



**Special Report to the
Senate Appropriations Committee**

Telehealth Licensure Report

REQUESTED BY: SENATE REPORT 111-66

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EXECUTIVE SUMMARY

As required by Senate Report 111-66, “Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2010, Report of the Committee on Appropriations on H.R. 3293,” this document provides an update on licensure portability. In the context of appropriations under the Telehealth line item, the Senate Report states,

*The Committee requests a report by March 15, 2010 on the level of cooperation among health licensing boards, the best models for such cooperation and the barriers to cross-state licensing arrangements.*¹

This report provides background information on licensure portability, summarizes the experience of grantees funded under the Health Resources and Services Administration’s (HRSA) Licensure Portability Grant Program, and discusses some of the issues and barriers affecting licensure portability. It focuses on physicians and nurses that are the two professional groups for which there is the most information on alternative approaches to overcoming licensure barriers to cross-state practice.

Recognizing that the issues of licensure and the delivery of telehealth services were evolving and becoming more complex, the U.S. Congress passed the Health Care Safety Net Amendments of 2002, Public Law (P.L.) 107-251. Section 102 authorized the award of incentive grants to state professional licensing boards to promote cooperation and encourage development and implementation of state policies that will reduce statutory and regulatory barriers to telehealth. The Federation of State Medical Boards (FSMB) and the National Council of State Boards of Nursing (NCSBN) received Licensure Portability Grants awards in the first competition.

The NCSBN developed a far reaching mutual recognition model for licensing nurses. Under this mutual recognition model, practice across state lines is allowed, whether physical or electronic, unless the nurse is under discipline or a monitoring agreement that restricts practice across state lines. In order to achieve mutual recognition, each state must enter into an interstate compact, called the Nurse Licensure Compact (NLC). The NLC was first implemented on January 1, 2000, when it was passed into law by the first participating states: Maryland, Texas, Utah and Wisconsin. Currently, 23 states participate in the NLC, with the 24th, Missouri, implementing it in June 2010.

Although the reasons for opposing the Compact vary state-to-state, the persistent challenges to the adoption of the NLC fall into five broad categories: control/loss of authority, lack of uniform standards, costs/loss of revenue, strike breaking, and misinformation about the Compact/lack of independent evaluation.

Unlike the NLC, a mutual recognition or similar model for cross-state licensure of physicians has yet to be adopted by a large number of states. The FSMB is a national non-profit organization representing medical boards in the United States and its territories. Responding

¹ **Note:** The Department requested an extension on the report because of the short time frame that the Department had to complete it. Public Law 111-117 did not pass until December 16, 2009.

to changes in the delivery of health care over the last two decades, the FSMB has incrementally addressed the issue of license portability and cross-state practice.

The FSMB is encouraging states to adopt the model of expedited endorsement. Expedited endorsement is a method of setting criteria to approve a valid license of another state. The process accepts a license issued in another state that was verified and sets requirements for endorsing a license granted in another state. Idaho, Michigan, Nevada, New Mexico, Rhode Island and Oregon currently use an expedited endorsement process and North Carolina and Wyoming are in the process of adopting rules to allow a similar process in their states.

Unfortunately, some states are uncomfortable with accepting the licensing process of another state. Some state medical boards have a number of concerns with the expedited endorsement process. Each state board determines their own criteria and requirements differ from state to state. For instance,- not every state board requires criminal background checks. State boards are ultimately responsible for maintaining public protection within the state and may be unwilling to expedite the license of a physician who has not undergone a criminal background check.

Some of the barriers to license portability could be eliminated. The section on possible next steps explains how the licensure process could be less burdensome if processes were streamlined.

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TABLE OF CONTENTS

INTRODUCTION	6
PRIOR CONGRESSIONAL REPORTS	6
REPORT REQUIREMENT	6
BACKGROUND	7
LEGAL FOUNDATION	7
AUTHORITY	7
STATE AUTHORITY.....	7
FEDERAL AUTHORITY	8
REGIONAL/MULTI-STATE AUTHORITY	9
THE LICENSURE SYSTEM	9
STANDARDS.....	9
ENFORCEMENT	9
ADMINISTRATION	9
GENERAL ALTERNATIVE MODELS	10
ENABLERS.....	12
UNIFORM CORE LICENSURE REQUIREMENTS	12
COMMON/UNIFORM LICENSURE APPLICATION.....	13
CREDENTIAL VERIFICATION ORGANIZATION.....	13
LICENSURE PORTABILITY GRANTS AND OTHER RECENT INITIATIVES	14
LICENSURE PORTABILITY GRANTS	14
MAJOR LICENSURE MODELS FOR NURSES AND PHYSICIANS.....	16
NURSES.....	16
THE NATIONAL COUNCIL OF STATE BOARDS OF NURSING/NURSE LICENSURE	
COMPACT MODEL	16
PHYSICIANS.....	25
FEDERATION OF STATE MEDICAL BOARDS.....	26
OPTIONS FOR NEXT STEPS.....	32
CONCLUSION	34
ATTACHMENTS	35
APPENDIX.....	44

INTRODUCTION

Licensure portability is seen as one element in the panoply of strategies needed to improve access to quality health care services through the deployment of telehealth and other electronic practice services in this country. But licensure portability goes beyond improving the efficiency and effectiveness of electronic practice services. Overcoming unnecessary licensure barriers to cross-state practice is seen as part of a general strategy to expedite the mobility of health professionals to address workforce needs, particularly in light of increasing shortages of health care professionals. It is also seen as a way of improving the efficiency of the licensing system in this country so that scarce resources can be better used in the disciplinary and enforcement activities of state boards, rather than in duplicative licensing processes.

State health professions licensing boards, as well as national groups representing these boards, such as the Federation of State Medical Boards and the National Council of State Boards of Nursing, are seeking ways to simplify the licensing process for physicians and nurses interested in obtaining licenses in more than one state.

PRIOR CONGRESSIONAL REPORTS

The Department of Health and Human Services (HHS) has worked closely with other Federal agencies and public and private organizations to study licensure issues affecting telehealth practice. The Department of Commerce, in collaboration with HHS, submitted the 1997 Report to Congress on Telemedicine that contained a chapter on Licensure issues impacting telehealth. In 2001, HHS submitted a Report to Congress that updated the 1997 Report licensure chapter. Each report identified licensure as a major barrier to the development of telehealth.² Since the publication of these reports, state regulatory boards have attempted to address questions of improving licensure portability (i.e., the practice across state lines) in a variety of ways.

REPORT REQUIREMENT

Senate Report 111-66, “Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2010, Report of the Committee on Appropriations on H.R. 3293,” requires that the Department of Health and Human Services submit a report to provide an update on licensure portability. In the context of appropriations under the Telehealth line item, the Senate Report states,

² See [Telemedicine Report to the Congress](#), GPO No: 0126-E-04 (MF), Washington, DC U.S. Department of Health and Human Services; and [2001 Telemedicine Report to Congress](#), GPO No: 619-261/65410, Washington, DC U.S. Department of Health and Human Services.

*The Committee requests a report by March 15, 2010 on the level of cooperation among health licensing boards, the best models for such cooperation and the barriers to cross-state licensing arrangements.*³

This report provides background information on licensure portability, summarizes the experience of grantees funded under the Health Resources and Services Administration's (HRSA) Licensure Portability Grant Program, and discusses some of the issues and barriers affecting licensure portability. Because the report was requested in the context of the United States, it focuses on the U.S. experience. Moreover, the report focuses on physicians and nurses, the two professional groups for which there is the most information on alternative approaches to overcoming licensure barriers to cross-state practice.

BACKGROUND

For over 100 years, health care in the United States has primarily been regulated by the states. Such regulation includes the establishment of licensure requirements and enforcement of standards of practice for health providers, including physicians, nurses, pharmacists, mental health practitioners, etc. The licensure authority is administered with the goal of ensuring that health care professionals are academically qualified, competent, and mentally and physically fit to provide the activities covered by the license.

As the U.S. health system evolves to meet the changing needs of consumers, traditional methods of health care delivery are being transformed. No longer do the patient and the provider need to always be in the same location to receive quality health services. Telehealth services are increasingly becoming part of the mainstream of health care.

Telecommunications and information technologies are being used to provide health care services in a more efficient and effective manner to address the shortages and maldistribution of health care professionals that result in lack of access to quality health care services, whether due to geographic, economic, or other social factors. For these reasons, the number of physicians and the number of other health providers practicing across state boundaries have increased in recent years and this trend is expected to continue to increase in the foreseeable future.

LEGAL FOUNDATION

AUTHORITY

Licensure authority defines who has the legal responsibility to grant a health professional the permission to practice their profession.

³ **Note:** The Department requested an extension on the report because of the short time frame that the Department had to complete it. Public Law 111-117 did not pass until December 16, 2009.

STATE AUTHORITY

States regulate the practice of clinical care under the police power reserved by the Tenth Amendment to the U.S. Constitution. States have the authority to regulate activities that affect the health, safety, and welfare of citizens within their borders.⁴ However, the states' power to regulate health care may not be absolute. The Commerce Clause of the Constitution limits states' ability to erect barriers against interstate trade⁵ and the practice of health care has been held to be interstate trade for the purpose of antitrust laws.⁶ The potential conflict between the states' power to regulate health professionals and the prohibition against restraints on interstate commerce has not been addressed by the courts.

The purpose of licensing health care professionals is to protect the public from incompetent or impaired practitioners. In order to provide professional health care services, most health professionals are required to obtain a certificate of licensure from the state in which their practice is located (see Nurse Licensure Compact exception below). Currently, each state has established Practice Acts that define the processes and procedures for granting a health professional a license, renewing a license and regulating professionals' practice within a state. Laws governing individual health care professions are enacted through state legislative action, with authority to implement the practice acts delegated to the respective state licensing board. Physicians or other licensed health professionals are considered to be practicing their professions in the state where the patient is located and are subject to that state's licensing laws unless there is an exception in statute, e.g., consultation exceptions, exceptions for national emergencies.

States do not have the authority to grant practice privileges in another state. In the absence of specific agreements (See Nurse Licensure Compact below), states also may not discipline health care professionals not licensed in their state if patient harm occurs as the result of the provision of health care services by an out-of-state practitioner.

FEDERAL AUTHORITY

The Supremacy Clause of the Constitution preempts state laws that interfere with, or are contrary to, the laws of the Federal government.⁷ However, there is a strong presumption against preemption.⁸ The Supreme Court has acknowledged that the regulation of health and safety matters has primarily and historically been a matter of exclusive state concern, and

⁴ *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 792 (1975); *see, also, Ferguson v. Skrupa*, 372 U.S. 726, 731 (1963); *Dent v. West Virginia*, 129 U.S. 114, 122 (1889).

⁵ "The Commerce Clause of the Constitution grants Congress the power 'to regulate Commerce with foreign Nations, and among the several states, and with Indian Tribes.' Art. I, Sec. 8, cl. 3. 'Although the Clause thus speaks in terms of powers bestowed upon Congress, the Court has long recognized that it also limits the power of the states to erect barriers against interstate trade.'" *Maine v. Taylor*, 477 U.S. 131, 137 (1986) (quoting *Lewis v. BT Investment Managers*, 447 U.S. 27, 35 (1980)).

⁶ *See, e.g., Arizona v. Maricopa County Medical Soc'y.*, 457 U.S. 332 (1982).

⁷ U.S. Constitution Art. VI, cl.2.

⁸ The Supreme Court first recognized the Federal-state balance in *McCulloch v. Maryland*, 14 U.S. (4 Wheat.) 316, 427 (1819). Since that time, "it has been settled" that the doctrine of preemption constitutes the resolution between Federal and state law, and all "state law that conflicts with Federal law if without effect." *Cipollone v. Liggett Group*, 505 U.S. 504, 516 (1992) (quoting *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)).

therefore preemption of state law should not occur in the absence of Congress' clear intent to supersede state law.⁹

REGIONAL/MULTI-STATE AUTHORITY

Under our Federal form of government, states are sovereign authorities that maintain those powers not ceded to the Federal government. The Constitution recognizes the states' authority to enter into compacts or agreement with one another subject to the consent of Congress.¹⁰ "An interstate compact is an agreement between two or more states established for the purpose of remedying a particular problem of multi-state concern."¹¹ Compacts are multi-state solutions that allow states to accomplish together what they could not accomplish alone. As discussed later, the nurses have developed a compact model for licensure that currently operates in 23 states, but as of June 2010, it will operate in 24 states, when Missouri implements the compact.

THE LICENSURE SYSTEM

STANDARDS

One of the primary functions of a licensure system is the establishment of academic and clinical competency standards for the practice of the profession. The licensure authority must ensure that those entering the profession are academically qualified, competent, and mentally and physically fit to provide the activities covered by the license.

The basic standards for medical and nursing licensure have become largely uniform in all states. Physicians and nurses must graduate from nationally approved educational programs and pass a national medical and nursing licensure examination. However, there are significant differences in the administrative, and filing requirements which could pose barriers to physicians and other health providers attempting to establish a multi-state practice. For physicians these obstacles can sometimes be overcome through "consultation exceptions" which allow occasional, infrequent, or limited practice within a state.

ENFORCEMENT

A licensure system must provide effective monitoring of the nurses' and physicians' competency and professional conduct, respond to the information brought to it by patients and health professionals, and provide a means to investigate and adjudicate complaints against a health professional. A licensure authority must have the means to hold the nurse or physician accountable for his or her actions and enforce the authority's disciplinary decisions.

⁹ *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 21 (1987).

¹⁰ U.S. Const. Art I, Sec. 10, cl. 3, provides in pertinent part, "No State shall, without the Consent of Congress...enter into any Agreement of Compact with another State..."

¹¹ Black's Law Dictionary.

ADMINISTRATION

A licensure system must be able to administer and enforce its standards. The system should efficiently issue licenses, monitor activities, and enforce its standards without imposing undue burdens on licensees or the public. Most importantly, the licensure and enforcement process should be consistent and fair.

GENERAL ALTERNATIVE MODELS

There are a variety of alternative licensure models of state cooperation that would allow a health professional to practice across state lines electronically. The most prominent models are addressed in the table below.

