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FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

January 6, 2021

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810 Vermont Ave., NW
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Re: RIN 2900-AQ94-Authority of VA Professionals to Practice Health Care

The staffs of the Federal Trade Commission's ("FTC") Office of Policy Planning, Bureau of Economics, and Bureau of Competition¹ (collectively, "FTC staff") appreciate the opportunity to respond to your request for comments on the Department of Veterans Affairs' ("VA") interim final rule entitled *Authority of VA Professionals to Practice Health Care* ("the Rule").² We write in support of the Rule, which "confirms VA's current practice of allowing VA health care professionals to deliver health care services in a State other than the health care professional's State of licensure, registration, certification, or other State requirement, thereby enhancing beneficiaries' access to critical VA health care services."³ The Rule also "confirms VA's authority to establish national standards of practice for health care professionals which will standardize a health care professional's practice in all VA medical facilities."⁴ National standards of practice determine a professional's scope of practice by specifying the tasks and duties that a VA health professional may perform.

The COVID-19 public health emergency, for which the VA has needed to rapidly deploy many health care professionals to locations where they may not be licensed, has highlighted the need for the VA to confirm its authority to allow VA health care professionals to practice across state lines pursuant to a national standard of practice. This regulatory preemption, which is consistent with the VA's longstanding practice and interpretation of VA statutory authority, protects VA health care professionals from potential adverse actions when practicing across state lines within the scope of their VA employment.

We agree with the VA that protecting VA professionals working within the scope of their employment pursuant to a VA national standard of practice will help enhance beneficiaries' access to critical VA health care services. Accordingly, FTC staff believes that the Rule is an improvement in the VA's medical regulations, facilitating beneficiaries' access to VA health care services, increasing the supply of available VA health care services, and potentially reducing health care costs. Thus, the Rule would benefit veterans, especially those at

underserved locations and other locations without sufficient staff to meet veterans' needs, and especially in an emergency.

The VA's rulemaking also sends an important signal to health care providers, state legislatures, employers, patients, and others regarding the need for rapid and effective license portability and national standards for licensure and practice. FTC staff has been actively engaged in advocacy on these issues, and the VA's policies in support of these principles provide important lessons for health care providers, patients, and policymakers throughout the United States.

I. Interest and Experience of the Federal Trade Commission

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁵ Competition is at the core of the U.S. economy,⁶ and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,⁷ research,⁸ and advocacy.⁹

For more than 30 years, the Commission and its staff have focused on occupational regulations that may unreasonably impede competition. FTC staff have conducted economic and policy studies on occupational licensing¹⁰ and focused inquiries into laws and regulations relating to licensing for various occupations, including health care professions.¹¹ In the 2004 report *Improving Health Care: A Dose of Competition*, the FTC recommended that states implement uniform licensure standards and adopt compacts to facilitate telemedicine practice across state lines.¹² A 2016 FTC staff comment to the Alaska legislature supported allowing Alaska physicians located out-of-state to provide telehealth services to patients in Alaska.¹³ In 2017, a staff comment to the VA supported the agency's proposed rule confirming the authority of VA health care providers acting within the scope of their employment to provide telehealth services across state lines, notwithstanding contrary state laws or regulations, regardless of the location of the VA employee or patient.¹⁴

Building on this work, in 2017 the FTC formed the Economic Liberty Task Force ("ELTF"), which examined a broad range of licensing issues, including occupational license portability.¹⁵ This led to the 2018 FTC staff report *Options to Enhance Occupational License Portability*, which examined legal procedures for providing services across state lines.¹⁶ Subsequently, a staff comment supported international portability of occupational licenses.¹⁷

In addition, FTC staff comments have addressed scope of practice and supervision requirements that may unnecessarily limit the range of procedures or services a practitioner may provide, or unnecessarily restrict a particular type of practitioner from competing in the market.¹⁸ The FTC staff report, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, provides an in-depth analysis of the legal and policy bases of these comments.¹⁹ With respect to the VA, a 2016 staff comment supported the agency's proposed rule preempting state nursing licensure laws that conflict with its grant of full practice authority to VA APRNs acting within the scope of their VA employment.²⁰

II. Current State Law, VA Law and Practice

As a general matter, states require health care practitioners to be licensed in the state where the patient is located,²¹ and to adhere to the state's laws and regulations regarding practitioners' scope of practice.²² Practicing without a license is prohibited by state statute and subject to civil or criminal penalties.²³

By statute, VA health care practitioners must be licensed, registered, or certified by *one* state to be eligible to practice within the VA system.²⁴ VA has long interpreted its statutory authorities to permit it to authorize VA health care professionals working within the scope of their employment to deliver services in any state, under the VA's national standards of practice regardless of state licensure or standards of practice.

Thus, although the VA's statutory authority does not expressly preempt conflicting state licensure and scope of practice laws and regulations with respect to in-person practice, the agency has concluded that its authority to do so is inherent in its Congressional mandate to establish a complete health care service for the medical care and treatment of veterans. Congress authorized the VA to establish a comprehensive personnel system, including requirements for minimum qualifications of health care professionals, hours and conditions of employment, a disciplinary process, and other regulation of their professional activities.²⁵ This national system is necessary for the VA to fulfill its primary function of providing medical care for veterans, including deploying its employees where needed and requiring them to work under the VA's standards of practice.²⁶

The VA has previously used its inherent authority to preempt state laws and regulations to provide comprehensive medical care to veterans, an important Federal interest. In 2016, it issued a rule that preempted "conflicting State and local laws relating to the practice of APRNs when such APRNs are working within the scope of their VA employment."²⁷ And in 2018, the VA used regulatory preemption to allow health care professionals to practice telehealth in any state regardless of state licensure, certification, or other state requirement.²⁸ Shortly after the VA's regulatory preemption, Congress adopted similar legislation giving the VA express statutory authority for preemption of state laws and regulations for telehealth purposes.²⁹

III. The Interim Final Rule

To provide additional legal protection for VA health care employees, who have sometimes been subject to adverse actions by states, the VA's Rule expressly preempts conflicting state laws and regulations by allowing them to provide services within the scope of their duties to VA beneficiaries, regardless of a state's licensure or scope of practice requirements. This legal protection applies regardless of whether VA health professionals provide services via telehealth or in-person.³⁰ While the Rule confirms VA's authority to allow its employees to work pursuant to a national standard of practice, it does not set forth a national standard of practice. Rather, such standards will be developed for each health profession as subregulatory policy.³¹

Consistent with Executive Order 13132, which sets forth requirements for preemption of state law by federal agencies, including when a federal statute does not expressly preempt state law, the rule preempts state law only when state law directly conflicts with the exercise of federal authority.³² Thus, the Rule preempts state law to the extent that it unduly interferes with the ability of VA health employees to practice health care within the scope of their VA

employment.³³ Unlike existing statutory and regulatory preemption of state licensure law for telehealth purposes, which applies regardless of whether the practitioner or patient are on federal property, the Rule is narrower, and does not address the location of practice.

