



The ATA's Recommendations on Enabling Healthcare Delivery Across State Lines

Background: Historically, individual states have regulated the practice of medicine. This authority has enabled appropriate state licensing boards of medicine, nursing, and other healthcare professions to manage clinician licenses, discipline, reporting, individual reprimands, and related activities in line with state law. These state licensing boards have argued this authority comes from important Federalism powers delegated to states and protected under the United States Constitution. These state licensing boards contend states should remain in full control of professional licensure so boards can hold their licensed clinicians accountable and discipline them when necessary to safeguard patients from bad actors. Further, because state laws regulating the practice of medicine are complicated and differ state-by-state, state licensing boards contend it is easier for individual boards to manage the implementation and oversight of their respective state laws.

In recent years, collections of state licensing boards of different healthcare professions have worked together to create processes through which providers who are licensed in one state can offer care in another state. These collaborative agreements differ by provider type, but they generally are referred to as “compacts” and have greatly expanded the ability for health care to be delivered across state lines.

To align with current federal and state authorities, Constitutional principles, and to ensure existing efforts are not duplicated, the ATA believes the necessary work of allowing care across state lines is best accomplished through state action. This may include, for example, states that voluntarily elect to participate in multistate compacts.

State of Play: Since the beginning of the COVID-19 pandemic, federal and state policymakers have temporarily waived a wide range of telehealth rules including certain licensure requirements. Recent actions by individual states to implement new flexibilities under their authority have allowed more clinicians to deliver telehealth services across state lines.

Throughout 2021, many state-level declarations of a public health emergency began to expire, which means some clinicians no longer benefit from the interstate licensure flexibilities available during the pandemic waiver period. During the pandemic, governing bodies for several clinician compacts sought to expand access to care by expediting their existing, pre-pandemic interstate licensure processes.

Each state has different requirements, making multistate licensure applications a cumbersome and often costly process for physicians, nurses, and other healthcare professionals. When the state level public health emergency declarations expire, these healthcare professionals will face a regulatory barrier that will result in once again limiting patients' access to care. Given the positive experiences providers and patients alike have had with increased licensing flexibility delivering quality care during the pandemic, interest in interstate delivery of telehealth services will persist.

ATA Recommendations: A core [Policy Principle](#) of the ATA is: **Enable Healthcare Delivery Across State Lines**. Adoption of interstate licensure compacts, flexibility for online medical second opinions, cross-state follow-ups for continuity of care, and other related licensure portability policies ensure that clinicians can treat patients safely across state lines. Policy barriers that impose undue administrative burden or restrictions that do not promote patient access, continuity of care, and quality medical services should be reduced. State and federal policy should ensure efficient licensure, both during public health emergencies and after.



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The federal government can play a positive role in state licensure by encouraging state legislatures to adopt reciprocal licensure compacts and helping ensure the compacts are working as planned. Policymakers in Washington can do so under the precedent that allows for the federal government to predicate funding on state legislatures adopting certain standards.¹

In pursuing such an approach, however, federal policymakers must do so in a way that respects the jurisdiction of the appropriate state licensing boards the state where the patient is located, in a patient-centered approach that upholds the standard of care.

The ATA encourages organizations pursuing compacts to ensure they are reciprocal in nature and for states to explore licensure frameworks that acknowledge the unique capabilities of telehealth to address provider shortages and expand patients' access to specialists, while still providing avenues for discipline and accountability.

As one way to achieve this, the ATA endorses the current approach followed by several states, as well as the current draft of the Uniform Law Commission's Model Telehealth Act, to create a registration system for telehealth providers which:

- Requires a clean disciplinary record and notification to the appropriate state licensing boards of disciplinary actions; adherence to state laws and regulations with respect to liability coverage and scope of practice; contains provisions that ensure that the physician can be disciplined by the applicable state board and will be subject to suit within the state.
- Limits registered providers to offering telehealth services and prohibiting in-person services within the state without a license.
- Contains exemptions for licensure or registration for telehealth practitioners who are providing limited follow-up care to an established patient who is outside the practitioner's state of licensure or offering second opinion consult.

For reasons of precedent, the U.S. Constitution's 10th Amendment, standards of care accountability, and political realities, the ATA believes the necessary work of opening care across state lines must be done through state action with federal support—not through federal mandates or preemption.

¹ In *South Dakota v. Dole*, the United States Supreme Court held that a statute conditioning receipt of federal highway funds on state adoption of a minimum drinking age is a legitimate use of federal spending power.