Model	Explanation
Consulting Exceptions	With a consulting exception, a physician who is unlicensed in a particular state can practice medicine in that state at the request of and in consultation with a referring physician. The scope of these exceptions varies from state to state. Most consultation exceptions prohibit the out-of-state physician from opening an office or receiving calls in the state. In most states, these exceptions were enacted before the advent of telehealth and were not meant to apply to ongoing regular telehealth links. However, some states permit a specific number of consulting exceptions per year.
Endorsement	State boards can grant licenses to health professionals in other states with equivalent standards. Health professionals must apply for a license by endorsement from each state in which they seek to practice. States may require additional qualifications or documentation before endorsing a license issued by another state. Endorsement allows states to retain their traditional power to set and enforce standards that best meet the needs of the local population. However, complying with diverse state requirements and standards can be time consuming and expensive for a multi-state practitioner.
Reciprocity	A licensure system based on reciprocity would require the authorities of each state to negotiate and enter agreements to recognize licenses issued by the other state without a further review of individual credentials. These negotiations could be bilateral or multilateral. A license valid in one state would give privileges to practice in all other states with which the home state has agreements.

Model	Explanation
Mutual Recognition	Mutual recognition is a system in which the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee's home state. Licensure based on mutual recognition is comprised of three components: a home state, a host state, and a harmonization of standards for licensure and professional conduct. The health professional secures a license in his/her own home state and is not required to obtain additional licenses to practice in other states. The nurse licensure compact is based on this model.
Registration	Under a registration system, a health professional licensed in one state would inform the authorities of other states that s/he wished to practice part-time there. By registering, the health professional would agree to operate under the legal authority and jurisdiction of the other state. Health professionals would not be required to meet entrance requirements imposed upon those licensed in the host state but they would be held accountable for breaches in professional conduct in any state in which they are registered. California had the authority to draft this type of model, but never did so.
Limited Licensure	Under a limited licensure system, a health professional would have to obtain a license from each state in which s/he practiced but would have the option of obtaining a limited license for the delivery of specific health services under particular circumstances. Thus, the system would limit the scope rather than the time period of practice. The health professional would be required to maintain a full and unrestricted license in at least one state. The Federation of State Medical Boards has proposed a variation of this model. According to the Federation, sixteen states have adopted a limited licensure model.
National Licensure	A national licensure system could be adopted on the state or national level. A license would be issued based on a universal standard for the practice of health care in the U.S. If administered at the national level, questions might be raised about state revenue loss, the legal authority of states, logistics about how data would be collected and processed, and how enforcement of licensure standards and discipline would be administered. If administered at the state level, these questions might be alleviated. States would have to agree on a common set of standards and criteria ranging from qualifications to discipline.
Federal Licensure	Under a Federal licensure system health professionals would be issued one license, valid through the U.S., by the Federal government. Licensure would be based on Federally established standards related to qualifications and discipline and would preempt state licensure laws. Federal agencies would administer the system. However, given the difficulties associated with central administration and enforcement, the states might play a role in implementation.

Source: Adapted from and updated from the U.S. Department of Commerce, “Report to Congress on Telemedicine,” 1997.

In addition to some of the health professions organizations (e.g., Federation of State Medical Boards, National Council of State Boards of Nursing), a number of groups have recently issued policies concerning alternatives to improve license portability. Some of these groups include: the American Telemedicine Association (ATA), the American Bar Association (ABA), the State Alliance for e-Health (National Governors Association), and most recently, the Federal Communications Commission.

In 2007, the ATA issued a policy position statement supporting policy at the Federal, state, and local levels that creates collaborative agreements between the states regarding medical licensure portability.¹² In its position statement, the ATA noted that although medical and allied professional groups have begun to change and adopt telemedicine demonstrations into integrated practice patterns, the regulatory environment governing telemedicine, and in particular interstate licensure, has not adapted as quickly. Recent state regulations and laws placing additional restrictions on licensure, purportedly put in place to protect the public, have effectively inhibited the adoption of telemedicine, a solution that can reduce disparities in healthcare and decrease healthcare cost. Policy recommendations that address license portability, while adhering to states’ standards of care and ensuring public safety, should be adopted to facilitate the use of telemedicine as a means to expand access, improve quality, and enhance efficiency of medical care services for all Americans regardless of location.

The American Bar Association, Health Law Section¹³ has also agreed on a model for allowing the cross-state licensure of physicians. The ABA, Health Law Section approved a resolution on May 6, 2008. The Report to the House of Delegates recommended that the ABA urge states and territories to provide for mutual telemedicine licensure recognition, whereby a physician with a current, valid and unencumbered license in any jurisdiction could file a single application which would permit the physician to practice telemedicine in some or all other jurisdictions subject to continuing compliance with those jurisdictions’ licensure fees, discipline, and other applicable laws and regulations, and adherence to professional standards of medical care. The Section further recommended that such legislation should specify a uniform definition of telemedical practice, the requisite procedures for telemedical licensure, a requirement that the telemedicine provider must agree to the jurisdiction of the patient’s home state for malpractice actions, and the continuing role of state medical boards in physician licensure and discipline. The model has been approved by the ABA but has not been adopted by the states.

The State Alliance for e-Health, *Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care*, issued recommendations in its first annual report to streamline the licensure process to enable cross-state e-health. The State Alliance proposed two stages for addressing the issue. First, the states should streamline the licensure application and credentials verification processes to allow providers to more easily apply for a license in multiple states. Second, the State

¹² Licensure Portability, Position Statement and Recommendations, American Telemedicine Association, 2007 - http://www.americantelemed.org/files/public/policy/Licensure_Portability.pdf.

¹³ American Bar Association, Health Law Section Report to the House of Delegates, 2008.

Alliance encouraged states to consider ways to accommodate e-health (including telemedicine and telepharmacy) practice while still maintaining state-based jurisdiction.¹⁴

The Federal Communications Commission released a National Broadband Plan in March 2010 that included a section on state licensure requirements, which urged states to revise licensure requirements to enable “e-care.”¹⁵ The Plan noted that current licensure requirements limit practitioners’ ability to treat patients across state lines, which hinders access to care. The Plan suggests that the nation’s governors and state legislatures could collaborate through such groups as the National Governors Association, the National Conference of State Legislatures and the Federation of State Medical Boards to craft an interstate agreement. If states fail to develop reasonable licensing policies to facilitate electronic practice over the next 18 months, the Plan recommends that the Congress should consider intervening to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care.

ENABLERS

Many of the above mentioned models require strategic or technical enablers to be implemented properly and efficiently. Some examples of enablers include: uniform core licensure requirements, uniform licensure application, and credential verification organizations.

UNIFORM CORE LICENSURE REQUIREMENTS

Professional licensure requirements assure that the individuals who are granted the authority to practice have demonstrated specified educational, examination and behavioral requirements. Core licensure requirements are defined as those minimum requirements that are essential to assure public protection. An example of a core requirement is the requirement of physicians and nurses to undergo a criminal background check. The purpose of developing uniform core licensure requirements is to assure common licensure standards critical to protect the public health, safety and welfare. Common standards also promote the mobility of licensed health professionals to practice in different states. Health professional mobility facilitates consumers having access to health services provided by health professionals qualified according to consistent licensure standards regardless of where in the country the consumer lives. Individual states may also include requirements in addition to the core requirements.

COMMON/UNIFORM LICENSURE APPLICATION

One way to reduce the barriers to cross-state licensure is to simplify the application process. The use of a common or uniform application is familiar to anyone whose child has applied to college using the common college application. A uniform licensure application is a single application for licensure that can be used by multiple states, thereby eliminating the

¹⁴ National Governors Association, ACCELERATING PROGRESS: Using Health Information Technology and Electronic Health Information Exchange to Improve Care, page 33, 2008.

¹⁵ Connecting America: The National Broadband Plan, 2010.

requirement for a state specific application, while allowing for state unique requirements to be met through the use of addendum material to the uniform application. The applicant can go to a single website and enter information and select the participating states that they want the application sent. The applicant may also need to complete the state specific addendum for each state. A uniform application is designed to make the licensure process more portable among states, convenient and less redundant.

The advantages of the uniform application are the elimination of the requirement to contact each state and obtain a state specific application. Once the uniform application is completed, it can be sent electronically to multiple states. It also allows the applicant to quickly update information at a later date and not have to re-enter the background information already provided. The application is maintained for future use, ending some of the redundancies of completing an entire application each time. The receiving state can update data fields in their licensing databases saving personnel time and costs in reproducing, mailing and entering applicant data. The addition of the discipline report and verification of licensing examination scores again saves time and cost at the state level.

Although the uniform application does save time and money, it does have some limitations. The uniform application is just an application and, while the main body of the application meets the needs of the some states, there still may remain state specific requirements that must be met. Some states that have developed their own online application may be reluctant to abandon their application process for another online application. Unless the application is linked to an automatically updated credentials verification data base, applicants must still request primary source documents to be sent to the state board, and the state board must still go through the primary source verification process. The lack of technology knowledge or training may limit the ability of the state to fully utilize all the advantages of the electronic transfer and storage methods available through the electronic application. The economic downturn has affected many state budgets limiting their ability to pursue technological improvements in their agencies and there is a cost associated with maintaining a uniform application process to the provider of the service.

CREDENTIAL VERIFICATION ORGANIZATION

A credentials verification organization (CVO) provides a service to the licensure applicant and state licensure authorities by obtaining and verifying the core¹⁶ documents and state specific requirements for licensure. Verifying credentials with the primary source (e.g., medical school graduation, job history) is a difficult and time consuming task in the licensure process. Once an applicant completes an application, state medical and nursing boards are under increasing pressure to make licensing decisions quickly and accurately. Using a CVO removes pressure from licensure authorities to carry out such tasks, with the added benefit that once these credentials are obtained by the CVO, the credentials are permanently maintained in a protected, secure environment.

¹⁶ Core documents are required by most state licensing authorities with little variation. They are stable, unchanging documents that once verified do not require re-verification. Examples of core documents are verification of basic medical education and post graduate training.

One of the biggest advantages of a CVO is that applicants are able to complete the basic credential package and send the information to multiple states. The CVO performs the primary source verification process of core documents and obtains primary source verification of multiple other requirements for state licensure including narrative information, National Practitioner Databank checks, licensing examination scores, and discipline information, thus eliminating the requirement for each state licensing board individually verify each one of the applicants' credentials. The credentials are maintained by the CVO and subsequent applications may require only minimal additional information to update and expedite the application process for another state licensing application.

A primary example in the United States is the Federation of State Medical Boards' Federation Credential Verification Service (FCVS). The FCVS serves as a repository of core documents for medical licensure and obtains and verifies a majority of state specific documents to expedite the licensure process. The National Council on State Boards of Nursing also uses a repository to verify core requirements of nurses. Nursys® collects and disseminates licensure data for public verification of licenses, board of nursing to board of nursing verification, discipline actions, and acts as the central information source for participating boards. Participating boards of nursing have been regularly feeding licensure and discipline data into Nursys® since 1999. There are currently 41 boards of nursing providing data to Nursys®. Nursys® provides online verification to a nurse requesting to practice in another jurisdiction. Nursys® keeps information on actions taken against nurses licensed in participating states and their privileges to practice in other participating NLC states.

Despite their advantages, there remain challenges in using CVOs. The initial credential process is labor intensive in obtaining and verifying documents and there is a cost to the applicant in addition to the cost of a state license. Obtaining international documents can be difficult and time consuming which may lengthen the verification process. Furthermore, states may require additional forms or verifications above those provided by the CVO. The state may still be required to maintain and store the application documents. The time to obtain the core credential package added to the time to complete additional state specific requirements may extend the time needed to obtain a license.

LICENSURE PORTABILITY GRANTS AND OTHER RECENT INITIATIVES

LICENSURE PORTABILITY GRANTS

Licensure portability has become increasingly important in advancing the availability and acceptance of telehealth services as new technologies increase the effective use of telehealth services. In many isolated and underserved areas, health care markets do not correspond with readily available health care where state jurisdictional boundaries present “artificial” boundaries. License portability extends the benefits of electronic practice to maximize the availability of affordable and cost-effective health care across state jurisdictions.

Recognizing that the issues of licensure and the delivery of telehealth services were evolving and becoming more complex, the U.S. Congress passed the Health Care Safety Net Amendments of 2002, Public Law (P.L.) 107-251. Section 102 authorized the awarding of incentive grants to state professional licensing boards to promote cooperation and encourage development and implementation of state policies that will reduce statutory and regulatory barriers to telehealth.

In the context of this authorization, the Health Resources and Services Administration's Office for the Advancement of Telehealth (OAT) executed a contract in 2004 whereby the Federation of State Medical Boards and two groups of state medical boards began to design multi-state telehealth demonstration projects in their respective multi-state regions (in the northeast and west). The two regional groups worked together to achieve a consensus as the broad outline of the models they would develop, and they submitted a preliminary report.

In 2005, OAT continued to work with the FSMB to outline a model interstate agreement among the participating state boards to facilitate licensure portability across state boundaries. The report from this contract provided the initial groundwork to develop specifications for the technical and organizational infrastructure required to implement the model agreement. This included: 1) a model interstate agreement among the participating state boards; 2) technical assessments on each individual state board's information technology capabilities and identification of technical needs for implementation of such a model interstate agreement; 3) specifications of technical architecture required for implementation; 4) a feasibility analysis, including costs, associated with the practical implementation of two state licensure portability demonstration projects; and 5) feasibility analysis of implementing interstate agreements to additional jurisdictions.

Pursuant to the authorization of the Health Care Safety Net Amendments of 2002, (P.L. 107-251), in 2006, Congress appropriated funds for incentive grant awards to state professional licensing boards to promote cooperation and encourage development and implementation of state policies to reduce statutory and regulatory barriers to telehealth. In 2006, OAT built upon the lessons learned from its 2004 and 2005 contracts with the FSMB to develop and implement the Licensure Portability Grant Program (LPGP). The program is designed to leverage the experience of state licensing boards that have a strong record in implementing cross-border activities to overcome licensure barriers to the provision of telehealth services across many states.

The FSMB and the National Council of State Boards of Nursing (NCSBN) received LPGP awards in the first competition. Under a 3-year Licensure Portability grant, the FSMB developed model agreements in two regions of the country (northeast and west) to expedite the licensure process and eliminate redundancies associated with applying for licenses in multiple jurisdictions. The need to harmonize licensure rules across states also has been well recognized by the nursing profession. The Nurse License Compact (NLC) was developed by the NCSBN in the late 1990s. The mutual recognition model of nurse licensure allows a nurse to have one license (in state of residency) and to practice in other states (both in person and electronically), subject to each state's practice law and regulation. Under the Licensure Portability grant, the NCSBN pursued a range of activities to overcome the barriers to adopting the NLC. More specifically, the grant focused on providing pathways to facilitate the adoption of the Uniform Core Licensure Requirements, critical prerequisites to joining

the NLC. Under the grant program, two additional states adopted the Nurse Licensure Compact and six states implemented criminal background checks. The LPGP was competed again in fiscal year 2009 for funding up to three years and the FSMB was successful in securing funding. They will continue their efforts to reduce the barriers to cross-state licensure.