IV. Likely Effects of the VA's Interim Final Rule

By ensuring that VA health care professionals can provide in-person services on the basis of a single state license and under a national standard of practice, the Rule enhances the VA's ability to rapidly provide services wherever needed, thereby further improving access, potentially increasing innovation and quality, and reducing costs. The rule is especially important in emergency situations, when the VA must provide services rapidly without subjecting employees to possible adverse actions by states that could jeopardize their credentials and even result in fines or imprisonment for the unauthorized practice of the profession.³⁴ But clear preemption of conflicting state laws and regulations is important under any circumstance, as it will also help the VA implement an efficient, nationwide electronic health record system and enhance the VA's ability to recruit and retain health care professionals.

A. License Portability

The COVID-19 public health emergency has created an acute need for the VA to confirm its authority to deploy its health care professionals across state lines quickly and freely, and to work under the VA's national standard of practice.³⁵ Pursuant to its Fourth Mission, to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters, the VA has shifted its resources to locations with critical shortages of health care personnel and other resources. As of mid-2020, the agency had deployed personnel to more than 45 states to support VA medical facilities and state and community nursing homes. It had mobilized 1,893 staff to meet its needs and respond to requests from the Federal Emergency Management Agency and others.³⁶ The VA's use of telehealth services, including delivery of services across state lines, also increased greatly due to the pandemic. Delivery of telehealth services to the home and across state lines was facilitated by the VA's express statutory and regulatory authority preempting conflicting state law. The Rule will similarly protect VA health care professionals who travel to states in which they are not licensed to provide in-person care.³⁷ As the Rule explains, "In light of the rapidly changing landscape of the pandemic, it is crucial for VA to be able to move its providers quickly across the country to assist when a new hot spot emerges without fear of any adverse action from a State be proposed or taken against a VA health care professional."³⁸

Although the pandemic has amplified the need for the VA to confirm its authority to send staff across state lines regardless of licensure, certification, or other state requirement, the ability to do so would provide benefits at any time.³⁹ VA health care professionals routinely travel to smaller medical facilities or rural locations in nearby states to provide care that is otherwise unavailable or difficult to obtain. Moreover, just before the pandemic, 14% of VA health care professionals were not licensed, registered, or certified in the state where their main VA medical facility is located, making them vulnerable to adverse actions by states. This vulnerability is shared by many of the VA health care professionals who provide services at clinics or mobile health units, which are often used in rural and underserved areas where they may not be licensed or otherwise credentialed.⁴⁰

The rule will also improve VA's ability to hire health care professionals, helping to alleviate shortages and increase veterans' access to care. Recruitment and retention of licensed health care practitioners is likely to improve because the VA will be able to hire professionals licensed in any state and protect them from adverse actions by states.⁴¹ A clear ability to practice across state lines could also enhance recruitment of military spouses, who move to another state frequently and face substantial burdens if they are required to re-license.⁴² The Rule could thus improve the ability of the VA to compete more effectively to hire qualified providers, expand the supply of VA health care professionals, and potentially increase the quality of care.⁴³

B. Nationwide Mobility Necessitates a National Standard of Practice

A nationwide standard or scope of practice is the natural corollary of nationwide mobility in which health professionals licensed in one state can practice freely in "secondary" jurisdictions (i.e., those where they are not currently licensed). As the VA explains, "a national standard of practice means that individuals from the same VA health care profession may provide the same types of tasks and duties regardless of the VA medical facility where they are located or the State license, registration, certification, or other State requirement they hold."⁴⁴ On a basic level, a national standard is optimal because it is difficult for professionals shifting from one state to another to quickly learn and adhere to unfamiliar standards that may allow certain tasks in one jurisdiction but prohibit them in another, and which are not necessary to ensure patient health and safety. For example, practitioners who have independent practice or prescribing authority in one state may find that they need a signature or supervision in another. Fulfilling such oversight requirements takes the time of both supervisors and supervisees, and can lead to worse outcomes when time is of the essence and a practitioner is qualified to act independently.⁴⁵

Different standards of practice can also reduce the effectiveness of electronic health record ("EHR") systems designed to facilitate availability of veterans' health records. The VA is modernizing its system by implementing a joint EHR with the Department of Defense ("DoD") to promote interoperability between the two agencies and provide a complete picture of veterans' health information. The system requires the VA and DoD to use the same set of allowed tasks and duties for each health profession and cannot accommodate state-by-state differences. The DoD has statutory authority to set a national standard of practice, preempting state law.⁴⁶ In the absence of such explicit authority for the VA, the agency would either have to expose its employees to possible adverse actions by states, or both the VA and DoD would have to adopt the standard of the most restrictive state to shield VA employees from potential adverse actions. Adopting a more restrictive standard would unnecessarily change the way care is delivered safely and effectively in less restrictive states, such as by stripping some practitioners of independent practice or prescribing authority; preventing nurses from administering medications on the basis of a protocol rather than a co-signature; or eliminating direct access to some practitioners, such as physical therapists.⁴⁷ Such changes could lead to delayed care, decreased access, and lower levels of care.⁴⁸ Accordingly, the Rule confirms the VA's authority to establish national standards of practice for each health care profession, preempting any state restrictions that unduly interfere with such standards.⁴⁹

In sum, regulatory preemption of conflicting state licensure requirements and standards of practice allows the VA to improve beneficiaries' access to care, respond to critical shortages of health care personnel, and avoid delays in care -- potentially improving outcomes and reducing costs. In addition, the VA's leadership in preempting conflicting state licensure

requirements and standards of practice sends an important signal to U.S. health care stakeholders regarding the likely benefits of increased license portability and harmonization of state practice standards, and the need for strong actions such as preemption to achieve these goals.

