



ATA American Telemedicine Association

Medical Licensure and Practice Requirements

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State-by-state medical licensure and practice regulation are a long-standing barrier to the deployment of telemedicine and equal access to quality care. Such requirements have the effect of restricting patient and consumer choice in healthcare. They result in economic trade barriers restricting the free flow of medical services and artificially protecting markets from competition. Most important, they prohibit residents from receiving critical, often life-saving medical services that may be available to their neighbors living just across the state line.

Complicating this matter, during the last few years at least 14 states have passed legislation placing even greater restrictions on the practice of telemedicine across state lines as groups of medical professionals have further insulated their practices from outside competition. Most often this restriction takes the form of requiring full and unrestricted state licensure for any out-of-state physician or other health practitioner providing services via telemedicine to residents of the State. It also requires physicians to pay duplicative licensure fees to every state.

Despite past defenses, such requirements are outdated and seriously harm the public and inhibit progress in the practice of 21st century medicine and patients.

Background

Governing powers that are not granted to the federal government under the Constitution are reserved to the states, as provided for by the Tenth Amendment of the United States Constitution. These activities are traditionally local in nature and most often pertain to health, safety, and welfare of a state's citizenry. Under this authority, state medical boards, whose members are usually political appointees of state governors, have used their authority to require physicians and other healthcare practitioners that provide medical services in more than one state to obtain full and unrestricted medical licenses in each state, pay for multiple licensure fees and adhere to individual and often conflicting state-based practice requirements. In many states, at least a portion of the medical board's budget is dependent on the fees collected from issuing licenses.

Professional Licensing

Unlike licenses granted for driving automobiles or trucks, there is no reciprocity of medical licenses. Unlike licenses for flying airplanes, licensure is still a state-by-state function. This is based on state jurisdictional claims and assertions that they need to maintain the right to protect their own citizens from unqualified medical professionals and practices.

Actually, in the past 30 years there has been a remarkable convergence in the requirements used by states to initially grant a license to practice medicine to physicians and other health professionals. For example, all states now rely on the United States Medical Licensing Examination (USMLE) to qualify potential physician candidates. In qualifying for the

examination, all states recognize appropriate credentials from nationally accredited medical schools and residency programs, regardless of location. All specialty board certification is conferred by national organizations and are based on national standards.

Today, state requirements for granting a medical license have far more similarities than differences. In fact, they only vary in terms of procedural and tangential issues, such as the number of times an applicant can take the USMLE (the range is from three to unlimited attempts) and the number of required postgraduate training years (the range is from zero to three years).

Because the entrance requirements are the same, there is little, if any data to support a claim that licensed physicians or other health professionals of one state are more or less qualified than those of any other state.

Such individual state-based licensing practices have become more and more peculiar to the United States.

- Allowing physicians the right of free circulation as providers of medical services within the 25-nation European Union (EU) was part of a founding EU principle for freedom of circulation of goods, persons and services. The EU lays out minimum training requirements for general practice and specialist physicians and provides for mutual recognition of physicians' qualifications. It also enforces measures to ensure that the licensing provisions of individual Member states permit the free movement of doctors both to establish themselves and to practice their profession in all Member states. This is currently covered under the [EU directive 2005/36/EC](#).
- Similarly, as of July 2010 Australia moved from a state-based system to a single national agency to implement a registration and accreditation program supporting the work of national boards governing 10 health professions. Four more medical professions are scheduled to be added to the national system in 2012. <http://www.ahpra.gov.au/>

Even the Federal Communications Commission in its broad ranging assessment of barriers to broadband-enabled health services one year ago discussed the immediate need for action by state licensing boards to accommodate multi-state licensure conclude by saying, "If states fail to develop reasonable e-care licensing policies over the next 18 months [by September, 2011], Congress should consider intervening to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care." (Connecting America: The National Broadband Plan, p. 206)

Finally, it should be noted that the problem is not with just the 50+ state medical boards – it is multiple state boards governing each of the health professions. An example of this compounded problem is the Nursing Licensure Compact. With high expectations and excitement, 13 years ago the National Council of State Boards of Nursing launched an interstate Compact initiative designed to alleviate the problem of requiring full nursing licenses in each state. Several states were quick to adopt the Compact, but that progress stalled out several years ago with less than half of the states participating.