The American Recovery and Reinvestment Act of 2009 (ARRA), P. L. 111-5, provided additional funding to support licensure portability initiatives. The ARRA LPGP grantees will continue developing programs under which licensing boards of various states will cooperate to develop and implement policies that will reduce statutory and regulatory barriers to telehealth. These grants will continue to focus on licensure issues for physicians and nurses. ARRA funding is one time, up-front funding for 2 years. The FSMB and the Department of Regulation and Licensing, State of Wisconsin were awarded grants beginning in March 2010, for projects to be completed by February 2012.

MAJOR LICENSURE MODELS FOR NURSES AND PHYSICIANS

Although a number of health professions are studying the licensure issues, medicine and nursing have taken the lead at this point by adopting formal approaches to adapting state licensure requirements to accommodate practice across state lines. In 1996, the Federation of State Medical Boards adopted, *A Model Act to Regulate the Practice of Medicine Across State Lines*, calling on state medical boards to adopt a “special purpose license” to authorize limited practice in states other than the physician’s state of practice. According to the Federation, 16 states have adopted limited licensure models. Since that time, the Federation has initiated a number of other approaches to expanding licensure portability. The National Council of State Boards of Nursing approved a Nurse Licensure Compact in 1998, by which states could agree to recognize a license granted by another participating state. The following section will further describe initiatives taken by each of these organizations and review the specific challenges and/or concerns that have arisen in implementing these models.

NURSES

THE NATIONAL COUNCIL OF STATE BOARDS OF NURSING/ NURSE LICENSURE COMPACT MODEL

DESCRIPTION¹⁷

Founded in 1978 as an independent, 501(c)(3) not-for-profit organization, NCSBN can trace its roots to the American Nurses Association (ANA) Council on State Boards of Nursing. The leadership of NCSBN consists of the NCSBN Board of Directors and the NCSBN Delegate Assembly (representative of the 60 state boards of nursing). The member boards

¹⁷ The material presented in this section is based on information provided by the National Council of State Boards of Nursing that can be found at <https://www.ncsbn.org/2002.htm> and <https://www.ncsbn.org/156.htm>

that comprise NCSBN protect the public by ensuring that safe and competent nursing care is provided by licensed nurses. NCSBN is the vehicle through which boards of nursing act and counsel together on matters of common interest.

The NCSBN has developed a far reaching mutual recognition model for licensing nurses. In 1998, the NCSBN Delegate Assembly adopted model legislation for state mutual recognition of nurse licenses across state lines.

The NLC was first implemented on January 1, 2000, when it was passed into law by the first participating states: Maryland, Texas, Utah and Wisconsin. Currently 23 states participate in the NLC, with the 24th, Missouri, implementing it in June 2010 [List of Nurse Compact States – Attachment 1]. According to the NCSBN, Indiana applied to join the Compact, but was not admitted twice, due to material differences with their NLC laws. NCSBN has noted that Indiana supporters have indicated that they will re-introduce legislation to join the NLC in the near future. New Jersey had passed NLC legislation but because the law sunset, New Jersey is no longer a member of the NLC. However, the state has pending NLC legislation supported by the New Jersey Nurses Association.

Under the NLC mutual recognition model, practice across state lines is allowed, whether physical or electronic, unless the nurse is under discipline or a monitoring agreement that restricts practice across state lines. In order to achieve mutual recognition, each state must enter into an interstate compact, called the Nurse Licensure Compact (NLC).

The NLC allows a nurse to have one license (in his or her state of residency) and to practice in other states (both physically and electronically), subject to each state's practice laws and discipline. The license is held by the nurse in her primary state of residence (home state) that grants her a multistate licensure privilege to practice in other Compact states (remote states). Sources used to verify a nurse's primary residence for the NLC may include, but are not limited to, driver's license, federal income tax return or voter registration.

The NLC is similar to the compact that allows individuals to hold a driver's license in one state and drive in all other states within the United States. A person holding a driver's license in his/her home state is permitted to drive in other states without applying for a driver's license in every state he/she drives through. Though requirements for a driver's license are similar across states, each state may determine and vary its own licensure requirements. The NLC is similar in that it allows nurses licensed in their home Compact states to practice in other Compact states without seeking an additional nursing license. Another similarity to the driver's license model is that the NLC is implemented through laws passed by the legislature of each participating state. The essence of any state NLC law must permit the nursing board of that state to recognize individuals licensed as nurses from other participating Compact states.

Thus, the NLC is a legal contract between states. In each state that adopts the NLC, the NLC is an additional statutory layer above the individual state's Nurse Practice Act, which remains in place. Enactment of the NLC does not change a state's Nurse Practice Act. The NLC gives states additional authority in such areas as granting practice privileges, taking actions and sharing investigative information with other NLC states prior to taking disciplinary action against a nurse.

All states that currently belong to the NLC also operate the single state licensure model for those nurses who reside legally in a NLC state, but do not qualify for multi-state licensure. Moreover, the licensing authority in the state where an application is made retains the authority not to issue a license if the applicant does not meet the qualifications or standards for granting a license.

The NLC model legislation includes registered nurses (RNs) and licensed practical or vocational nurses (LPN/VNs), but did not include advanced practice nurses. A separate model compact was developed for advanced practice nurses. The remainder of this section will focus on the NLC.

Once the NLC is enacted, each Compact state designates a Nurse Licensure Compact Administrator to facilitate the exchange of information between the states relating to Compact nurse licensure and regulation. On January 10, 2000, the Nurse Licensure Compact Administrators (NLCA) was organized to protect the public's health and safety by promoting compliance with the laws governing the practice of nursing in each party state through the mutual recognition of party state licenses.

The NLCA develops rules and regulations to administer the Compact. Individual state boards of nursing in the NLC adopt the rules, and the rules must be promulgated according to each state's administrative procedures act. If an individual state refuses to adopt the rules the NLCA develops, that state would be in violation of the NLC contract and thus could lose the right to belong to the NLC.

Only the state where the nurse has declared residency and which issues the license under the Compact (home state) can take direct action against a nurse's license under the NLC. Action by that state means any administrative, civil or criminal penalty permitted by that state's laws which is imposed on a nurse by the board of nursing or other authority in the state of residency/licensure. This includes actions against an individual's license.

Nevertheless, the NLC provides that nurses are held accountable for complying with the nursing practice laws and other regulations in the state where the patient is located at the time care is rendered (state of practice), be it in their home state or in a remote state. The remote state is the Compact state that is not the state of residency/licensure and represents a new authority granted to the participants of the NLC. Remote state action is any administrative, civil or criminal penalty imposed on a nurse by a remote state's licensure board or other authority.

Under the NLC, disciplinary action can be taken by both the state of licensure ("state of residency" or "home state") and state of practice where the patient is located at the time an adverse incident has occurred. Complaints in a remote Compact state would be processed in the state the violation was reported to have occurred, and the action taken would also be reported to the state of residency. For example, the state of practice may issue a cease- and-desist order against the nurse, and the state of residency may also take disciplinary action against the license of that nurse. Many states choose to investigate the complaint in the state in which the incident occurred and transfer that information to the licensing board for action, so it is taken on the licensee only once.

The NCSBN has developed a coordinated licensure information system called Nursys® to enable the sharing of information. All information involving any action is accessible to all NLC states. Additional information in Nursys® is also available to participating non-Compact states.

Every state in the Compact must report any actions taken to the Nursys® database. The remote NLC state must report any significant current investigations underway regarding complaints lodged against nurses in the state. The home state will be notified through Nursys® of any significant investigative information and any actions on the privilege to practice in the remote state. All NLC states share contact information for persons undergoing a current investigation.

BENEFITS OF THE NURSE COMPACT MODEL

According to the NLCA, the NLC offers the following benefits for advancing nurse practice in the United States:

- It clarifies the authority to practice for many nurses currently engaged in providing telehealth services or practicing across state lines.
- It simplifies and streamlines the burden and cost of obtaining multiple licenses to practice in multiple states, thereby enhancing the mobility of nurses.
- It improves access to nursing care, especially in the modern age of electronic practice where nurse can electronically be brought to the patient, wherever they may be, which may not be congruent with the boundaries of state geographic borders.
- It enhances the ability of licensed nurses to respond to disasters or respond to changes in the demand for qualified nursing services.
- It enhances the ability of state nursing boards to exercise discipline over nurse aberrant behavior; through ready exchange of investigatory information, the Compact states have the most current and accurate information in order to better determine the appropriate course of action in disciplinary cases.

Many groups have endorsed the nurse compact model, including many state nurse associations, largely reflecting their belief that the Compact will simplify government processes and remove regulatory barriers to increase access to safe nursing care as nursing practice is no longer easily defined by geographic boundaries. In their support of the Compact, these groups frequently cite its role in facilitating cross-state practice and the mobility of the nursing workforce that is a growing fact of life in modern nursing. The need to practice across state lines can be a significant factor in health care practices involving nurse advice lines, telehealth, long distance monitoring of patients, and hospital follow-up care.

Examples of the national groups supporting the Compact are: American Academy of Ambulatory Care Nursing, American Nephrology Nurses Association, American Telemedicine Association, American Association of Occupational Health Nurses, American Organization of Nurse Executives, Case Management Leadership Coalition and Case Management Society of America, Disease Management Association of America, the Emergency Nurses Association, and the Center for Telehealth and E-Health Law. Several

state nursing associations have expressed support for the Compact, including the Arkansas, Idaho, and Texas Nurses Associations.

Additional support for the Compact has been provided by the National Governors Association's State Alliance for e-Health. In its "First Annual Report and Recommendations from the State Alliance for e-Health," the Alliance recommended that governors and state legislators should direct their state's nursing board to participate in the NLC. Moreover, they recommended that governors and state legislatures should provide financial support to the nursing boards for the initial implementation of the NLC and ensure that the boards are funded at levels needed to assure public protection operations.¹⁸

CHALLENGES/BARRIERS

Despite the many groups that have supported the NLC, one very important group has expressed concerns about it. In 1998, the American Nurses Association (ANA) first introduced the mutual recognition concept at its House of Delegates (HOD) and it resulted in a resolution outlining 14 issues the HOD believed must be addressed for the ANA to support the Compact model. The 14 points of concern were reduced to 7 talking points in 2007. It should be noted that the talking points were not based on empirical research or evaluation of the Compact.

The ANA has chosen not to endorse the model but has not revisited this issue since 2007. It maintains that official support or opposition to the model is within the purview of individual state nursing associations. In states where the state nurse associations and others have opposed the NLC, a variety of reasons have been given for the opposition, but most frequently these 7 talking points are cited. As such, it is important to understand the points being raised, as well as the National Council's response. The detailed ANA talking points and the NCSBN responses are provided in the Appendix.

Although the reasons for opposing the Compact vary state-to-state, the persistent challenges to adoption of the NLC can be categorized into five broad groups:

- Control/Loss of Authority
- Lack of Uniform Standards
- Costs/Loss of Revenue
- Strike Breaking
- Perception vs. Actual Experience/Lack of Independent Evaluation

Control/Loss of Authority: In order to adopt the NLC, each state must pass legislation enacting the Compact. Subsequent to enactment of the Compact, each state appoints a Compact Administrator to oversee the Compact in his/her own state, who also participates in the Nurse Licensure Compact Administrators (NLCA). The NLCA oversee implementation of the Compact and establish basic standards for operating within the Compact, including

¹⁸ National Governors Association, ACCELERATING PROGRESS: Using Health Information Technology and Electronic Health Information Exchange to Improve Care, page 37, 2008.

development of uniform rules to facilitate and coordinate implementation of this Compact. These uniform rules must be adopted by each state before it can enter the Compact. As such, some legislators, boards and nursing associations have come to see the NLCA as a third tier of government to which they must respond. This is particularly an issue for some nurse associations and unions who believe that the NLCA will be less responsive to their concerns than their own state board. Opposition to the Compact also arises from concerns regarding the ability to enforce nurse practice acts, especially with regard to disciplinary actions against nurses who practice in their state but do not reside in the state. As noted in the Appendix, nothing in the NLC abrogates state practice acts or the obligation of state boards to oversee nurse practice in their state.

Lack of Uniform Standards: The multi-jurisdictional nature of the Compact agreement assumes a level of trust among the licensing boards to carry out responsibilities in a thorough and responsible manner to ensure the protection of their citizens. Because of variations in state nurse practice acts and administrative practices, this level of trust is not always shared, although the Compact has introduced greater harmonization of standards through its core requirements. The NLC promotes a set of core licensure requirements, but it does not supersede each state's nurse practice act and procedures. Underlying the opposition to joining the Compact by some state boards is the perception that other states in the Compact do not uniformly adhere to the same vigorous standards for administration, reporting, and discipline as they do. Moreover, not all states have implemented the core licensure requirements. For example, criminal background checks (CBCs) are a core licensure requirement adopted by the NCSBN Delegate Assembly. Currently, 17 of the 23 states participating in the NLC are conducting fingerprint based state and federal CBCs. The remaining states continue to work on getting legislation passed to grant them the statutory authority that is necessary in order to obtain the CBCs, but there are sometimes statutory barriers in the states to doing so. Further, there are often associated costs to implementing some of these core requirements (See discussion of costs below).

As noted above, states are required to investigate nurses who practice in their state (either physically or electronically) and who have been accused of violating the state's nurse practice act. If the nurse does not reside in their state, the state cannot revoke the nurse's license, but can revoke the nurse's privilege to practice in their state and the state must report its findings to Nursys®. Moreover, the Compact allows participating states to share pre-decisional investigatory information, allowing party states to determine whether it should deny a nurse the privilege to practice in their state, pending the outcome of any investigations in other party states. This provides an added protection for the public against venue shopping by nurses that may be under investigation, but provides an opportunity for party states to determine for themselves what actions, if any, they wish to take under these circumstances.

Cost/Revenue Losses: The ANA and others opposing the Compact have noted that there are significant costs, which a state must incur when implementing the Compact. For example, there are associated IT costs (hardware and software) in implementing Nursys®. Potential ongoing staffing costs include additional staff to administer the Compact, oversee criminal background checks, report disciplinary actions, and conduct investigations. Although some of these additional costs might be ultimately offset by savings, the state boards do not necessarily have the funds to make the up-front investments or support expanded operational costs, especially at this time of declining budgets. Nor do the boards necessarily control their

budgets, as some nursing boards are part of conglomerate boards that oversee several professional groups, wherein the nursing board does not have independent authority to set its priorities, control its budget, or conduct disciplinary investigations.