V. Portability and Harmonization Outside the VA System

Many health care professions have recognized the need to improve license portability and harmonize standards of practice; some have developed interstate compacts or model laws to do so. If these initiatives sufficiently satisfied the needs for portability and harmonization, the VA might not have needed the Rule to confirm that its health care employees may work in any state pursuant to the VA's national standard of practice.

A. The Need to Improve License Portability and Harmonize Practice Standards

FTC staff recognizes that state licensing can serve a beneficial role in the health professions by protecting the health and safety of the public.⁵⁰ However, licensing regulations erect barriers to entry, limiting the number of workers who can provide certain services. This constraint on the labor supply can restrain competition and potentially result in higher prices and reduced access to services,⁵¹ especially those provided across state lines. Indeed, a recent study shows that occupational licensure requirements limit the interstate mobility of licensed workers in a variety of occupations, especially those with state-specific licensing requirements.⁵² Moreover, while licensing increases the wages of licensees at the expense of higher prices paid by consumers, most studies show that it does not improve quality.⁵³ Thus, licensing requirements should be narrowly tailored to address legitimate health and safety issues.

It is particularly hard to justify licensing-related barriers to entry when a qualified practitioner licensed by one state seeks to provide services in another state. Because licensing rules are almost always state-based,⁵⁴ it can be difficult for a person licensed by one state to become licensed in another. Even when a profession's underlying examination and education standards are national and state licensing requirements are similar -- as is often the case for health professions -- the process of obtaining a license in another state is often slow, burdensome, and costly.⁵⁵

The health care professions, as represented by state boards and professional organizations, have developed a number of initiatives to improve license portability. Taken as a whole, however, these efforts have not sufficiently streamlined cross-state practice, especially for emergency needs. This is in part because of the slow, state-by-state process of adoption of the initiatives, and also because most only partially eliminate the burdens of obtaining authorization to practice in secondary jurisdictions. If these initiatives had sufficiently reduced the barriers to cross-state practice, the VA would not have had to issue a rule preempting conflicting state licensure law and standards of practice. In 2020, the need for state emergency measures to temporarily enable cross-state practice during the public health emergency further revealed the inadequacy of the pre-pandemic status of licensure portability.

Most of the health care professions that have developed portability initiatives have favored interstate compacts that preserve the existing infrastructure and expertise of state licensing boards and rely on states to adopt them. Interstate compacts are constitutionally authorized, binding contracts between states that provide long-term, enforceable mechanisms to address matters involving multiple states.⁵⁶ There are seven interstate licensure compacts in the

health professions, including nursing, medicine, psychology, physical therapy, emergency medical services, audiology/speech language pathology, and advanced practice registered nursing.⁵⁷ Another portability initiative, for pharmacists, is a noncontractual model law, which could be easier to revise in response to changing circumstances than a compact.⁵⁸ But portability initiatives are not available for other health professions, such as physician assistants, dentists, and occupational therapists, so the existing initiatives do not eliminate the need for additional measures to improve cross-state practice, especially during an emergency such as a pandemic.

Another reason that portability initiatives have not sufficiently streamlined cross-state practice is that variations in state scope of practice have inhibited their adoption. Most interstate licensure compacts do not address these standards of practice, harmonizing only criteria related to licensure.⁵⁹ However, if states vary significantly with respect to key standards of practice such as supervision or prescribing authority, a compact that does not address these matters may subject practitioners to unacceptable variations in authority when they practice in different states.⁶⁰ On the other hand, if a compact attempts to change standards of practice, it may encounter opposition from the states with standards that would be changed, and from organizations that oppose the changes. For example, the APRN Compact, which would require independent practice and prescribing authority in all states, was strongly opposed by the American Medical Association (“AMA”) and other physicians’ organizations that support collaboration or supervision requirements for APRNs. Thus, the APRN Compact has been adopted by only three states, less than the minimum number to become effective.⁶¹ To encourage widespread adoption and reduce barriers to portability, harmonization of standards of practice, preferably at the least restrictive level acceptable to ensure patient health and safety, may be necessary.

And, despite the efforts of many stakeholders, few portability initiatives have come close to achieving the widespread adoption and reduction of restrictions necessary to support both in-person practice across state lines and the growing use of telehealth that accompanied the widespread use of smartphones. Only the Electronic Licensure Transfer Program (“e-LTP”) of the National Association of Boards of Pharmacy (“NABP”), a longstanding program dating to NABP’s founding in 1904, has been adopted by all U.S. jurisdictions. Stakeholders often work for years, even decades, to obtain nationwide acceptance and adoption of portability initiatives, but none of the interstate licensure compacts have achieved that goal.⁶² Of the seven interstate licensure compacts, only five, for nursing, medicine, psychology, physical therapy, emergency medical services, are in operation. Of these, the number of states that have adopted the legislation ranges from 15 to 34, and for several compacts, some states are not fully participating.⁶³ Eight states, including some of the most populous, have not enacted any of the compacts.⁶⁴

Another issue that has limited the effectiveness of some of the portability initiatives is that they do not fully eliminate the burdens of cross-state practice and licensure. Those that use expedited licensure, the Interstate Medical Licensure Compact (“IMLC”) and the NABP’s e-LTP, retain at least some of the burdens of licensure because they require practitioners licensed by one state to be licensed in all other jurisdictions of practice. Although licensure in secondary jurisdictions is expedited, multistate practice under an expedited licensure model is a multistep

process involving actions by the principal/initial state of license, central administrative bodies, and the state boards of the secondary jurisdictions; the process may have to be repeated when an applicant subsequently seeks licensure in another state.⁶⁵ Applicants must pay fees to each central administrative body and all state boards, renew licenses in all states, and meet continuing education requirements for all states of licensure.⁶⁶ In addition, the IMLC sets the standards for expedited licensure higher than any individual state, which exacerbates the inherent potential of licensure to exclude qualified applicants and reduce competition between professionals, and is not necessary to protect patient health and safety.⁶⁷ Only the Nurse Licensure Compact, which uses a “mutual recognition model” that gives most nurses licensed in a compact state a privilege to practice, without notice, in all other compact states, eliminates licensure barriers to cross-state practice.⁶⁸ Other initiatives have procedures posing hurdles to multistate practice in between expedited licensure and mutual recognition, for example by requiring applications, notice, or fees.⁶⁹

