⁴⁶ Health organizations in Nebraska were so desperate for staff during the Delta variant COVID-19 surge this past summer, they attempted to recruit unvaccinated nurses.⁴⁷ While many states have officially ended their public health emergencies, hospitals across the country continue to struggle to maintain sufficient staffing to run facilities safely.⁴⁸ Maximizing provider licensure flexibilities during this extraordinary time could ease some of the staffing shortages hospitals are facing.

- ***Lack of standardization across state lines will continue to dog proponents of a federal licensure system, requiring workaround policies.*** Standards of medical practice vary between states, and conflicting state laws make it difficult for providers to treat patients the same way across state lines. For example, Hawaii requires an in-person physical examination to prescribe a medication (unless referred by another clinician who conducted the exam and provided the telehealth provider with the necessary data).⁴⁹ However, in Colorado, an in-person physical exam is not required. Any efforts to promote national licensure would need to be accompanied by efforts to establish national, evidence-based clinical standards of care for telehealth.

States also vary in their licensing standards — for example, while most states [require](#) criminal background checks for physicians, a handful do not.⁵⁰ Achieving the right balance between stricter and looser licensing standards will continue to challenge states. One option is to promote state participation in licensure compacts, which promote reciprocity while sidestepping the challenges with creating a federal standard of care. Another option is to increase adoption of telehealth-specific licenses.⁵¹ Twelve states currently allow providers to obtain such licenses or give telehealth-specific exceptions that allow providers to deliver services via telehealth from out-of-state.⁵² Sometimes these special-purpose telehealth licenses require providers to agree to certain conditions, such as not opening a physical office in that state.

For states that continue to opt out of licensure compacts, telehealth-specific licenses or telehealth-specific exceptions to licensure can be an effective option, especially for the delivery of behavioral health services. In addition, to remove some of the unnecessary complications, the Bipartisan Policy Center has previously [recommended](#) that Congress defer to state law and eliminate the federal requirement that providers be licensed in the state where a patient receives services.⁵³

- ***Momentum is building to increase interstate licensure portability through participation in licensure compacts.*** Over the years, federal grants have encouraged the development of licensure compacts for several professions. Currently, seven major health professional compacts exist, and more are under development (such as for physician assistants and dentists and dental hygienists).⁵⁴

Because military families are frequently asked to relocate, the armed services have long invested in improving licensure portability and the creation of licensure compacts.⁵⁵ In 2018, the secretaries of the Navy, Army, and Air Force sent a joint letter to the National Governors Association making it aware that military leaders would be encouraged to consider licensure reciprocity for military families in future basing decisions.⁵⁶ Effective January 1, 2021, the National Defense Authorization Act included

formal consideration of interstate portability of licensure as a factor in future military-basing decisions (Public Law 116-283).⁵⁷

With the rise of telehealth adoption during the pandemic, state interest in compact participation grew immensely. [Fifteen states](#) enacted legislation or became effective members of PSYPACT, the compact for psychologists to practice via telehealth across state lines, since the beginning of the pandemic, bringing the total number of participating states to 26 plus the District of Columbia.⁵⁸

The [Interstate Medical Licensure Compact](#) (IMLC) is a mutual agreement to expedite the traditional process to obtain an out-of-state medical license.^{59,60} Before the pandemic, fewer than 1% of physicians in participating states used the compact to obtain a license in another state; by March 2021, the number of physicians using the compact almost doubled, and an additional four states introduced legislation to join the IMLC.^{61,62,63} The IMLC streamlines the existing system of state-based licensure, but physicians still need to pay for and maintain a license for every state in which they practice.

Some experts suggest the IMLC should go further toward true reciprocity.^{64,65} For example, the [Nurse Licensure Compact \(NLC\)](#) operates most like a driver's license and allows nurses whose primary state of residence is in a compact state to practice in all other compact states without needing to apply to the licensure boards of individual states and pay additional licensing fees.⁶⁶ This multistate license structure facilitates the movement of nurses across state borders, but also contributes to pushback the NLC receives from nursing unions who fear it allows hospitals to easily hire replacement nurses during a strike.⁶⁷ In September 2021, Medicare released [guidance](#) confirming its recognition of non-physician compacts, such as the NLC and PSYPACT, which do not require providers to apply independently to each state for separate licenses as is required by the IMLC for physicians.⁶⁸

Policy Options

Given states' historical control over provider licensure as well as the lessons learned during the pandemic, the most practical path forward likely builds off the existing system of state-based licensure. Policymakers should capitalize on the newfound interest surrounding licensure compacts by reducing existing barriers to participation and incentivizing more states to join. Governors in particular have significant influence over state legislative policy priorities and can be strong advocates for licensure reform. In 2019, eight governors mentioned occupational licensing in their State of the State addresses, and relevant legislation was passed in six of the eight states.⁶⁹

To further accelerate the recognition of cross-state licensure, Congress could do for Medicare beneficiaries what has already been done for veterans accessing VA care — mandate that any physician with a valid medical license be allowed to deliver services via telehealth to Medicare beneficiaries residing in any state.⁷⁰ Federal legislation to permanently implement reciprocity in the Medicare program was previously proposed in 2013.⁷¹

Such a policy would necessitate additional guardrails, though. For example, bad actors in one state could maintain good standing in another and continue to care for Medicare beneficiaries. A 2019 Government Accountability Office (GAO) [audit](#) found that the VA similarly experienced challenges preventing disqualified providers from delivering patient care.⁷² The full delineation of provider accountability and disciplinary mechanisms would need to be further defined; however, one option could be to base provider liability on the location of the provider, rather than the location of the patient. Additionally, given the GAO audit findings, state licensing boards could receive additional incentives to continuously monitor the NPDB for provider misconduct as well as relevant training.