In addition to concerns about the potential for increased costs of implementing the Compact, opposition to the Compact has also centered on potential revenue losses. Many states rely upon licensure fees to sustain their operating expenses. Under the Compact, states can lose revenues from out-of-state nurses who practice in their states that formerly would have had to obtain a license to practice in their states. At the same time, these states could experience increased costs associated with investigations and discipline actions that might need to be taken against errant out-of-state nurses. The ANA in its 2007 talking points noted that a number of Compact states estimated that they would see increased costs and decreased out-of-state licensure revenues as a result of implementing the Compact.

In 2008 and 2009, 14 Compact states participated in an analysis of the actual fiscal impact on states adopting the Compact. Funding for the study was provided by a Licensure Portability grant from the Office for the Advancement of Telehealth. Cost information was collected focusing on the following four main areas: IT costs, communication costs, administrative costs, and revenue changes. Among the 15 states, two states indicated that the implementation of the NLC did not have any specific fiscal impacts for them, therefore, no actual expense figures were provided. For the remaining 13 states, there were significant variations in the expenditures for setting-up the NLC, the costs ranging from \$8,350 to \$216,000. These set-up costs primarily involved administrative expenses which included adding a separate NLC administrator position (not required by implementing the NLC), employing temporary staff as well as the costs related to workload increase at the early stage of implementing the NLC. The revenue gains and losses following entry into the NLC were related to increases or decreases in the number of new applications based on the new NLC state of residence rule. They are primarily involved with: 1) licensure renewals, 2) endorsements, 3) verifications of credentials, and 4) temporary practice permits.

As noted by the NCSBN, the operational cost data also revealed significant variations from state to state. A possible cause for having the large variations in the fiscal impacts on state boards for implementing the NLC could be related to the technical and human resources of the boards as well as residency of the practicing nurses in those states. The study further showed a positive relationship between the number of licensees registered in a state and the costs of implementing the NLC. This suggests a tendency that the larger the nursing population in a state, the more likely the cost of implementing the NLC could be, but this finding was not found to be statistically significant. On average, the total cost of implementing the NLC was \$78,448, ranging from having a gain of \$112,800 to a loss of \$343,000. The study authors estimate that an average cost of \$1.17 per licensee could be used to estimate the total cost of entry.

Since states participated in the NLC at different time periods ranging from 2000 to 2007, the NCSBN further examined if there were any differences in the reported costs between those states who participated in the NLC five years earlier compared to more recent participants. On average, the six states (50 percent) who entered the NLC before 2003 reported a much

lower cost than the six (50 percent) who entered into the NLC after 2003, even though this difference is not statistically significant¹⁹.

Strike Breaking: With the exception of Texas, the Compact is currently composed of medium and small states in which union presence is not as strong as in some of the large, non-compact states (e.g., New York, California). Moreover, 14 of the 24 states in the Compact, as of June, are "Right-to-Work" states (58 percent), compared to 31 percent of the non-compact states.

In some of the non-compact states, unions and the state nurses associations have opposed the Compact in part based on their belief that it would facilitate strikebreaking. Thus, if the Compact is to significantly grow, it must address this concern. It should be noted, however, that in the states that have implemented the Compact, there has been no evidence presented that associates the NLC with strikebreaking.

Moreover, to the extent an individual state is concerned about the strikebreaking potential of the Compact, it can include language in the Compact agreement explicitly stating that the NLC does not supersede any existing labor law. Further, under the current single state licensure system, it is possible to utilize nurses from other states in strike situations. However, there are many obstacles and considerations to the physical relocation of nurses. The implementation of NLC is unlikely to reduce these practical obstacles to facilitate strikebreaking.

Perception vs. Actual Experience/Lack of Independent Evaluation: Since the first state entered into the Compact in 1998, there has been two evaluations of the Compact model. In December of 2003, NCSBN provided an impact evaluation, conducted by the Gallup Corporation, of the Compact which included information from eleven boards of nursing in Compact states, and in 2009, a fiscal impact study was conducted by the NCSBN. Opposition to the Compact is often based on perceived barriers to the Compact, including those voiced by the ANA talking points, but not based on actual experience. The Gallup evaluation provided some early data on the Compact, but failed to address many of the underlying issues raised by the ANA. Perhaps more importantly, the Gallup evaluation reflected the early experience of the Compact states rather than the over nine years of experience of Compact states. For example, it would be helpful to have an independent evaluation of the benefits of the Compact in providing pre-decisional disciplinary information to the states in preventing errant nurses from practicing in a state or the impact on efficiency of the licensure process in a state.¹⁹

APPROACHES TO ADDRESSING THE CHALLENGES

Despite the challenges discussed above, the NLC has proven itself to be a resilient model over the past 10 years. Nevertheless, for this model to significantly impact licensure portability, more states will need to join. It has been posited that a minimum of 30-35 states will need to join the NLC before a "tipping point" is reached wherein the Compact becomes

¹⁹ NCSBN Research Department, National Council of State Boards of Nursing: Nurse Licensure Compact Economic Model Evaluation Update (May 2009) found at: https://www.ncsbn.org/FinancialModelReport_0529.pdf

the predominant model of licensure in the United States. However, given the slow rate of adoption in the past six years, it will require a concerted effort on the part of the NCSBN and the NCLA for this tipping point to be reached. The following actions/activities are either underway or have been proposed as strategies for addressing some of the challenges discussed above.

Harmonization of Standards/Criminal Background Checks: To facilitate state adoption of the NLC, adherence to the NCSBN's Uniform Licensure Requirements is an increasingly important step to overcome objections that arise from a lack of common standards among the states. Ultimately, NCSBN and its member boards know that adoption of these requirements will diminish concerns over disparate qualifications for licensure in the compact states. The NCSBN Committee on Uniform Licensure Requirements is revisiting this issue and is slated to release its recommendations by August, 2010.

A critical licensure requirement is the conduct of Federal criminal background checks (CBC) on all nurses applying for a license to practice. Crimes may relate adversely to an individual's ability to practice nursing safely. Boards of nursing perform criminal background checks to identify individuals who may pose a threat to the health, safety, and welfare of the public. One barrier to states implementing CBCs is cost. Costs include software for fingerprint tracking, support staff to assist with mailings and data entry, postage, staff training, etc. Moreover, in certain states, specific legislation must be passed to authorize state boards to conduct these checks. Under the Licensure Portability Grant Program, the NCSBN provided funds that enabled six states to adopt CBCs. One of the major barriers encountered in this project was the inability of states to be able to share criminal background checks with each other. Under the FBI's current regulations each state needs to request (and each nurse must pay for) its own criminal background check on a nurse, even if that nurse has undergone a recent check (or simultaneous check) in another state. This process can cause unnecessary duplication and costs in the system.

NCSBN is vigorously supporting state boards in their implementation of criminal background checks, irrespective of their being in the NLC. However, the NCSBN is looking to reduce the costs of doing so by finding an appropriate mechanism for states to share this information without individually having to conduct background checks on nurses seeking to practice in multiple states. To this end, they are working with the FBI and the Department of Justice to explore the concepts surrounding the sharing of criminal background check information as it could relate to facilitating nurse licensure portability. In particular, the NCSBN is exploring strategies to promote state adoption of the National Crime Prevention and Privacy Compact (NCPPC).²⁰ The NCPPC facilitates electronic information sharing among the Federal Government and the states and permits the exchange of criminal history records for noncriminal justice purposes when authorized by federal or state law. State ratification of the NCPPC provides the legal framework for the establishment of a cooperative Federal-State system for the interstate exchange of criminal history records for noncriminal justice uses. Federal agencies conducting background checks for employment and licensing purposes benefit from receipt of the most complete and accurate criminal

²⁰ On October 9, 1998, President Clinton signed into law the National Crime Prevention and Privacy Compact Act of 1998 (Compact) United States Code, (U.S.C.) Title 42, Chapter 140, Subchapter II, Sections 14611-14616.

history record investigations (CHRI) available. Adoption of the NCPPC would lower the cost of CBCs for states and facilitate the accurate and timely sharing of critical criminal background information.

Evaluation: An independent evaluation of the impact of the NLC, both positive and negative, offers the promise of correcting misinformation regarding the Compact and offers opportunities for states to work together to address any continuing issues that have arisen from the Compact, based on fact and not fear. This evaluation should provide empirical data, not simply interview data, on the impact of the Compact on employers, nurses, board licensure efficiency, the disciplinary process, and on workforce mobility.

Education: Despite significant progress in reaching out to state boards and providing cogent educational materials about the NLC, significant misconceptions remain. Although some of these could be addressed by the evaluation suggested above, the best data and research often has limited impact on public policies unless coupled with a focused strategy for disseminating this information. For the NLC to expand, a concerted educational outreach strategy needs to be pursued that is customized to the different non-compact states and their particular issues.

Funding: Additional resources will need to be devoted to overcoming many of the barriers discussed above, some of which will require external sources of funding, given the current crisis in state budgets. Until recently, issues of state licensure have not been a high priority in the states, given the myriad of other challenges they face. However, recent negative publicity regarding the adequacy of the licensure process in large states, such as California and Illinois, states may be rethinking their priorities.²¹

PHYSICIANS

Unlike the nurses, the states have not yet come to a consensus for a model for cross-state licensure for physicians. Currently, there are 735,000 active licensed physicians in the United States. Some physicians are licensed in one state, others in more than one. Physicians licensed in more than one state may have gone through the onerous process of initial licensure in the new state. However, some physicians may have obtained a license in the new state if the new state acknowledged the license issued by the original state by a model of endorsement. Approximately, 22 percent of all active licensed physicians hold multiple licenses.

The Federation of State Medical Boards and the State Alliance for e-Health have been studying the issues of licensure portability for physicians and have set forth some recommendations for improvement of the process.

FEDERATION OF STATE MEDICAL BOARDS

²¹ http://www.propublica.org/site/author/charles_ornstein

DESCRIPTION²²

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing medical boards in the United States and its territories. Responding to changes in the delivery of health care over the last two decades, the FSMB has incrementally addressed the issue of license portability. An Ad Hoc Committee on Licensure by Endorsement was formed in 1995. The Ad Hoc Committee identified the need for a centralized system for primary source verification and archiving of core physician credentials on behalf of state medical boards, as well as the need to address regulatory issues associated with telehealth and barriers to license portability. The policy that resulted from the Ad Hoc Committee on Licensure by Endorsement led to the development of the Federation Credentials Verification Service (FCVS) and the policy, *Report of the Ad Hoc Committee on Licensure by Endorsement*.

In 1996, the FSMB adopted *A Model Act to Regulate the Practice of Medicine Across State Lines*. This model act required physicians who frequently engaged in the practice of medicine across state lines, by electronic or other means, to obtain a special license issued by the state medical board. As with limited licensure, physicians holding a special license would be prohibited from physically practicing medicine within the state unless a full and unrestricted license was obtained. It subjects the licensee to the Medical Practice Act of the issuing state, and to the regulatory authority of the state's medical board. Each state would have the option of denying such a special license but would be encouraged to issue the license if it found that the applicant would not present a threat to the public. The Model Act would narrow the consultation exception to ad hoc consultations which are neither compensated nor performed under a contractual relationship.

Recognizing that barriers continued to exist that impeded implementation of an expedient process for licensure by endorsement, the Special Committee on Uniform Standards and Procedures set forth recommendations to improve consistency of licensure requirements and disciplinary terminology and processes in 1998. In April 2000, the FSMB established the Special Committee on License Portability to explore mechanisms that could significantly improve the portability of state medical licensure. The Committee evaluated licensure models including the mutual recognition model utilized in Australia and proposed in Canada, as well as the licensure compact model developed by the National Council of State Boards of Nursing. The Committee recommended that state medical boards offer an expedited licensure process for physicians meeting identified and accepted standards. The expedited licensure process would be also dependent upon the development of a standard medical license application and acceptance of established standards for primary source verification of physician core credentials.²³

In 2004 and 2005, the Office for the Advancement of Telehealth (OAT) contracted with the FSMB to outline a model interstate agreement among the participating state boards to facilitate licensure portability across state boundaries that would incorporate lessons learned from FSMB's prior activities. In 2006, OAT further built on its previous efforts with FSMB and implemented the Licensure Portability Grant Program, pursuant to the authorization of

²² The material presented in this section is based on information provided by the Federation of State Medical Boards. Additional information can be found at: <http://www.fsmb.org/>.

²³ Federation of State Medical Boards, Report of the Special Committee on License Portability, 2002.

the Health Care Safety Net Amendments of 2002 (P.L. 107-251). The FSMB received Licensure Portability grants in 2006 and 2009. The grant program is designed to leverage the experience of state licensing boards that have a strong record in implementing cross-border activities to overcome licensure barriers to the provision of telehealth services across many states.

Under the first grant, FSMB targeted their project on the adoption of the Common Licensure Application Form (CLAF), the integration with FCVS, and licensure endorsement agreements. The CLAF was a common license application form that resided at the FSMB and was well positioned to work in conjunction with the previously developed FCVS. The FCVS was established to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials. The FSMB believed that adoption of the CLAF, together with adoption of the FCVS and licensure through endorsement, would greatly expedite license portability.

The FSMB's original focus of the grant was for participating state medical boards to scan and share licensure documents in an electronic format²⁴. The new approach for the second grant, awarded in 2009, is to build on the successes of the first grant and encourage states to adopt the Uniform Application (UA) and expedited endorsement agreements.

Historically, endorsement meant that a physician must apply in the state they wished to practice. Endorsement is based on acceptance of original license examination and active status with other state medical boards. With endorsement, all credentials typically have to be re-verified. Under the Licensure Portability grant, the FSMB has worked to streamline the endorsement process, referred to as the "Expedited Endorsement Model." To qualify for licensure under expedited endorsement, an applicant must be licensed in another state and be eligible for primary source verification of core credentials from the state in which the physician was originally licensed; demonstrate currency (i.e. current specialty board certification); be in good standing in all other states licensed; and have no formal disciplinary actions or pending investigations. States are entitled to develop their own criteria but, at a minimum, the above criterion is commonly used.