B. Limitations Highlighted by the Public Health Emergency

The pandemic has laid bare the limitations of the piecemeal approach of relying on initiatives that do not fully streamline multistate practice, and do not cover all health care professions or all states. The COVID-19 pandemic has made it necessary to respond quickly to shortages of health care professionals in hotspot jurisdictions or locations, either in person or by telehealth, yet licensing issues presented challenges early on that required emergency action.⁷⁰ To maximize the availability of health care professionals during the public health emergency, all states have taken action to reduce licensure barriers for out-of-state licensees. These have generally been executive orders and/or emergency regulations issued by state boards that provide waivers or procedures for temporary licensing applicable to all or many health care professions.⁷¹ Each state took a different approach; some states’ waivers applied only to COVID-related illnesses, some to telehealth, and some to in-person care. Obtaining a temporary license could also be challenging.⁷²

In addition to addressing licensure barriers, both federal and state governments have acted to reduce supervision requirements during the pandemic. The Centers for Medicare & Medicaid Services temporarily reduced certain Medicare supervision requirements.⁷³ Because these changes in the applicability of federal law and regulation do not affect state-required supervision or other standards of practice, the U.S. Department of Health & Human Services (“HHS”) recommended that states also take action consistent with the federal changes to avoid delays in the provision of services.⁷⁴ HHS also recommended that states “allow health care professionals like nurse practitioners (NPs), other registered nurses, and physician assistants (PAs) to practice to the fullest extent of their license and without restrictive supervision requirements.”⁷⁵ Most states took action consistent with these recommendations, but the need for federal action and encouragement of corresponding state changes highlights the need for both federal and state efforts to permanently reduce restrictive scope of practice requirements nationwide.⁷⁶

C. The Rule Suggests that Stronger Portability and Harmonization Measures Are Necessary

While we continue to encourage the development and state adoption of portability initiatives, particularly initiatives that maximize ease of interstate practice, the pandemic has highlighted the need for stronger measures that achieve nationwide results more quickly. In that respect the approach taken in VA's Rule—preempting conflicting state licensure and scope of practice laws and regulations with respect to in-person practice—provides support for the view that some forms of federal encouragement or preemption may be necessary and appropriate to achieve nationwide license portability and standards of practice, even outside a closed system such as the VA. The VA's earlier authority regarding telehealth and APRN practice, and similar statutory preemption for DoD health care professionals, also support the use of preemption.

VI. Conclusion

By confirming that VA health care professionals may practice health care consistent with the scope and requirements of their VA employment, notwithstanding any state license or practice requirements, the Rule is likely to enhance the VA's supply of health care services and improve access to services in rural and underserved locations, expand options for beneficiaries, reduce delays in care, improve health outcomes, and reduce costs. For these reasons, we support the Rule, which should benefit VA beneficiaries—including many of our nation's most vulnerable veterans—and potentially non-VA health care consumers as well.

We appreciate your consideration.

Respectfully submitted,

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¹ This letter expresses the views of staff in the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has authorized us to submit these comments.

² Authority of VA Professionals to Practice Health Care ("VA Professionals"), 85 Fed. Reg. 71,838 (Nov. 12, 2020) (to be codified at 38 CFR § 17.419).

³ *Id.*

⁴ *Id.* at 71,839.

⁵ Federal Trade Commission Act, 15 U.S.C. § 45.

⁶ *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

⁷ *See generally* MARKUS H. MEIER ET AL., FTC, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, [https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care\(most-recent-version-under"Core Health Care Competition Documents"\)](https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care(most-recent-version-under-Core-Health-Care-Competition-Documents)).

⁸ *See, e.g.*, FTC & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <http://www.ftc.gov/reports/healthcare/040723healthcare rpt.pdf>.

⁹ FTC and staff advocacy can include letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, and reports. *See, e.g.*, Comment from FTC Staff to the Centers for Medicare & Medicaid Services ("CMS"), Dep't of Health & Human Services (May 29, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-letter-centers-medicare-medicaid-services-regarding-interim-final-rule-policy-regulatory/v200009_staff_advocacy_letter_cms_telehealth_comment.pdf (supporting provisions in CMS Interim Final Rule that reduce or eliminate restrictive Medicare payment requirements for telehealth during the pandemic, and suggesting that CMS consider making some of these changes permanent); Comment from FTC Staff to Thomas E. Brinkman, Jr., Representative, Ohio House of Representatives (Jan. 9, 2020),

https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-ohio-house-representatives-concerning-ohio-house-bill-177/v200005ohiohb177aprncomment.pdf (discussing the likely procompetitive effects of a Bill that would expand the scope of practice of APRNs in Ohio by ending Ohio’s mandatory written collaborative agreement requirement); Brief of Amicus Curiae FTC in Support of No Party, In re Nexium (Esomeprazole) Antitrust Litig., No. 15-2005 (1st. Cir. Feb. 12, 2016), https://www.ftc.gov/system/files/documents/amicus_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf (explaining that a reverse payment from a brand-name drugmaker that is used to settle patent litigation can violate the antitrust laws if it induces a generic drugmaker to abandon its patent challenge and stay out of the market); FTC STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (“APRNs”) (2014), <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf> [hereinafter COMPETITION AND THE REGULATION OF APRNs] (presenting an overview of FTC staff comments regarding APRNs, and an in depth analysis of the competitive effects of statutes and rules governing APRN scope of practice and supervision).

¹⁰ See, e.g., CAROLYN COX & SUSAN FOSTER, BUREAU OF ECON., FED. TRADE COMM’N, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION (1990), http://www.ramblemuse.com/articles/cox_foster.pdf. See also Christine S. Wilson & Pallavi Guniganti, *Deregulating Health Care in a Pandemic—and Beyond*, 34 Antitrust 14, (2020) (describing decades of bipartisan health care competition advocacy at the FTC, including comments on occupational licensing, scope of practice, and telemedicine).