There are several opportunities for federal leadership to promote interstate recognition of licensure. Policy options range from broad and disruptive to more moderate in nature.

Modeling prior legislation that mandated licensure reciprocity in the context of the VA, Congress should consider:

- Allowing any physician with a valid medical license to deliver services via telehealth to Medicare beneficiaries residing in any state.
- Authorizing telehealth services for Medicare beneficiaries based on the location of the provider, rather than the location of the patient. This could apply to both issues of licensure as well as provider liability.

To minimize existing barriers to compact participation and incentivize more states to join, Congress and the administration should consider:

- Additional federal incentives to promote increased state participation in licensure compacts, such as further prioritizing future military investments in states that participate in licensure compacts.
- Directing an impartial entity, such as the GAO, to review existing health professional compacts and identify persistent barriers to provider and state participation, including, but not limited to, costs to providers and barriers to providers' exporting services out of state (especially to medically underserved areas).
- Additional federal incentives to promote increased adoption of telehealth-specific licenses or telehealth-specific exceptions to licensure, especially for behavioral health services, for states that continue to opt out of licensure compacts.

To promote interstate provider licensure recognition, federal leaders should also consider:

- Eliminating the federal requirement for Medicare, Medicaid, and the Children's Health Insurance Program providers to be licensed in the state where a patient receives services, when the provider is licensed in another state. Congress should either eliminate the federal in-state licensure requirement for practitioners licensed in another state or expand the HHS secretary's authority to waive the requirement outside of a declared emergency.
- Directing the FBI to issue guidance to State Identification Bureaus regarding statutory requirements for authorization to perform background checks, as this has been a challenge for states. Alternatively, the FBI could approve sample legislative language for use by state lawmakers when drafting compact legislation.

While utilization of telehealth has leveled off, patients overwhelmingly want to continue using the virtual care services accessed during the pandemic.⁷³ A July 2021 [consumer survey](#) conducted by the BPC showed that over 90% of adults were satisfied with the quality of their most recent telehealth visit and 8 in 10 said they would use telehealth in the future.⁷⁴ Unfortunately, state-based licensure has historically posed a barrier to the widespread adoption of telehealth services. Moving forward, Congress and the administration will play a critical role in determining telehealth's future and breaking down barriers to licensure will be key to progress.

Appendix A: Interstate Licensure Compact Participation by State

State	Audiology & Speech Language Pathology (ASLP-IC) ⁷⁵	Emergency Medical Services (EMS) ⁷⁶	Medicine (IMLC) ⁷⁷	Nursing (NLC) ⁷⁸	Occupational Therapy (OTC) ⁷⁹	Psychology (PSYPACT) ⁸⁰	Physical Therapy (PTC) ⁸¹
Alabama	X	X	X	X		X	X
Alaska							
Arizona			X	X		X	X
Arkansas				X		X (Enacted by state, but not yet formally adopted by PSYPACT Commission)	X
California							
Colorado	X	X	X	X	X	X	X
Connecticut							
Delaware		X	X (Effective 7/1/2022)	X		X	X
District of Columbia			X (Implementation delayed)			X	X
Florida				X			
Georgia	X	X	X	X	X	X	X
Hawaii							
Idaho		X	X	X			
Illinois			X			X	
Indiana		X		X			X
Iowa		X	X	X			X
Kansas	X	X	X	X		X (Effective 1/1/2022)	X
Kentucky	X		X	X		X	X
Louisiana	X	X	X	X			X
Maine			X	X	X	X	
Maryland	X		X	X	X	X	X
Massachusetts							
Michigan			X				
Minnesota			X			X	

State	Audiology & Speech Language Pathology (ASLP-IC) ⁷⁵	Emergency Medical Services (EMS) ⁷⁶	Medicine (IMLC) ⁷⁷	Nursing (NLC) ⁷⁸	Occupational Therapy (OTC) ⁷⁹	Psychology (PSYPACT) ⁸⁰	Physical Therapy (PTC) ⁸¹
Mississippi		X	X	X			X
Missouri		X		X	X	X	X
Montana			X	X			X
Nebraska	X	X	X	X		X	X
Nevada			X			X	
New Hampshire	X		X	X	X	X	X
New Jersey				X		X (Effective 11/23/2021)	X
New Mexico				X			
New York							
North Carolina	X			X	X	X	X
North Dakota		X	X	X			X
Ohio	X		X	X	X	X	X
Oklahoma	X		X	X		X	X
Oregon							X
Pennsylvania			X (Implementation delayed)	X		X	X
Rhode Island							
South Carolina		X		X			X
South Dakota		X	X	X			X
Tennessee		X	X	X		X	X
Texas		X	X	X		X	X
Utah	X	X	X	X		X	X
Vermont			X	X			
Virginia		X		X	X	X	X
Washington			X				X
West Virginia	X	X	X	X		X (Enacted by state, but not yet formally adopted by PSYPACT Commission)	X
Wisconsin			X	X			X
Wyoming	X	X	X	X			
TOTAL	15	21	34	37	9	27	34

Endnotes

- 1 Ohio was the only state that did not offer emergency or temporary licensure for out-of-state physicians during the federal public health emergency due to COVID-19.
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Bipartisan Policy Center

1225 Eye St NW, Suite 1000
Washington, DC 20005

bipartisanpolicy.org

202 - 204 - 2400

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