BENEFITS OF EXPEDITED ENDORSEMENT

The level of cooperation among health licensing boards has improved significantly since the initial telehealth program was funded. Over the last five years, regulatory boards have worked together to improve the license portability process and promote the effective use of technologies to improve access to health services. Initially, there were 14 state boards participating in the license portability grant program. Today, there are 19 state boards participating in the program [List of Portability States – Attachment 3]. An additional ten state medical boards are implementing one or more elements to improve the medical licensure process.

The expedited endorsement model saves time and personnel costs to the state licensing agency and is a less labor and time intensive application process for the applicant. The physician is able to enter practice within the state in a shorter time frame. Public safety is

²⁴ A Detailed History of FSMB's grant project is attached in Attachment 1.

assured by the negative practice history, national database information and criminal background checks.

According to the FSMB, expedited endorsement also offers the following benefits for advancing physician practice in the United States:

- A faster licensing process saves staff and applicants time and money.
- Licensing faster is advantageous for physicians, patients and the state.
- Boards determine their own criteria. The fewer the criteria, the faster the process.
- Staff can devote more time to the “problem” applicants or other duties.
- Can revise processes to get more meaningful data.
- Governors, Congress, medical and hospital associations, and group practices all desire faster licensing processes and support the work FSMB is doing.

There are other benefits of expedited licensure by endorsement. State medical boards, that adopt uniform core requirements, a uniform application (UA), and a credential verification organization, save time and money for the physician and the medical board. States would be more likely to trust the licensing process of another state if the core requirements were standardized. The UA eliminates the requirement for the physician to fill out an application for each state. The UA can quickly be sent electronically to multiple states. The application is also maintained for future use.

The FCVS allows the applicant to complete the basic credential package and send information to multiple states. The credentials are maintained by the FCVS and may require only minimal additional information to update and expedite the application process for another state licensing application.

CHALLENGES/BARRIERS

Unfortunately, some states are uncomfortable with accepting the licensing process of other states. Some state medical boards have a number of concerns with the expedited endorsement process. Each state board determines their own criteria, and requirements differ from state to state. For example, not every state board requires criminal background checks. State boards are ultimately responsible for maintaining public protection within the state and may be unwilling to expedite the license of a physician who has not undergone a criminal background check.

In many states, there are also internal challenges. Some states oppose expedited endorsement because there are significant costs associated with it. For example, there are associated IT costs (hardware and software) in implementing the UA and FCVS. Some medical boards do not necessarily control their budgets and are part of conglomerate boards ("Umbrella Boards") that oversee several professional groups. As such, the medical board does not have independent authority to set its priorities, control its budget or conduct disciplinary investigations. The state structure is a huge issue because medical boards within a bureaucracy may have little authority and may be discouraged from taking innovative independent action. The FSMB supports the notion that medical boards have independent governance.

Opposition to expedited endorsement has also centered on potential revenue losses. Many states rely upon licensure fees to sustain their operating expenses. Under expedited endorsement, states can lose revenues from out-of-state physicians who practice in their states that formerly would have had to obtain a license to practice in their states. At the same time, these states could experience increased costs associated with investigations and discipline actions that might need to be taken against out-of-state physicians.

Another impeding barrier to portability is a lack of uniformity in state confidentiality laws. Specifically, the inability of state medical regulatory agencies to share investigative and complaint information is a barrier to gaining widespread support for adoption and implementation of an expedited licensure process. The inability to share such information compromises public protection and interferes with boards' ability to make an informed decision concerning a license application.

Additional barriers include inadequate human and financial resources to incorporate technological enhancements to accommodate the UA, as well as the differences between required credentials and methods of verification among the states.

Lastly, a significant barrier is the current economic environment and the lack of resources (both economic and technological capabilities) which prohibits state agencies from incorporating technological advancements into the licensure process. This is significant because information technology capabilities vary greatly among states.

APPROACHES TO ADDRESSING THE CHALLENGES

PROMOTION OF ENABLERS TO EXPEDITE LICENSE PORTABILITY

The Federation of State Medical Boards

The CLAF was initially designed as a paper form and not readily available online. The CLAF was ultimately enhanced and repackaged as the Uniform Application for Physician Medical Licensure (UA). The UA offers basic information required by all boards, an addendum for state-specific questions and an executed affirmation and is available online. The UA was first implemented 2008.

State medical boards (SMBs) see the evolving UA as an opportunity for major improvement in licensure for physicians seeking initial licensure and licensure by endorsement. As the UA is enhanced, currently licensed physicians seeking licensure in another state will be able to retrieve their completed online UA, update it, fill in state-specific addenda and submit a processing fee online to have the entire application submitted to one or more states at a time. The online application can reduce redundancy in paper work and facilitate licensure portability. With the UA, applications can be sent to states within five minutes and state-specific addenda will be sent via the U.S. Postal Service normally within one week. Applicants can use the FCVS to expedite the process further. Seventy percent of the UA data is pre-populated from FCVS. Currently, 25 state medical boards are in some phase of implementation of the uniform application [List of State Boards Participating in UA – Attachment 4]. Eight states are using the online version, two states are using the paper version, and 15 states are navigating through the implementation process.

The original FCVS, established by the FSMB in 1996, has not kept pace with the evolving board and physician needs. The FCVS charges a fee for gathering and forwarding the initial profile and only a processing fee for forwarding additional profiles. The average processing time to collect and forward the initial profile was approximately 8 weeks. Once the permanent file was established, subsequent requests were typically forwarded within 2-3 weeks. Recognizing that a centralized credentials verification organization was critical to the advancement of license portability and that FCVS did not have the capacity to support and significantly impact license portability, the FSMB board of directors approved and initiated a project to redesign the FCVS work processes, portal, communication and data management systems. With financial assistance from HRSA, this project began in September 2009 and a new and improved FCVS will launch in December 2010. From December 2010 to November 2011 and from December 2011 to November 2012, the FSMB will use HRSA funds and funds from other sources for continuous improvement and refinements to the new FCVS system. FSMB has engaged stakeholders, including representatives of state medical boards and Administrators in Medicine, to provide input and expertise to the comprehensive project. Currently, all states except Arkansas and Nebraska accept the FCVS and about twelve states require it [List of State Boards Accepting FCVS – Attachment 5].

The FSMB recognizes that administrative inconsistency and the general lack of medical board autonomy in key operational areas pose grave threats to the future of state-based regulation, and thus has crafted recommendations to improve consistency and promote uniform standards for the effective regulation of the medical profession.

State requirements for medical licensure are very close to uniform. All states use national standards such as graduation from an accredited medical school and attainment of a passing score on the medical licensing examination.^{25,26} Further, while the number of years may vary somewhat from state to state, all states require some level of post-medical school training. Alternatively, not all state medical boards require criminal background checks as part of the licensure application process. Criminal background checks (CBCs) are requested by the state and performed by the Federal Bureau of Investigation. The physician is required to pay for a CBC for each state he or she is applying to get a medical license because the state medical boards are not permitted to share investigative information. Streamlining this process would help ease the burden to states and physicians interested in obtaining multiple state licenses. Establishing a mechanism to share information from the National Practitioner Data Bank, Federal Bureau of Investigation criminal background information, and other investigative/disciplinary information would provide additional efficiencies within the licensure process.

Utilizing enablers such as a uniform application, and a credential verification organization, and the development of uniform core requirements, some states have recognized the licenses issued by other states through expedited endorsement agreements. Expedited endorsement is a method of setting criteria to approve a valid license of another state. The process accepts a license issued in another state that was verified and sets requirements for endorsing a license

²⁵ United States Medical Licensing Examination - <http://www.usmle.org/>

²⁶ National Board of Osteopathic Medical Examiners, Inc. - <http://www.nbome.org/>

granted in another state. These requirements may include a specified period of time that the individual has held a valid state license, an absence of disciplinary history, restriction or limitation on the license, board certification by a state approved certification authority, and a non-significant or absent malpractice history. The applicant may be asked to affirm their qualifications and/or complete a streamlined application to obtain licensure. Public safety is assured by verification with national physician databases and criminal background check requirements. Idaho, Michigan, Nevada, New Mexico, Rhode Island and Oregon currently use an expedited endorsement process and North Carolina and Wyoming are in the process of adopting rules to allow a similar process in their states.

The grants administered under OAT have helped support the development of the Uniform Application and enhancement of the FCVS. The FSMB recommends that state medical boards acknowledge the licenses issued by another state by the method of endorsement. The FSMB encourages state medical boards to simplify administrative tasks through the use of the UA and the FCVS. The grants also provided funds to bring participating boards together to discuss and evaluate portability models that will facilitate cross-border practice, including the expansion of telehealth services. State medical boards' primary responsibility is public protection and any model that has the potential to compromise such public protection is not considered viable.

The FSMB will continue to enhance the UA and the FCVS. The FSMB will also encourage states to adopt uniform core requirements which are acceptable to certain states in order for physicians to obtain an expedited license.

State Alliance for E-Health

In 2009, the State Alliance for E-Health issued recommendations in its first annual report, *Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care*. Included in the report was a recommendation to streamline the licensure process to enable cross-state e-health.

The State Alliance proposed two stages for addressing the issue. First, the states should streamline the licensure application and credentials verification processes to allow providers to more easily apply for a license in multiple states. Second, the State Alliance encouraged states to consider ways to accommodate e-health (including telemedicine and telepharmacy) practice while still maintaining state-based jurisdiction.²⁷

On February 5-6th, 2009, a group of 40 people representing 22 State Medical Boards, the National Governors Association Center for Best Practices, the Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services (HHS), and the Federation of State Medical Boards (FSMB) met to establish a consensus-based approach to streamline the licensure process for physicians in such a way as to ensure licensure recognition by other states. The participants in the State Alliance for e-Health License Portability Summit were challenged to build a model that would provide a platform for most states to participate in a license portability process.

²⁷ National Governors Association, [ACCELERATING PROGRESS: Using Health Information Technology and Electronic Health Information Exchange to Improve Care](#), page 33, 2008.

Consensus from this meeting provided a model to expedite the processing of licenses and improve license portability that included the proliferation of a uniform licensure application, use of a centralized credentials verification organization, and development of a set of a core credentials, criteria and acceptable verification sources that could be commonly adopted for an expedited licensure process for physicians with an existing license in another state. The advantages of such a model include increased efficiencies through the use of a standardized electronic application accepted by the majority of states and reduced redundancies in credentials verification.²⁸

OPTIONS FOR NEXT STEPS

As noted above, considerable progress has been made in promoting licensure portability for both nurses and physicians, but much remains to be done if the U.S. is to achieve true licensure portability for health professionals. This report focused on licensure portability for physicians and nurses. However, great variation exists in the licensure laws for other practitioners such as pharmacists, psychologists, therapists, dentists and other professionals dispensing health care services. A practitioner must be licensed, or follow state reciprocity rules, prior to working in a state. Given the challenges of ensuring an adequate workforce, licensure issues for these health professionals will need to be addressed, including related issues that go beyond cross-state practice to issues of scope of practice and harmonization of standards.

With regard to nurses and physicians, a number of different strategies/activities are underway to advance licensure portability, some of which have been described above.

1. **Criminal Background Checks:** Not every state requires a CBC and thus some states may be reluctant to acknowledge the license of a state that does not require a CBC for either physicians or nurses. CBCs are requested by the state and performed by the Federal Bureau of Investigation (FBI). The applying nurse or physician is responsible for covering the fee for the CBC. The applicant must pay a fee for each separate state they intend to be licensed. The FBI can only share the results of the CBC with another investigative authority. The information may not be shared between state licensing boards. The CBC process is a significant barrier to obtaining multiple state licenses. The NCSBN is looking to reduce the costs of all states implementing CBS by finding an appropriate mechanism for states to share this information without individually having to conduct background checks on nurses seeking to practice in multiple states. As noted above, the Council is exploring strategies to promote state adoption of the National Crime Prevention and Privacy Compact (NCPPC).
2. **Independent Evaluations:** Independent outside evaluations of both the Nurse Licensure Compact and the FSMB portability states that have adopted expedited endorsement need to be performed. These evaluations would provide objective

²⁸ State Alliance for e-Health License Portability Summit, February 5-6, 2009, Summary Document.

assessments of the impact of these licensure portability initiatives that would help dispel misconceptions and identify areas for improvement.

3. **Implementation Toolkits:** There is a need to develop better “tools” to assist states in the adoption of the NLC and expedited licenses. These toolkits should be web-based, interactive “manuals” that are based on the experience of successful states in adopting streamlined approaches to licensure. Ideally, they would also reflect the findings from the independent evaluations suggested above.
4. **Harmonization of Standards and Reporting:** Ultimately, the NCSBN and its member boards know that adoption of uniform core requirements will diminish concerns over disparate qualifications for licensure and promote adoption of the Compact. And even in single licensure states, adoption of the uniform requirements should contribute to improved quality of the nursing workforce. To this end, the NCSBN formed a committee to revisit its current uniform core licensure requirements and make recommendations for improving harmonization of these standards across states. The committee’s report is due to be released by August, 2010. The NCSBN is also working to expand state reporting to Nursys® to all licensure jurisdictions. This expansion should facilitate timely nurse and state board access to credential and disciplinary information, which are critical enablers to licensure portability.

As noted above, the FSMB is pursuing a variety of strategies to enhance deployment of expedited licenses and adoption of the Uniform Licensure Application. One of the issues being pursued by the State Alliance for e-Health is harmonizing the attestation clauses in the Uniform Licensure Application. The State Alliance for e-Health is trying to simplify the licensure process even further by coming up with uniform language for attestation clauses. Currently, states use different attestation clauses in their applications. The goal is to bring together state board attorneys in certain states and have them create and agree on uniform language for attestation clauses.

5. **Licensure Portability Grants:** The American Recovery and Reinvestment Act of 2009 (ARRA), P. L. 111-5, provided additional funding to support licensure portability initiatives. The ARRA LPGA grantees will continue developing programs under which licensing boards of various states will cooperate to develop and implement policies that will reduce statutory and regulatory barriers to telehealth. These grants will continue to focus on licensure issues for physicians and nurses. ARRA funding is one time, up-front funding for 2 years. The FSMB and the Department of Regulation and Licensing, State of Wisconsin were awarded grants beginning in March 2010, for projects to be completed by February 2012. In addition, future competitions will be focused on specifically addressing barriers that have been identified above and will likely emerge.