¹¹ See FTC Staff Comment to the Hon. Laura Ebke, Nebraska State Senator 2 (Jan. 17, 2018), https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-nebraska-state-senate-regarding-nebraska-lb299-occupational/v180004_ftc_staff_comment_to_nebraska_state_senate_re_lb_299_jan-18.pdf (referring to FTC advocacy comments on nurses, eye doctors and vendors of optical goods, lawyers and other providers of legal services, dental hygienists, and real estate brokers).

¹² See FTC & U.S. DEP’T OF JUSTICE, *supra* note 8, at ch. 2. p. 33. See also *id.* at Executive Summary, Recommendation 2(c) (“States should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state.”).

¹³ See Comment from FTC Staff to Steve Thompson, Representative, Alaska State Legislature (Mar. 25, 2016), <https://www.ftc.gov/policy/policy-actions/advocacy-filings/2016/03/ftc-staff-comment-alaska-state-legislature-regarding> (regarding telehealth provisions in Senate Bill 74, which would allow licensed Alaska physicians located out-of-state to provide telehealth services).

¹⁴ See Comment from FTC Staff to the Director, Regulation Policy and Mgmt., Dep’t of Veterans Affairs (Nov. 1, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf (supporting the VA’s proposed rule that would confirm the authority of VA health care providers to provide telehealth services to or from non-federal sites regardless of whether the provider is licensed in the state where the patient is located).

¹⁵ See, e.g., *Occupational Licensing: Regulation and Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 115th Cong. 1, 3, 6-7 (2017) (statement of Maureen K. Ohlhausen, Acting Chairman, Federal Trade Commission), https://www.ftc.gov/system/files/documents/public_statements/1253073/house_testimony_licensing_and_rbi_act_sept_2017_vote.pdf.

¹⁶ See FTC STAFF, POLICY PERSPECTIVES: OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY (2018), <https://www.ftc.gov/reports/options-enhance-occupational-license-portability> [hereinafter OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY].

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- ¹⁷ See Comment from FTC Staff to the New York State Education Dep't (April 6, 2018), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-yorks-proposal-allow-licensure-endorsement-canadian-dental-licenses/v180007_ftc_staff_comment_to_nys_ed_dept_re_dental_licensure_requirements.pdf (supporting a proposed amendment that would allow experienced, licensed Canadian dentists to use the same procedures that established, practicing dentists in other U.S. states follow to become licensed in New York State).
- ¹⁸ See, e.g., Comment from FTC Staff to Daniel R. Hawkins, Rep., Kansas House of Representatives (Jan. 9, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-kansas-house-representatives-concerning-kansas-house-bill-2412/v200006kansashb2412aprnscomment.pdf (commenting on a bill that would eliminate a written collaboration agreement requirement for APRNs, and shift regulatory authority over APRNs from the nursing board to the medical board).
- ¹⁹ See COMPETITION AND THE REGULATION OF APRNs, *supra* note 9.
- ²⁰ Comment from FTC Staff to the Dep't of Veterans Affairs (July 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/comment-staff-ftc-office-policy-planning-bureau-competition-bureau-economics-department-veterans/v160013_staff_comment_department_of_veterans_affairs.pdf (supporting proposed rule allowing APRNs to provide VA services required by the VA without the oversight of a physician).
- ²¹ See, e.g., OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY, *supra* note 16, at 4; NAT'L CONFERENCE OF STATE LEGISLATURES, THE STATE OF OCCUPATIONAL LICENSING: RESEARCH, STATE POLICIES AND TRENDS 2 (2017), <http://www.ncsl.org/research/labor-and-employment/report-the-state-of-occupational-licensing.aspx> ("An occupational license is a credential that government—most often states—requires a worker to hold in certain occupations."); Eric M. Fish, Shiri A. Hickman, & Humayun J. Chaudhry, 10 SCITECH LAWYER (2014), http://www.americanbar.org/content/dam/aba/publications/scitech_lawyer/2014/spring/state_licensure_regulations_evolve_to_meet_demands_modern_medical_practice.authcheckdam.pdf ("Fifty-seven state medical and osteopathic boards and the District of Columbia Board of Medicine now require physicians engaging in telemedicine to be licensed in the state in which the patient is located."); *Dent v. West Virginia*, 129 U.S. 114 (1889) (upholding the right of the state of West Virginia to license physicians).
- ²² See, e.g., NAT'L CONF. OF STATE LEGISLATURES & ASS'N OF STATE AND TERRITORIAL HEALTH OFFICIALS, SCOPE OF PRACTICE POLICY, NURSE PRACTITIONER OVERVIEW, <http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/> (last visited Nov. 16, 2020) (showing states with full independent practice authority, those for which a transition to independent practice period is required, and those requiring a physician relationship); AM. ASS'N OF NURSE PRACTITIONERS, 2019 NURSE PRACTITIONER STATE PRACTICE ENVIRONMENT (Dec. 20, 2018), <https://storage.aanp.org/www/documents/state-leg-reg/statereregulatorymap.pdf>; E. KATHLEEN ADAMS & SARA MARKOWITZ, THE HAMILTON PROJECT, IMPROVING EFFICIENCY IN THE HEALTH-CARE SYSTEM: REMOVING ANTICOMPETITIVE BARRIERS FOR ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS, POLICY PROPOSAL 22-24 (June 2018), https://www.hamiltonproject.org/assets/files/AdamsandMarkowitz_20180611.pdf; AM. MED. ASS'N, PHYSICIAN ASSISTANT SCOPE OF PRACTICE 2 (2018), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/state-law-physician-assistant-scope-practice.pdf> (46 states and D.C. require physician supervision of PAs, two require collaboration agreements, two allow other arrangements).
- ²³ AM. MEDICAL ASS'N, COUNCIL ON MEDICAL EDUCATION, REPORT 6-A-10, TELEMEDICINE AND MEDICAL LICENSURE 1-2 (2010).
- ²⁴ See 38 U.S.C. § 7402(b) (setting forth qualifications, including licensure, for physicians, dentists, nurses, podiatrists, optometrists, pharmacists, psychologists, social workers, marriage and family therapists, mental health counselors, chiropractors, and others). See also VA Professionals, 85 Fed. Reg. at 71,839 (discussing VA authority under 38 U.S.C. § 7402(b) to hire health care professionals).
- ²⁵ See VA Professionals, 85 Fed. Reg. at 71,839.
- ²⁶ See VA Professionals, 85 Fed. Reg. at 71,838-40 ("Put simply, it is crucial for VA to be able to determine the location and practice of its VA health care professionals to carry out its mission without any unduly burdensome restrictions imposed by State licensure, registration, certification, or other requirements.").