Medical Practice Requirements – Protecting Patient Safety

States govern the practice of medicine, which is enforced through the policing of individual providers. While this has supported the idea of local laws protecting local citizens, there are two problems that strongly inhibit the transformation of medical practice, limiting patient choice and threaten patient safety.

Lack of uniformity – State-based medical practice acts have added to the complexity to providers offering care to patients in more than one state. This creates yet another barrier to patients seeking access to qualified medical professionals located outside of a state's boundaries. While there are important differences in reporting, continuing medical education and record keeping laws. However, the most important differences are in medical practice laws, specifically who can prescribe medicines and on what basis.

- According to the U.S. Department of Justice, as many as 12 different types of mid-level healthcare professionals are authorized by various states to issue some form of prescriptions. These professionals include physician assistants, nurse practitioners, medical psychologists and registered pharmacists. Often these individuals are only allowed to prescribe certain low risk drugs. In some cases, but not all, the prescribing professional is required to be under the direct supervision of a licensed physician. In most areas a nurse or allied health professional is used to administer flu shots, a normally prescribed drug, without the need for a prescription.
- State rules requiring in-person visits vs. visits performed vs. video conferencing also differ. Some states require a face-to-face meeting with the physician prior to an online visit while others allow video-based consultations. However, no state specifies what should be involved in such an examination.

Unresolved jurisdictional coordination - Further complicating this is the complexity of disciplining health professionals located outside of the state. Often state rules do not allow sharing of any disciplinary information with other states until the proceeding is completed. This seriously impedes the ability of states to protect patient safety.

Improving Medical and Health Licensure and Regulating Medical Practice

ATA urges policy makers to adopt changes in the current system of providing health professional licensure and regulating medical practices that frees consumers to choose and access health care services and health care providers regardless of location. Making a change in public policy right away will enable the benefits of telemedicine including improved quality of care, lowered costs and expanded access to be available across the nation. Such change is entirely in harmony with the goals embraced by all parties to reform the current healthcare system.

There are four potential approaches toward resolving the current state-by-state barriers to the practice of medicine and health and ensuring patient safety.

Federal Licensure and Regulation would grant licensure and enforcement at the federal level. An example of national licensure is aviation. All civilian pilots (including airline transport pilots) are licensed at the federal level. The Federal Aviation Administration (FAA) manages pilot certification in the U.S. and maintains a national data base of all pilots and governs the practice with national regulations.

In-State Licensure and Regulation supports the states' ability to license and regulate activities of medical professionals located within each state but not to professionals providing telemedicine services from other states. This maintains the ability of the state to retain its licensing and enforcement activities but it treats a telemedicine interaction the same way as if the patient were traveling to the physician. Federal disclosure requirements for pending and final state disciplinary actions will be needed in order to protect patient safety.

Preemption would grant functional licensure in certain circumstances by superseding state statutes. Such is the current case for Department of Defense and Veterans Administration professionals practicing in federal facilities. Another form could be federal pre-emption for medical services paid by federal programs, such as Medicare.

Mutual Recognition and Portability of licensure between states is based on the concept of reciprocity. Such mutual recognition requires either an interstate agreement or federal mandate.

The driver license is one example of automatic reciprocity in which the holder of a license in one state can legally drive in any other state. Under the 1960 national Driver License Compact (now called the Driver License Agreement), states maintain a policy titled "*One Driver, One License, One Record*" where states exchange information concerning license suspensions and traffic violations of non-residents and forward them to the state where they are licensed known as the home state. The home state would treat the offense as if it had been committed at home, applying home state laws to the out-of-state offense.

Alternatively, the Nursing Licensure Interstate Compact grants nursing licensure privileges in all participating states provided the nurse already has a valid license in at least one state and subjects the nurse to each state's practice law and regulation. Enacted in 2000, to date, only 24 states have adopted the compact and only 4 states in the last 5 years.

Conclusion

Current approaches to state-based licensing and regulation of health professionals are outdated and seriously harm the public and inhibit progress in the practice of 21st century medicine and patients. Resolution of this growing problem is a critical priority to implement any of the varying approaches being considered for health reform. ATA encourages the federal government to take a strong leadership role in resolving this issue.