CONCLUSION

For the past 5 years, HRSA has engaged in funding activities to promote states adopting regulations or legislation to allow physicians and nurses to practice across state lines. These

efforts have seen some successes: 1) the Nurse Licensure Compact has been adopted in 23 states, with the 24th, Missouri, implementing it in June 2010; 2) 19 states participating in the Licensure Portability Grant Program have begun using multiple models and tools developed to promote physician licensure portability, including an online uniform application, participation in centralized credentialing verification, and increased progress to states entering into licensure by endorsement of physicians outside of their own state.

However, states have increasingly experienced difficulties in adopting the very systems that would facilitate licensure portability. Some states are still unable to implement the systems that are currently available or to participate in building the information systems that support licensure portability, such as fingerprint scanning equipment to facilitate FBI criminal background checks, or IT infrastructure to facilitate electronic processing. Given the financial crisis states are experiencing, the states have been forced to reduce their workforce in all areas, including the licensing boards, making it even more difficult for states to engage in adopting new systems or even effectively implementing those they already have. Greater Federal support may be needed to assist states in adopting the very reforms necessary to enhance the efficiency and effectiveness of their licensure processes.

Finally, as noted above, the Federal Communications Commission released its National Broadband Plan in March 2010, which advised the states to revise their licensure requirements to enable e-care (electronic health care practice). In its plan, the FCC recommended that if collaboration between state governors and state legislators failed to develop effective licensure policies to reduce barriers to electronic practice across state lines within the next 18 months, then the Congress should intervene to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care. The legal and practical challenges of achieving significant progress in licensure portability are not insignificant, potentially requiring major legal, administrative, and technological retooling of how we license health professionals in this nation.

ATTACHMENTS

ATTACHMENT 1: NURSE LICENSURE COMPACT (NLC) STATES

COMPACT STATES	IMPLEMENTATION DATE
Arizona	7/1/2002
Arkansas	7/1/2000
Colorado	10/1/2007
Delaware	7/1/2000
Idaho	7/1/2001
Iowa	7/1/2000
Kentucky	6/1/2007
Maine	7/1/2001
Maryland	7/1/1999
Mississippi	7/1/2001
Nebraska	1/1/2001
New Hampshire	1/1/2006
New Mexico	1/1/2004
North Carolina	7/1/2000
North Dakota	1/1/2004
Rhode Island	7/1/2008
South Carolina	2/1/2006
South Dakota	1/1/2001
Tennessee	7/1/2003
Texas	1/1/2000
Utah	1/1/2000
Virginia	1/1/2005
Wisconsin	1/1/2000
Missouri (Implementation Pending)	6/1/2010 (Est)

ATTACHMENT 2 – DETAILED HISTORY OF FSMB

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing medical boards in the United States and its territories. Responding to changes in the delivery of health care over the last two decades, the FSMB has incrementally addressed the issue of license portability. An Ad Hoc Committee on Licensure by Endorsement was formed in 1995. The Ad Hoc Committee identified the need for a centralized system for primary source verification and archiving of core physician credentials on behalf of state medical boards, as well as the need to address regulatory issues associated with telehealth and barriers to license portability. The policy that resulted from the Ad Hoc Committee on Licensure by Endorsement led to the development of the Federation Credentials Verification Service (FCVS) and the policy, *Report of the Ad Hoc Committee on Licensure by Endorsement*.

In 1996, the FSMB adopted *A Model Act to Regulate the Practice of Medicine Across State Lines*. This model act required physicians who frequently engaged in the practice of medicine across state lines, by electronic or other means, to obtain a special license issued by the state medical board. As with limited licensure, physicians holding a special license would be prohibited from physically practicing medicine within the state unless a full and unrestricted license was obtained. It would subject the licensee to the Medical Practice Act of the issuing state, and to the regulatory authority of the state's medical board. Each state would have the option of denying such a special license but would be encouraged to issue the license if it found that the applicant would not present a threat to the public. The Model Act would narrow the consultation exception to ad hoc consultations which are neither compensated nor performed under a contractual relationship.

Recognizing that barriers continued to exist that impeded implementation of an expedient process for licensure by endorsement, the Special Committee on Uniform Standards and Procedures set forth recommendations to improve consistency of licensure requirements and disciplinary terminology and processes in 1998. In April 2000, the FSMB established the Special Committee on License Portability to explore mechanisms that could significantly improve the portability of state medical licensure. The Committee evaluated licensure models including the mutual recognition model utilized in Australia and proposed in Canada, as well as the licensure compact model developed by the National Council of State Boards of Nursing. The Committee recommended that state medical boards offer an expedited licensure process for physicians meeting identified and accepted standards. The expedited licensure process would be also dependent upon the development of a standard medical license application and acceptance of established standards for primary source verification of physician core credentials.

In 2004 and 2005, OAT contracted with the FSMB to outline a model interstate agreement among the participating state boards to facilitate licensure portability across state boundaries that would incorporate lessons learned from FSMB's prior activities. In 2006, OAT further built on its previous efforts with FSMB and implemented the Licensure Portability Grant Program (LPGP), pursuant to the authorization of the Health Care Safety Net Amendments of 2002 (P.L. 107-251). The FSMB received LPGP grants in 2006 and 2009. The grant

program is designed to leverage the experience of state licensing boards that have a strong record in implementing cross-border activities to overcome licensure barriers to the provision of telehealth services across many states.

During the first grant cycle, the FSMB was to develop model agreements in two regions of the country (northeast and west) to expedite the licensure process and eliminate redundancies associated with applying for licenses in multiple jurisdictions. Fourteen state medical boards were involved in this initiative – 1) in the Northeast, six states: Connecticut, Maine, Massachusetts, Rhode Island, New Hampshire and Vermont; and, 2) in the West/Midwest eight states: North Dakota, Kansas, Colorado, Minnesota, Iowa, Idaho, Oregon, and Wyoming.

Under the grant, participating boards were encouraged to reduce administrative redundancy in processing applications to speed up the licensure process and improve efficiency. One source of redundancy was the need for each board to conduct primary source verification of credentials by every state to which a physician applies for a license. The participating boards identified two mechanisms for achieving this goal. First, the boards could use a one-time verification by the primary licensing state that additional boards would endorse. Second, the boards could use a centralized verification organization (CVO), which the other boards would accept in lieu of repeating the verification process. Further enhancing license portability would be the use of an online uniform application for every state. Such actions would also create greater trust among the boards and ultimately facilitate greater acceptance of each others' procedures, thereby reducing the resistance to enter into endorsement or mutual recognition agreements to reduce barriers for multi-state licenses.

For the first six months of their project, the FSMB made good progress on their goals and objectives. They met with the northeast and west groups and agreed on what license application data would be included in the centralized interactive data management system (CIDMS) as a foundation for the proposed streamline licensing process. They developed two data collection instruments to collect individual state statutory, policy and technology data requiring analysis and comparison in terms of the portability project. After reviewing all responses from the data collection instruments, the FSMB created the Licensure Portability Project Website under the Federation Extranet to facilitate communication between boards participating in each regional project. Idaho and Wyoming boards agreed to work together in developing a mutual recognition agreement to enable license applicants satisfying certain criteria to be eligible for mutual recognition in both states. The northeast and west groups also identified performance measures to demonstrate that the proposed interactive data management system actually reduced the time required for states to approve license applications and therefore, increased the number of physicians licensed in multiple states.

However, in the first quarter of Year 2, it was determined that a centralized data repository that could be assessed by participating boards was neither feasible nor sustainable. The portability groups identified policy and legal issues that affected each state's ability to share relevant licensure data through the proposed CIDMS. Likewise, the FSMB's Information Technology team identified logistical, security, feasibility and sustainability barriers with the CIDMS plan. The IT team identified a hardware problem. A number of the boards were not permitted to install the necessary equipment because of network security, and other boards did not have the technical staff to support the system.

The northeast and west groups met in separate meetings to discuss alternatives to the CIDMS plan. Ultimately, both groups agreed to pursue a simpler solution. The boards agreed to pursue the authority to issue licenses by endorsement and to share core documents through scanning and the Internet. The core documents would only include those documents already a matter of public records; thus avoiding some of the legal pitfalls with sharing documents through CIDMS.

The FSMB proposed to refocus their project toward the adoption of the Common Licensure Application Form (CLAF) and endorsement agreements. In Year 2, the FSMB proposed to implement the CLAF in up to five boards and implement endorsement licenses in up to four boards.

The CLAF was a common license application form that resided at the FSMB. Once a physician completed the application, the physician would not have to complete future applications when moving to another state that has adopted the CLAF. The CLAF was initially developed in paper form and would only work for states that required the FCVS. The grant enabled the FSMB to convert the CLAF to a web-based platform, which enabled all of the states to use it, rebrand it to the Uniform Application for State Medical Licensure (UA), and offer it free of cost to state medical boards. The FSMB believed that adoption of the UA, coupled with licensure through endorsement, would greatly expedite license portability.

The FSMB had previously developed the FCVS. The FCVS was established to provide a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials. This service was designed to lighten the workload of credentialing staff and reduce duplication of effort by gathering, verifying and permanently storing the physician's credentials in a central repository at the FSMB's offices. The FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician to establish a confidential, lifetime professional portfolio with FCVS. The information can be forwarded, at the physician's request, to any SMB that has established an agreement with FCVS or other health care entity.

FCVS charges a fee for gathering and forwarding the initial profile and only a processing fee for forwarding additional profiles. The average processing time to collect and forward the initial profile is approximately 8 weeks. Once the permanent file is established, subsequent requests are typically forwarded within 2-3 weeks.

The creation of CLAF and the FCVS has helped reduce the burden of physicians interested in obtaining multiple state licenses, but the process still took too long. The standardization of many key core requirements has also sped up the licensure process in certain states. State requirements for medical licensure are very close to uniform. All states use national standards such as graduation from an accredited medical school and attainment of a passing score on the medical licensing examination. Further, while the number of years may vary somewhat from state to state, all states require some level of post-medical school training. Alternatively, not all state medical boards require criminal background checks as part of the licensure application process. Criminal background checks (CBCs) are requested by the state

and performed by the Federal Bureau of Investigation. The physician must pay for a CBC for each state he or she is applying to get a medical license because the state medical boards are not permitted to share investigative information.

The FSMB's original focus of the grant was for participating state medical boards to scan and share licensure documents in an electronic format. The new approach for the second grant, awarded in 2009, is to build on the successes of the first grant and encourage states to adopt the Uniform Application and endorsement agreements.

Historically, endorsement meant that a physician must apply in the state they wished to practice. Endorsement is based on acceptance of original license examination and active status with other state medical boards. With endorsement, all credentials typically have to be re-verified. Under the Licensure Portability grant, the FSMB has worked to streamline the endorsement process and now calls the model expedited endorsement. To qualify for licensure under expedited endorsement, an applicant must be licensed in another state and be eligible for primary source verification of core credentials from the state in which the physician was originally licensed; demonstrate currency (i.e. current specialty board certification); be in good standing in all other states licensed; and have no formal disciplinary actions or pending investigations. States are entitled to develop their own criteria but, at a minimum, the above criterion is commonly used.

The level of cooperation among health licensing boards has improved significantly since the initial telehealth program was funded. Over the last five years, regulatory boards have worked together to improve the license portability process and promote the effective use of technologies to improve access to health services. Initially, there were 14 state boards participating in the license portability grant program. Today, there are 19 state boards participating in the program. An additional ten state medical boards are implementing one or more elements to improve the medical licensure process.

ATTACHMENT 3 – LIST OF PORTABILITY STATES IN OAT GRANT

2006-2009 Grant (14 States)	2009-2012 Grant (19 States)
Northeast:	Northeast:
Connecticut	Connecticut
Massachusetts	Massachusetts
Maine Medical	Maine Medical
New Hampshire	New Hampshire
Rhode Island	Rhode Island
Vermont Medical	Vermont Medical
	Michigan Medical
	North Carolina
	Ohio
	Virginia
West:	West:
Colorado	Iowa
Iowa	Idaho
Idaho	Kansas
Kansas	Minnesota
Minnesota	South Dakota
North Dakota	Oregon
South Dakota	Wyoming
Oregon	Missouri
	New Mexico
	Oklahoma Medical
	Oklahoma Osteopathic

ATTACHMENT 4 – LIST OF STATE BOARDS PARTICIPATING IN UNIFORM APPLICATION (UA)

States Using UA (10)	States Implementing UA (15)	States Evaluating UA (8)
Idaho Indiana Kansas Kentucky New Hampshire Ohio Rhode Island South Dakota Vermont Medical Oklahoma Osteo	Connecticut Guam Iowa Louisiana Massachusetts New Mexico Medical Oklahoma Medical Wyoming Minnesota Montana Nevada medical Utah Medical Utah Osteo Washington Medical Delaware	California Medical Maine Medical Missouri North Carolina Vermont Osteo Georgia Washington Osteo West Virginia Medical

ATTACHMENT 5 – LIST OF STATE BOARDS ACCEPTING FCVS

Requiring	Highly Recommending	Accepting	Not Accepting
Kentucky	Illinois	Alabama	Arkansas
Louisiana	Florida Medical	Alaska	CNMI
Maine Medical	Florida Osteopathic	Arizona Medical	Nebraska
Nevada Osteopathic	New Mexico Medical	Arizona Osteopathic	Pennsylvania Osteopathic
New Hampshire	New Mexico Osteopathic	California Medical	Puerto Rico
New York IMG	New York	California Osteopathic	West Virginia Osteopathic
North Carolina	North Carolina	Colorado	
Ohio	Texas	Connecticut	
Rhode Island		Delaware	
South Carolina		District of Columbia	
Utah Medical		Georgia	
Utah Osteopathic		Guam	
Virgin Islands		Hawaii	
Wyoming		Idaho	
		Indiana	
		Iowa	
		Kansas	
		Maine Osteopathic	
		Maryland	
		Massachusetts	
		Michigan Medical	
		Michigan Osteopathic	
		Minnesota	
		Mississippi	
		Missouri	
		Montana	
		Nevada Medical	
		New Jersey	
		North Dakota	
		Oklahoma Medical	
		Oklahoma Osteopathic	
		Oregon	
		Pennsylvania Medical	
		South Dakota	
		Tennessee Medical	
		Tennessee Osteopathic	
		Vermont Medical	
		Vermont Osteopathic	
		Virginia	
		Washington Medical	
		Washington Osteopathic	
		West Virginia Medical	
		Wisconsin	

ATTACHMENT 6 – LIST OF ABBREVIATIONS

ABBREVIATIONS

ABA – American Bar Association
ANA – American Nurses Association
ARRA – American Recovery and Reinvestment Act of 2009
ATA – American Telemedicine Association
CBC – Criminal Background Check
CHRI – Criminal History Record Investigation
CLAF – Common Licensure Application Form
CVO – Credential Verification Organization
FBI – Federal Bureau of Investigations
FCVS – Federation Credentials Verification Service
FSMB – Federation of State Medical Boards
HHS – Department of Health and Human Services
HOD – House of Delegates
HRSA – Health Resources and Services Administration
LPGP – Licensure Portability Grant Program
LPN – Licensed Practical Nurse
NGA – National Governors Association
NCPPC – National Crime Prevention and Privacy Compact
NCSBN – National Council of State Boards of Nursing
NLC – Nurse Licensure Compact
NLCA – Nurse Licensure Compact Administrator
OAT – Office for the Advancement of Telehealth
ONC – Office of the National Coordinator for Health Information Technology
P.L. – Public Law
RN – Registered Nurse
UA – Uniform Application
VN – Vocational Nurse

APPENDIX

The Nurse Licensure Compact: The American Nurses Association (ANA) Talking Points and the National Council of State Boards of Nursing (NCSBN) Response²⁹

BACKGROUND:

The National Council for State Boards for Nursing (NCSBN)'s Nurse Licensure Compact was first introduced at American Nurses Association (ANA) 1998 House of Delegates (HOD) and resulted in a resolution outlining fourteen issues the HOD believed must be addressed for ANA to support the Compact model. Delegates reaffirmed their beliefs at the 1999 ANA House. Dialogue between ANA and NCSBN continued. On February 24, 2005, members of the ANA Board of Directors Task Force related to the Compact, ANA staff, three compact administrators, and NCSBN staff participated on a conference call to discuss the ANA's remaining issues with the interstate compact model. In 2007, the number of issues were reduced to seven, but the ANA maintained its position on the Compact, namely to "agree to disagree" with the NCSBN. The ANA has not revisited these issues or conducted any independent research or evaluation of the Compact.