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- ²⁷ 38 C.F.R. § 17.415(e). *See also* Advanced Practice Registered Nurses, 81 Fed. Reg. 90,206 (Dec. 14, 2016).
- ²⁸ *See* 38 C.F.R. § 17.419(c); Authority of Health Care Providers to Practice Telehealth, 83 Fed. Reg. 21,897, 21,902-03 (May 11, 2018) (final rule, codified at 38 C.F.R. § 17.419) (explaining the agency’s authority for preemption, which “allows agencies to preempt State law so long as the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute”); Authority of Health Care Providers to Practice Telehealth, 82 Fed. Reg. 45,756, 45,757, 45,759-60 (Oct. 2, 2017) (proposed rule, to be codified at 38 C.F.R. § 17.419).
- ²⁹ *See* 38 U.S.C. § 1730C (“Notwithstanding any provision of law regarding the licensure of health care professionals, a [VA] health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where the covered health care professional or the patient is located, if the covered health care professional is using telemedicine to provide treatment to” a beneficiary under the VA system).
- ³⁰ *See* VA Professionals, 85 Fed. Reg. at 71,846 (38 C.F.R. § 17.419(b), (c)). *See also* VA Professionals, 85 Fed. Reg. at 71,839-41 (discussing practice across state lines, national standard of practice, preemption).
- ³¹ *See* VA Professionals, 85 Fed. Reg. at 71,840-41, -46 (national standard of practice; 38 C.F.R. § 17.419(b)(1)).
- ³² *See* VA Professionals, 85 Fed. Reg. at 71,841-42 (preemption); Exec. Order No. 13,132, 64 Fed. Reg. 43,255, 43,257 (Aug. 10, 1999) (Federalism; Sec. 4, Special Requirements for Preemption).
- ³³ *See* VA Professionals, 85 Fed. Reg. at 71,838, 71,839, 71,842, 71,844, 71,846 (38 C.F.R. § 17.419(a)(2)(ii), (b)(1)).
- ³⁴ *See* VA Professionals, 85 Fed. Reg. at 71,841-42.
- ³⁵ *See* VA Professionals, 85 Fed. Reg. at 71,839-40, 71,844.
- ³⁶ *See* VA Professionals, 85 Fed. Reg. at 71,839-40 (“As of July 2020, VA has deployed personnel to more than 45 States. . . . As of June 2020, a total of 1,893 staff have been mobilized to meet the needs of our facilities and Fourth Mission requests during the pandemic.”).
- ³⁷ *See* VA Professionals, 85 Fed. Reg. at 71,840.
- ³⁸ *Id.*
- ³⁹ *See id.*
- ⁴⁰ *See id.* (“As of January 14, 2020, out of 182,100 licensed health care professionals who are employed by VA . . . 14 percent do not hold a State license, registration, or certification in the same State as their main VA medical facility.”).
- ⁴¹ *See id.*
- ⁴² *See id.*; OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY, *supra* note 16, at 23-24.
- ⁴³ *See* VA Professionals, 85 Fed. Reg. at 71,840; Comment from FTC Staff to the Director, Regulation Pol’y and Mgmt., Dep’t of Veterans Affairs, *supra* note 14, at 5.
- ⁴⁴ VA Professionals, 85 Fed. Reg. at 71,840.
- ⁴⁵ *See* VA Professionals, 85 Fed. Reg. at 71,841 (unnecessary supervision or co-signature requirements can delay care, leading to deterioration of a patient’s condition); Comment from FTC Staff to the Centers for Medicare & Medicaid Services, Dep’t of Health & Human Services, *supra* note 9, at 8-9 (unnecessary supervision requirements result in inefficient duplication of efforts by supervisors and supervisees and delays in the provision of services).
- ⁴⁶ *See* VA Professionals, 85 Fed. Reg. at 71,841 (“DoD has specific authority from Congress to create national standards of practice for their health care professionals under 10 U.S.C. § 1094.”).
- ⁴⁷ *See id.* (discussing delays, increased workload, and lower levels of care from co-signature requirements and loss of direct access to certain practitioners).

⁴⁸ See VA Professionals, 85 Fed. Reg. at 71,841 (VA health care professionals could avoid adverse state actions if DoD and the VA adopted the standard of the most restrictive state, but adopting the standard of “the most restrictive State is not an acceptable option because it will lead to delayed care and consequently decreased access and level of health care for VA beneficiaries.”).

⁴⁹ See VA Professionals, 85 Fed. Reg. at 71,840-41, -46 (national standard of practice; 38 C.F.R. § 17.419(b)(1)).

⁵⁰ Such considerations may be especially important in the health professions, where the risk of harm from an unqualified provider may be considerable and consumers may have difficulty determining whether a provider is qualified. See, e.g., COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES, *supra* note 9, at 12-13 (describing information asymmetries between professionals and consumers and other reasons supporting the importance of licensure in health care).

⁵¹ See, e.g., Maury Gittleman et al., *Analyzing the Labor Market Outcomes of Occupational Licensing*, 57 INDUS. RELATIONS 57 (2018) (those with a license earn higher pay and are more likely to be employed); Morris M. Kleiner & Evgeny Vorotnikov, *Analyzing occupational licensing among the states*, 52 J. REG. ECON. 132, 134, 155 (2017) (the restriction in the supply of labor created by occupational licensing has long been known to increase the price of services paid by consumers, which are transferred to licensed workers in the form of higher wages); Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, 59 J.L. ECON. 261 (2016) (explaining that “occupational licensing may function as a barrier to entry that drives up wages in the licensed profession and increases the price of products and services that are produced by licensed workers”). Cf. Beth Redbird, *The New Closed Shop? The Economic and Structural Effects of Occupational Licensure*, 82 AM. SOCIOLOGICAL REV. 600 (2017) (contrary to the consensus that licensure creates wage premiums by establishing economic monopolies, “licensure does not limit competition, nor does it increase wages.”).