The following section is organized according to ANA Talking Points (issues), followed by the NCSBN response.

ANA Talking Point 1: The state of practice, rather than the state of residence, holds greater logic for licensure, since licensure is intended to grant the nurse authority to practice while protecting the health and safety of the citizens of the state in which the license is held.

The state of predominant practice should be the state of licensure; if the nurse is not practicing, the nurse should be licensed in his/her state of residence (HOD Policy #8.13. paragraph 4.1). The state's authority to regulate practice applies to other health care professions who possess licenses within that state and is consistent with state courts jurisdiction over actions taken only within the state.

A complaint against a nurse is most likely to be registered within the state of practice, with that state committed to aggressive investigation and appropriate action in order to fulfill its mission of protecting the public from harm. Crossing borders, with varying statutes, rules and regulations would inhibit the timely exchange of information for both the licensee as well as the complainant. And may even stop the sharing of information altogether. The nurse would be in a better position to defend against a complaint where practice occurred because of better access to witnesses and records. Additionally, some employers, private and governmental have policies requiring licensure /current registration in the state of practice.

²⁹ This section is extracted from material that can be found at:
https://www.ncsbn.org/ANA_TP_NLC_Response_Rev071409.pdf

NCSBN Response: The selection of licensure by state of residence was made specifically to enhance public protection while retaining state-based authority and reducing administrative burden. Issuing a license in a nurse's state of practice was rejected because of the great difficulty in determining the state of practice in this era of working for multiple employers, at multiple sites across state lines and via telenursing. In addition, tracking a nurse in the event of a complaint/investigation would be more readily accomplished with a residence link (address) than an employment/practice link. Furthermore, linking licensure with practice would pose significant problems for nurses currently not employed or moving in and out of the workforce.

Under the NLC, a nurse receives a license in the state of residence and is granted a **privilege to practice** (PTP) in states that are party to the NLC. The authority to practice in other states comes from the privilege that is granted by the home state license. Nurses are required to abide by all of the laws that govern nursing practice in the state(s) where practice takes place.

States have the authority to take any action on the PTP that is allowed for action on a home state license. This would mean that a remote state could respond rapidly and efficiently to any reported practice violation. Final actions on a PTP are reported in the coordinated licensure information system (Nursys®) and to the federal HIPDB (Note: Now integrated with the National Practitioner Data Bank). States that take action on a PTP share the investigative findings with the home state. The NLC also requires states to report any significant investigation that has been initiated to alert other states. The NLC requires that an application for license in a new state be held in abeyance until the action is finalized in the investigating state.

The NCSBN maintains that rather than hindering the flow of information, information sharing is enhanced in this model of licensure. According to the NCSBN, there have been no reports of employers (federal or private) not accepting a multistate license as valid authority to practice.

ANA Talking Point 2: There are many inconsistencies between states in relation to licensure / re-registration requirements, such as mandatory continuing education, criminal background checks, disciplinary causes of action, and evidentiary standards; all of which impede the states' ability to regulate practice in a constitutionally mandated manner and can create confusion for nurses and employers.

Interstate practice must not be implemented in a way that allows persons to circumvent or contravene existing public policy as expressed by a state's laws or policies, including laws on the use of strikebreakers and striker replacement or initial and continuing licensure requirements (HOD Policy #8.13, paragraph 4n.). Approaches to interstate advanced practice nursing should be addressed for consistency in connection with interstate practice for other RNs (HOD Policy #8.13, paragraph 4.i). The right of individual nurses to a fair hearing of any disciplinary matter must be protected; and, no unfair or undue burden, financial or otherwise, should be placed on a nurse's exercising his/her right to a fair hearing; (HOD Policy #8.13, paragraph 4.h)

The rule-making process to implement any interstate practice legislation should be clearly spelled out in the legislation, and proposed implementation regulations for key provisions should be developed simultaneously with legislation; (HOD Policy #8.13, paragraph 4.b.)

The inconsistency of standards between states in such areas as continuing education requirements, timing for licensure re-registration, eligibility for practice by foreign educated nurses and licensee reporting requirements not only create confusion, but leads to the potential of nurses working side by side with different requirements for practice.

Provisions in the Compact require Party states to unconditionally accept the licensure standards of other states which could lead to a “lowest common denominator” of state licensure standards. Remote states (Party states other than the Home state) do not have the ability to set licensure standards for nurses licensed in other states (Party states) but yet who are practicing in their state.

NCSBN Response: The multistate model of licensure (NLC) does not allow licensees to circumvent state laws and rules. The nurse must meet all requirements for initial licensure and ongoing renewal in the state of residence. If a licensee changes state of residence, all requirements for licensure in the new state of residence must be met. All states require graduation from an approved program and successful completion of the NCLEX® examination in order to be licensed. There is no inconsistency in the way foreign educated nurses are licensed by NLC states. The education is reviewed by a state or designated credentials agency vendor to determine eligibility for licensure and all must successfully pass the NCLEX.

Mandatory continuing education is a continued competence methodology. Continued competence is also demonstrated by other methods such as employment in nursing for a specified number of hours or a portfolio process. There is no consensus on which method is the most effective measure of continued competence. The nurse is required to meet the continued competence requirements in the home state. Nurses working side by side will have met core licensure requirements of graduation from an approved education program, successful completion of the NCLEX and a check of any past encumbrances on their licenses. The only variation will be the method in which they demonstrate continued competence.

Criminal background checks (CBCs) are a core licensure requirement adopted by the NCSBN Delegate Assembly. Currently 17 of the 23 states participating in the NLC (as of March 2010) are conducting fingerprint based state and federal criminal background checks. The remaining states continue to work on getting legislation passed to grant them the statutory authority that is necessary in order to obtain the CBCs.

The National Council does not believe that the NLC facilitates strikebreaking. However, to the extent an individual state believes it might, language can be included from the enabling language options explicitly stating that the NLC does not supersede any existing labor law.

As a matter of public policy, state boards of nursing do not consider where or in what circumstances a qualified nurse plans to practice. The reality is that the turnaround time to grant a temporary permit or temporary license is a matter of days in most states.

The initiation of a strike is typically an event of last resort that mandates prior notice to affected facilities. There is time for contingency planning. Under the current licensure system, it is possible to utilize nurses from other states in strike situations. However, practically speaking, there are many obstacles and considerations for the physical relocation of nurses. For example, locating housing, moving, resolving personal issues and acclimation to a new environment all take time. Even traveling nurses have to finish current assignments. The implementation of mutual recognition will do nothing to reduce these practical obstacles. No evidence has been presented that associates the NLC with strikebreaking.

Nurses are granted due process in any disciplinary proceedings regardless if the action is against a license or a PTP. This is a requirement of the US Constitution, Amendment 14. No nurse can be deprived of a license (property right) without due process which includes the right to a fair hearing. Licensees have the right to appeal decisions made by an administrative board to a court of law.

The rule making authority of the NLC is clearly identified in Article VI and VII of the NLC. Model rules were promulgated and have been implemented by the states that are party to the NLC. A process is in place for amendment of the rules.

The ability to skirt the authority of the state of practice to regulate criminal behavior and allow nurses who could not get licensed in the state of practice to practice under the compact privilege assumes that there is a large disparity in the types of criminal behaviors that states will tolerate for the purpose of licensure. While it is true that some states have permanent bars to licensure and others do not, every board of nursing makes a determination that an individual is eligible/safe to be licensed. A state has the authority to take any action on a PTP that can be taken on a license.

The multistate model of licensure is a state based system that is recognized nationally and enforced locally. National recognition of a license is dependent upon the party states acceptance of a state's licensure decision. Public protection is the mission of the Boards of Nursing. If an individual has been convicted of a crime and subsequent licensure action is taken, the state can also take action on the PTP which is reported to Nursys®. Anytime an active license would be placed into Nursys®, the PTP action from the previous state would be automatically subsumed thus alerting all states of the PTP action in the prior state of residence. This is an additional safety feature. A state is not allowed to grant a multi-state license to an individual who has an encumbered license in another compact state. Again, any action can be taken on the PTP that can be taken on the license and this action is reportable to Nursys® and HIPDB so all states would have knowledge of this action.

ANA Talking Point 2a: The interstate nursing compact structure mandating regulation based on state of residence, not practice, undermines the states' regulatory intent.

Nurses with licenses in one state yet practicing in another state, can skirt the authority of the state of practice to regulate criminal behavior in licensees; and the interstate compact could have the perverse effect of allowing nurses who could not get licensed in the state of practice to practice under the Compact privilege. Nurses who have questionable employment records or whose patterns of practice could signal aberrant, dysfunction or criminal behavior, have options which allow them and their practices to remain outside of standard avenues of

discovery. Although criminal background checks are performed by states participating in the Compact, associated laws and reporting requirements are inconsistent from state to state. With such variance in state criminal background check laws and statutorily-imposed limitations on licensure based on past criminal history, states have little authority to regulate practice in their constitutionally mandated manner.

Again, those statutes were specifically designed to protect the public within that state. The nurse licensure Compact, in conjunction with criminal background check laws, could force nurses who obtained their education in one state to move to another border state for licensure, and then seek employment in the original state of education.

A Party state could take action to limit the nurse's ability to practice in a Remote state, but if the Home state failed to take action against the nurse's license, the nurse would be free to practice in any other Party state without the board's knowledge. This limits the ability of the state to establish a regulatory means to protect the public, thus impacting state sovereignty.

States create administrative processes which vary drastically. The way in which investigations are conducted: informal or formal hearings and types of sanctions imposed such as censure/reprimand, limitation of licensure, suspension and revocation of licensure also vary widely. State law determines the type of hearing utilized and the sanctions available. The hearing and sanction schemes have not been standardized. A failure to standardize the disciplinary process leads to inequity in the adjudication process and the implementation of the NURSIS/CLIS reporting requirement, as some disciplinary actions that result in censure in one state (which does not require reporting) or may lead to suspension or licensure limitations in another state, which requires reporting of the disciplinary action and nurses' rights related information reported into the system has been compromised. The distinctions are highlighted when viewed in the context of the Health Quality Improvement Act (and regulations) reporting requirements.

NCSBN Response: Again, the multistate model of licensure was intended to be a state based system that is recognized nationally and enforced locally. It does not require that every state does everything the same. This would defeat the concept of state rights. It does require that the party states recognize the licensure decisions of the party states. Every state must follow its own administrative procedures act. This is an issue not unique to NLC states.

ANA Talking Point 2b: There is also a lack of standardization in the drug diversion program discipline reporting process.

In an effort to address diversion and treat diversion as an illness, many regulatory options have been developed. Initially, diversion programs were designed to allow nurses to come forward, admit to addiction to obtain treatment. If the nurse successfully completed the diversion program and did not have subsequent lapses, the lapse would be expunged from the nurses' record. State laws have been changed to alter programs which require reporting of that information. Some states now require hearings on the diversion and a finding by the board prior to entry in diversion programs, which requires reporting of the administrative hearing finding into state and federal disciplinary databanks. And, some states now treat administrative pleadings of nolo contendere as admissions of guilt in nursing licensure cases, which once again require reporting of the action to state and federal databases. These

requirements were enacted because the states of enactment wanted additional protection for its citizens. Because the compact has been designed to regulate the state of residence, not of practice, these additional protections are not necessarily applied in a manner consistent to protect the desired constituency. Also, lack of uniformity in the law and process leads to inequitable application of the disciplinary provisions of state practice acts. None of the literature prepared by the NCSBN or the compact administrators has addressed this concern.

NCSBN Response: Once again, the multistate model of licensure is a state based system that does not require all party states to function in the same manner. Party states are obligated to follow the laws and rules of the NLC. The NLC specifically addresses participation in alternative programs defined as a voluntary, non-disciplinary monitoring program approved by a nurse licensing board. Article VI of the NLC states: “Nothing in this compact shall override a party state’s decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain non-public if required by the party state’s laws. Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state. The NLCA have reviewed all party states alternative program contract requirements to ensure that all contracts contain this language.

ANA Talking Point 2c: As a result of the variation in state laws, nurses may find themselves subject to multiple investigations and disciplinary proceedings arising from the same incident.

The nurse could be required to bear the cost of investigation and disciplinary proceedings. Due process issues also arise when a nurse has to represent him/herself in multiple jurisdictions at one time. There are also conflicting evidence standards for jurisdictions. Information and case requirements in one jurisdiction may not withstand scrutiny in another jurisdiction.

NCSBN Response: The home state has jurisdiction over the license and the remote state has jurisdiction over the PTP. If a violation occurs in a remote state, that state takes the lead on the investigation. The investigation is shared with the home state. Final action can be taken on both the PTP and the home state license. This process is coordinated by the states involved with the violation. The issue that has been raised is not unique to the NLC, it is common to single-state and multi-state models of licensure. With the single state model of licensure, all states can take action on a license based on action in another jurisdiction. The NLC does not change this. To date no evidence of due process violations have emerged regarding the NLC.

ANA Talking Point 2d: It is not clear what the result of the availability of parallel disciplinary processes is likely to be.

How much weight is afforded by a Remote state to an adverse action by the Home state – by the Home state to an adverse action by a Remote state? What kinds of incidents lead a Remote state to “limit or revoke the multi-state licensure privilege of any nurse to practice in their state” – will these be the same kinds of incidents that lead to suspension or revocation of licensure in the Home state? What is the relationship between the two kinds of actions?

The compact authorizes state boards of nursing to recover from a nurse the cost of investigations and dispositions of cases resulting from any adverse action taken against the nurse. This adds a financial burden that is not the case with the current licensure system and is not required by other state licensing laws for any other occupation. And, it is questionable if this type of financial burden imposed by one state to address multiple state investigations violates due process. Again, it should be noted that neither NCSBN nor any other entity has conducted studies of the impact this cost has on licensure.

Response: This is not unique to the NLC. Depending on the state, you will find the ability to recover costs from disciplined nurses in state statutes.

ANA Talking Point 3: The benefits of Compact entry have not been demonstrated to be commensurate with the associated costs to the states and resultant loss in revenue.

Many states rely upon licensure fees to sustain their operating expenses. In 1998, the Iowa Board of Nursing estimated that the Compact would decrease out-of-state licensure revenue by \$39,000, \$130,000 per biennium and approximately \$24,000 per year in license verification fees. In 2003, the Virginia Board of Nursing estimated a loss of out-of-state nursing revenue of \$627,760 per biennium. Virginia estimated an additional loss of approximately \$135,000 biennium from license verification fees. The Mississippi Board of Nursing saw endorsement revenue decrease by 51.4% during the first year of the Compact (2004). The Board saw proportionate reductions in new and temporary licensure fees, which remain constant. The Colorado Legislative Council estimated that the Board of Nursing would lose the following revenue in 2006/07: endorsement fees - \$3,500 and renewal fees - \$1,239. Since it is estimated that 12% of nurses hold multiple licenses, it could be argued that all nursing boards face an average of at least 12% reduction in revenue. And, if multiple nurses were to hold licensure in more than two states, that impact would be far greater.

In addition to a loss of revenue, states face an increase in expenses when joining the Compact. The NCSBN requires each state to comply with its hardware and software requirements for transmittal and receipt of interstate compact data. Review of state fiscal impact statements on Compacts costs and subsequent review of board finances have indicated that boards of nursing have not accurately determined the cost of complying with software and hardware requirements associated with utilization of Nursys®. And, states have not included the costs of hiring staff for computer maintenance and upkeep. In addition to underestimated costs associated with computer upgrades, states have had added printing costs for board of nursing materials and brochures and expenses for legal counsel. For example, Colorado estimated that their entry into the Compact would cost \$327,461, with subsequent infrastructure and membership costs at \$85,539. Although the NCSBN believes that the electronic database Nursys® would provide adequate information to other states related to discipline, there has been no data collection on the cost of preparing a case for discipline in multiple states or on the amount of recovery of these costs by Compact states. With the responsibility to discipline, comes the responsibility and the financial burden of monitoring the multi-state discipline. This would be done in an environment where boards are faced with declining budgets as states seek to resolve budget deficits, compounded by less revenue from nurse licensure fees.

NCSBN Response: NLCA members participated in a NCSBN external study of costs associated with the NLC. The study was funded by the Licensure Portability Grant that NCSBN received from the Office for Advancement of Telehealth (OAT). NCSBN (initially through an external researcher) asked participating boards of nursing who are members of the NLC to provide information on changes to their revenue and expenditures as a result of participating in the NLC. The information gathered from the current study will be used as a guideline for states that are in the process of or considering adoption of the NLC and provide a basic estimate of financial impacts.

Based on the input from state boards of nursing, meetings with members of the Licensure Portability Grant (LPG) Panel and review of related literatures, a refined model of expenditures is being developed. Cost information was collected focusing on the following four main areas: IT costs; communication costs, administrative costs; and revenue changes. A total of 15 state boards provided cost data. Among them, two states indicated that the implementation of the NLC did not have any specific fiscal impacts for them, therefore, no actual expense figures were provided. The current summary is based on the data provided by 13 state boards and there were significant variations in the expenditures for setting-up the NLC among these 13 states, the costs ranging from \$8,350 to \$216,000. These set-up costs primarily involved administrative expenses which included adding a separate NLC administrator position (not required by implementing the NLC), employing temporary staff as well as the costs related to workload increase at the early stage of implementing the NLC. The revenue gains and losses following entry into the NLC were related to increases or decreases in the number of new applications based on the new NLC state of residence rule.

The operational cost data also revealed significant variations from state to state. A possible cause for having the huge variations in the fiscal impacts on state boards for implementing the NLC could be related to the technical and human resources of the boards as well as residency of the practicing nurses in those states. This report further shows a positive relationship between the number of licensees registered in a state and the costs of implementing the NLC. This suggests a tendency that the larger the nursing population in a state, the more likely the cost of implementing the NLC could be, but this finding is not statistically significant. Since states participated in the NLC at different time periods ranging from 2000 to 2007, we further examined if there were any differences in the reported costs between those states who participated in the NLC five years earlier compared to those recent participants. On average, the six states (50%) who entered the NLC before 2003 reported a much lower cost than the six (50%) who entered into the NLC after 2003, even though this difference is not statistically significant.

Additionally, NCSBN was able to provide monetary assistance to member boards through its grant to support licensure portability. Two contracts went to NLC states for implementation for \$50,000 each. Additionally, member boards were also eligible for contracts for CBC implementation and five boards received contracts for that area. Technical and human resource support is also afforded to all member boards when join Nursys®, the coordinated nurse licensure database.

ANA Talking Point 4: The Nurse Licensure Compact does not allow state regulators to identify everyone practicing in the state, not only limiting the states' ability to protect its' citizens from potential harm, but also making it impossible to collect workforce data

to guide future projections and determine needed strategies to ensure an adequate number of nurses. Mechanisms should be in place to ensure that a board of nursing knows who is practicing in its state under authority of a license granted by another state or through an interstate practice agreement; (HOD Policy #8.13, paragraph 4.k)

The NCSBN contends that the Compact neither enhances nor detracts from the board of nursing's ability to identify and track nurses, yet nursing organizations and entities continue to hear complaints about boards of nursing not knowing who and how many nurses have entered the state to practice under the Compact. The Registrar of the Alberta, Canada Association of Registered Nurses (Board of Nursing) outlined the difficulties encountered when trying to verify practice of nurses in the United States. Alberta requires a nurse to verify practice in all regulated jurisdictions where she/he has worked. When working under the Compact, the boards of nursing (in states other than the Home state) do not know if a nurse has practiced in their state and cannot verify the practice. This requires the Home state to sign off on all practice jurisdictions which has led to delays in confirming practice for nurses who want to practice in Alberta and has increased the administrative burden for the Home state and the Alberta licensure board.

Compact proponents have indicated that the existing regulatory process does not allow state boards of nursing to identify all parties practicing in the state because most states enacted an exemption of federal employees working in federal facilities. This exemption was created to allow the military to provide federal health benefits and services to military employees, under the war powers provision of the federal constitution. Thus, those nurses working in federal enclaves are providing federal services. Federal (VA) nurses who provide care outside of their employment are required to give notice and get approval for temporary services, a temporary or permanent license. To address concerns related to their practice, federal rulemaking was adopted to mandate the reporting of federal employees to state boards of nursing when the employees violated the state scope of licensure. Although the state does not have an actual count of all nurses practicing in federal facilities, those facilities and parties are bound by state law to report infractions. This regulation protects the state; and combined with the limitations on practice does mandate notice of licensed nurses who are providing private or state-related services. The compact allows individuals who are not regulated through state or federal law to practice within the state. How does this unregulated practice provide states with tools to protect the needs of its citizenry?

It is believed that only 12% of nurses practice in more than one state, but practicing in participating Compact party state makes the percentage more difficult to pinpoint. Many states are increasingly working to determine nursing supply and demand requirements especially related to the nursing shortage. Since a Remote state nurse is not required to register with the board of nursing, the state will not be aware of the actual number of nurses working in the state making workforce projections even more difficult to determine.

NCSBN Response: Identification of everyone practicing in a state is not an issue that is created or solved by the NLC. States do not issue licenses based on place of employment: only that they have a valid nurse license in both models of licensure. Employment is subject to frequent change which makes it next to impossible to know where every licensee is working at any given time. All Boards of Nursing protect the public by ensuring that only those individuals who have met standards for licensure are allowed to practice. Having a

license in a state may or may not mean that the licensee is practicing in that state in either model of licensure. It means that they have met the standards to be licensed and practice in the state of issuance. Licensees can be tracked by address which gives an indication of where the licensee is working. States that participate in the NLC are able to monitor workforce data in the same way as states that offer only a single state license and NCSBN has been working on a workforce pilot to assist all states in these efforts. The piece of information that is not readily available is the utilization rate of the privilege to practice (PTP). The NLCA is currently working on a process to obtain this data. Some states that have adopted the NLC have developed a registry as a means for tracking nurses who practice under the NLC privilege, and they incorporated this in the enabling language for the NLC in that state. Recommended language is “To facilitate workforce planning, the legislature finds it necessary for [this state] to grant the board of nursing the authority to collect employment data on nurses practicing on the multi-privilege in the NLC, on a provided form, provided that the submission of this data is not a requirement for practice under the multi-state privilege.”

No state board can accurately determine who is practicing in their state regardless if the state is part of the NLC or not. Holding an active state license does not necessarily mean that a nurse is employed or practicing in the state. Also, thousands of nurses working in the military, in federal facilities and for federal agencies practice on the basis of holding one state license and then are allowed to practice in any federal setting under the doctrine of Federal Supremacy and exemptions defined in the each state’s Nurse Practice Act. However this does not constitute unregulated practice and particularly in the case of the NLC states. Employers are still obligated and citizens still have the right to report complaints of substandard practice to the Board of Nursing. Regardless whether the nurse holds a Missouri license or a license from another NLC state, an investigation is done and disciplinary action can be taken both to protect Missouri citizens by removing the privilege to practice in this state and further by working with the home state licensing Board to discipline the actual license, further protecting all U.S. citizens.

Workforce data collection is important and helpful to guide future projections and strategies to ensure an adequate number of nurses. Once 100% participation has been achieved in the NLC, we will have the first-ever unduplicated count of active nurse licenses in this state and country. In fact, by Missouri joining the NLC, more options and opportunities are available to share information and work more closely with another jurisdiction, resulting in enhanced discipline and sharing the burden of resources to conduct an investigation.

ANA Talking Point 5: There is a lack of clarity as to the Compact Administrators authority, related obligations, and processes used when communicating with Compact states.

Articles of the Nurse Licensure Compact grant authority to the Compact Administrators to develop uniform rules to facilitate and coordinate process. The nurse licensure compact does not reconcile the requirements associated with state notice and comment requirements related to the rulemaking process.

NCSBN Response: All states that have implemented the NLC have passed the legislation necessary to join the compact. Any changes to the model administrative rules are first agreed

upon by the NLCA. Following adoption of new model rules or amendments to the existing rules by the NLCA, each compact administrator must promulgate the rules in his/her own state according to the rulemaking process in that state which includes the notice, public hearing, comment period etc. There is definite clarity and uniformity as to the NLCA administrators' authority and role in facilitating the operations of the NLC. States must abide by their individual rules and laws when promulgating regulations and notifying interested community parties, however the actual regulations are and must be uniform among all NLC states. Twenty-three states (23) have already successfully promulgated these rules and are operating accordingly.

ANA Talking Point 6: There is a significant risk the nurse's right to due process will be diminished, The Nurse Licensure Compact is the first compact to address licensure of individuals. Typically, compacts address environmental, correctional or safety issues; and compact administrators develop rules which may or may not require administrative review and participate in the rulemaking process. The rules are developed by the compact, the public is given notice and an opportunity to comment, the standard for amending them would require all states who are parties of the compact to republish or conduct added administrative review. The practical effect of the process is to deny the public the opportunity to participate in rules development.

Additionally, hearings are not conducted in multiple settings or venues that would allow nurses to hear or participate in the public hearing process. ANA believes that little legal analysis or review has been directed to this due process consideration.

NCSBN Response: Nurses are granted due process in any disciplinary proceedings regardless of the licensure model. This is a requirement of the US Constitution, Amendment 14. No nurse can be deprived of a license (property right) without due process which includes the right to a fair hearing. Each state has an administrative procedures act that defines the requirements for due process. Licensees have the right to appeal decisions made by an administrative board to a court of law. Again, no evidence of due process violation has surfaced in NLC states.

ANA Talking Point 7: The compact model raises significant questions related to liability.

Boards of nursing protect the public not only through licensing and disciplinary functions, but also through interpreting and enforcing the state nurse practice acts. Working with the Compact model impedes the boards' ability to perform these vital functions. This raises questions such as, "Who, then is liable for failure to practice within state standards or within recognized state scope: the nurse, employer, the state in which the nurse is licensed or the state board of nursing in which the nurse is practicing?"

Insurance is a state-based function. The underwriting of insurance is based on an actuarial assessment of risk for practice within the state of practice, with the assumption that the state of licensure is the state of practice. This assumption allows the insurer to develop certain factors for evaluating and assessing risk. How does a state-based insurance underwrite the practice of nursing by out-of-state licensees? What benchmarks should be utilized to determine competence to practice in another compact state, and the type of risk of suit the

insured is incurring by practicing outside the state of licensure without direct regulation? If the state of practice has a continuing education requirement or additional training/education requirements for certain practices and the state of licensure does not, how is the insurer to factor in the differences in failure to comply with state of practice licensing requirement?

NCSBN Response: The 23 states that are party to the NLC (as of March 2010) have not had issues with interpreting and enforcing the state nurse practice acts. After nine years of implementation, there is no evidence to suggest that the NLC impedes the functions of the boards of nursing (participating or otherwise). The nurse is responsible to be licensed in the primary state of residence and to practice within the laws and rules of the state where practice occurs. Employers are responsible for verification that employed nurses hold a valid license in the state of residence. This is true for both single state and multistate (NLC) licensure models.

The NLC does not speak to insurance underwriting. These questions need to be directed to the insurance industry.