⁵² See Janna E. Johnson & Morris M. Kleiner, *Is Occupational Licensing a Barrier to Interstate Migration*, 12 AM. ECON. J. 347 (2020) (comparison of licensed occupations that require a national examination with those based on state-specific examinations shows that “licensing reduces interstate migration, but the magnitude of the effect can only account for a small part of the overall decline in recent decades.”).

⁵³ See, e.g., INDRE BAMBALAITÉ ET AL., OCCUPATIONAL ENTRY REGULATIONS AND THEIR EFFECTS ON PRODUCTIVITY IN SERVICES: FIRM-LEVEL EVIDENCE 12, ¶ 18, OECD ECONOMICS DEPT WORKING PAPERS NO. 1605 (2020) (concluding from a review of the literature that “most of the research in this area failed to demonstrate quality improvements resulting from stricter regulatory entry barriers, or a reduction in the quality of goods and services following an easing of such barriers.”); MORRIS M. KLEINER, THE HAMILTON PROJECT, REFORMING OCCUPATIONAL LICENSING POLICIES 5, 12-13, 15 (2015), http://www.hamiltonproject.org/assets/legacy/files/downloads_and_links/reforming_occupational_licensing_morris_kleiner_final.pdf (a review of studies finds that occupational licensing has little effect on the quality of products or services, but it may function “as if the government were granting a monopoly in the market for the service, with the long-term impacts being lower-quality services, too few providers, and higher prices”); Sean Nicholson & Carol Propper, *Medical Workforce*, in HANDBOOK OF HEALTH ECONOMICS, Vol. 2, ch. 14, 885 (2012) (empirical studies of the effects of licensing in medical labor markets “conclude that licensing is associated with restricted labor supply, an increased wage of the licensed occupation, rents, increased output prices, and no measurable effect on output quality.”). Studies of the effects of licensure on quality often consider the effects of higher and lower standards of licensure, rather than the effects of newly enacted licensing laws that set standards for a health care occupation for the first time. However, one study found that requiring midwives to be licensed reduced maternal mortality and led to a modest reduction in infant mortality. See D. Mark Anderson et al., *The Effect of Occupational Licensing on Consumer Welfare: Early Midwifery Laws and Maternal Mortality*, 128 J. POLIT. ECON. 4,337 (2020).

⁵⁴ See *supra* note 21 and accompanying text.

⁵⁵ See, e.g., AM. MEDICAL ASS'N, MEDICAL LICENSURE (“The process of obtaining a medical license can be challenging and time consuming. . . . Physicians seeking initial licensure or applying for a medical license in another state should anticipate delays due to the investigation of credentials and past practice as well as the need to comply with licensing standards.”), <https://www.ama-assn.org/residents-students/transition-practice/obtaining-medical-license> (last visited Nov. 21, 2020); HEALTH RESOURCES & SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVICES (“DHHS”), SPECIAL REPORT TO THE SENATE APPROP. COMM., TELEHEALTH LICENSURE REPORT 9 (2010) (Requested by Senate Rep't 111-66) (“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.”).

⁵⁶ See MICHAEL L. BUENGER ET AL., *THE EVOLVING LAW AND USE OF INTERSTATE COMPACTS* xxi, 1, § 2.1.2 (2d ed. 2016) (Interstate compacts are formal, binding contracts between two or more states that are neither purely state nor purely federal in nature. States acting in their sovereign capacity enter into these contracts by enacting proposed compact legislation.); “No state shall, without the Consent of Congress . . . enter into any Agreement or Compact with another State, or with a foreign Power[.]” U.S. Constitution, art. I, § 10, cl. 3. None of the existing occupational licensure compacts have required the consent of Congress.

⁵⁷ See *OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY*, *supra* note 16, at 9-11 (discussing 6 health care compacts); *AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT (ASLP-IC)*, <https://www.asha.org/Advocacy/state/Audiology-and-Speech-Language-Pathology-Interstate-Compact/> (last visited Nov. 20, 2020).

⁵⁸ See *infra* note 62 and accompanying text; *OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY*, *supra* note 16, at 14-15 (modifying noncontractual model laws that do not have to be adopted verbatim may be easier than modifying interstate compacts for which each state’s legislation must be identical).

⁵⁹ See *supra* notes 57-58 and accompanying text; *OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY*, *supra* note 16, at n.34 and accompanying text (“compacts generally do not alter the scope of practice provisions of state practice acts”); *id.* at 20-21 (discussing harmonization of licensure requirements).

⁶⁰ See *supra* notes 47-49 and accompanying text.

⁶¹ See, e.g., Molly Kathleen Bachtel, et al., *The push to modernize nursing regulations during the pandemic*, 68 *NURSING OUTLOOK* 545 (2020) (only Idaho, North Dakota, and Wyoming have adopted the APRN Compact, which requires adoption by 10 states to become effective; unnecessary restrictions on APRNs’ scope of practice have impeded their mobilization during the pandemic and otherwise); Letter from the AMA and other national and state medical organizations to Katherine Thomas, President, National Council of State Boards of Nursing, May 10, 2018, <https://www.aafp.org/dam/AAFP/documents/advocacy/workforce/scope/LT-NCSBN-APRNCompact-051018.pdf> (“[T]he APRN Compact is the only compact that changes the health professional’s scope of practice. . . . We strongly object to the use of interstate licensure compacts as a mechanism through which to expand scope of practice laws . . . [and] . . . grant prescriptive authority and allow APRNs to practice independent of a supervisory or collaborative relationship with a physician, notwithstanding state law to the contrary”). See also AMA, *Allied Health Professions, Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988* (2018) (opposing independent practice by APRNs and the APRN Compact “due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration, or oversight.”).

⁶² See *OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY*, *supra* note 16, at 13 nn.67-70 and accompanying text; Sandra Evans, *The Nurse Licensure Compact: A Historical Perspective*, 6 *J. NURS. REG.* 11 (2015).

⁶³ See *INTERSTATE COMMISSION OF NURSE LICENSURE COMPACT ADMINISTRATORS, NLC MEMBER STATES*, <https://www.ncsbn.org/nlcmemberstates.pdf> (last visited Nov. 21, 2020) (operational in 2000; currently 34 member states; but partial implementation in New Jersey); *Interstate Medical Licensure Compact (“IMLC”)*, <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/> (adopted by 29 states, DC, and Guam, including 43 medical and osteopathic licensing boards, but implementation delayed in DC, PA, and LA, and GA, OK, and VT issuing expedited licenses but not determining whether state licensees qualify for them); . The IMLC became began expediting licenses in 2017. See *OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY*, *supra* note 16, at 10. See also *Psychology Interjurisdictional Compact (“PSYPACT”)*, Map, <https://psypact.org/page/psypactmap> (last visited Nov. 21, 2020) (15 states have adopted PSYPACT legislation, but the law will not go into effect in Virginia and North Carolina until 2021); *PSYPACT, FAQs*, <https://psypact.org/page/faq> (last visited Nov. 21, 2020) (PSYPACT began accepting applications on July 1, 2020); *Physical Therapy Compact, PT Compact Frequently Asked Questions (FAQ) 6* (June 12, 2019), (last visited Nov. 21, 2020) http://ptcompact.org/Portals/0/images/PTCFrequentlyAskedQuestionsV_20190612.pdf (“First member states began issuing compact privileges on July 9, 2018”); *PT Compact, PT Compact Map*, <http://ptcompact.org/ptc-states> (last visited Nov. 21, 2020) (28 states have enacted PT Compact legislation, but eight are not yet issuing or accepting compact privileges); See *Interstate Commission for EMS Personnel Practice, Interstate EMS Personnel Licensing*

Compact Declared Operational to Help Communities Respond to COVID-19 (March 13, 2020), <https://s3.amazonaws.com/nremt.content/static/documents/13+MAR+2020+EMS+Compact+Declared+Operational.pdf>; Interstate Commission for EMS Personnel Practice, EMS Compact Member States & Commissioners, <https://www.emscompact.gov/the-commission/member-states/> (last visited Nov. 21, 2020) (21 states have enacted the Recognition of EMS Personnel Licensure Interstate Compact (“REPLICA”), but Louisiana’s legislation does not become effective until 2021).

⁶⁴ Alaska, California, Connecticut, Hawaii, Massachusetts, New York, Ohio, and Rhode Island. *See supra* note 63 (compact maps or lists of states). Rhode Island was a member of the Nurse Licensure Compact, but left the compact as of July 18, 2018. *See* INTERSTATE COMMISSION OF NURSE LICENSURE COMPACT ADMINISTRATORS, NLC MEMBER STATES, *supra* note 63. *See also* Bachtel et al, *supra* note 61 (regarding the APRN Compact); ASLP-IC, Compact Map, <https://aslpcompact.com/compact-map/> (last visited Nov. 22, 2020) (ASLP-IC has not been enacted in AK, CA, CT, HI, MA, NY, or OH).

⁶⁵ *See* Interstate Medical Licensure Compact, A Faster Pathway to Physician Licensure, <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/> (last visited Nov. 22, 2020); Interstate Medical Licensure Compact, Frequently Asked Questions, <https://www.imlcc.org/faqs/> (last visited Nov. 22, 2020) (FAQs for Physicians); NABP, Licensure Transfer, <https://nabp.pharmacy/programs/licensure/#eligibility> (last visited Nov. 22, 2020). Applicants for licensure transfer under the e-LTP also must pass the Multistate Pharmacy Jurisprudence Examination for each state of transfer. *See* NAPLEX/MPJE 2020 Candidate Application Bulletin 2 (2020), https://nabp.pharmacy/wp-content/uploads/2019/03/NAPLEX-MPJE-Bulletin_July_2020-1.pdf. *See also* Anita Slomski, *Telehealth Success Spurs a Call for Greater Post-COVID-19 License Portability*, 324 JAMA 1021-22 (2020) (“Although the compact expedites multi-state licensure, ‘it functions more like a clearinghouse instead of extending true license reciprocity’ across states”).

⁶⁶ *See* Interstate Medical Licensure Compact, Frequently Asked Questions, *supra* note 65; NABP, Licensure Transfer, *supra* note 65. Many states have a post-licensure requirement for pharmacists licensed via the licensure transfer process: they must maintain their license by original examination, and pay fees and fulfill continuing education requirements for that state indefinitely, even if they do not plan to practice there again. *See* NABP, State Restrictions for Licensure Transfer (Oct. 5, 2020), <https://nabp.pharmacy/wp-content/uploads/2020/10/Licensure-Transfer-State-Restrictions-October-2020.pdf>; Mel Seabright, *Advice for Recent Pharmacy School Graduates*, PHARMACY TIMES, July 22, 2015, <https://www.pharmacytimes.com/contributor/mel-seabright-pharmd-mba/2015/07/advice-for-recent-pharmacy-school-graduates>.

⁶⁷ *See* Interstate Medical Licensure Compact § 2(k) (definition of physician), <https://www.imlcc.org/wp-content/uploads/2020/02/IMLC-Compact-Law.pdf>; Robert Steinbrook, *Interstate Medical Licensure: Major Reform of Licensing to Encourage Medical Practice in Multiple States*, 312 JAMA 695 (2014) (“Only some physicians, such as those with specialty certification or a time-unlimited specialty certification and a full and unrestricted medical license for at least 3 years, would be eligible” [to apply for expedited licensure under the IMLC]).

⁶⁸ OPTIONS TO ENHANCE OCCUPATIONAL LICENSE PORTABILITY, *supra* note 16, at 17-18, 20.

⁶⁹ *See, e.g.*, PSYPACT, Practice Under PSYPACT, https://cdn.vmax.com/psypact.org/resource/resmgr/practice/july_2020_practice_under_psy.pdf (last visited Aug. 17, 2020) (the procedure avoids applications to individual states and their continuing education requirements, but requires applications, annual renewals, and fees to both the Association of State and Provincial Psychology Boards and the PSYPACT Commission). The PT Compact requires physical therapists to purchase a “Compact Privilege” from the PT Compact Commission for each state of practice and states may require a jurisprudence examination. Applicants must pay fees to the PT Compact Commission and 20 states; renewal of the privilege may require another jurisprudence examination and fees. *See* PT Compact, Fee and Jurisprudence Table, <http://ptcompact.org/Compact-Privilege-Fee-Jurisprudence-and-Waiver-Table> (last accessed Aug. 13, 2020); PT Compact Frequently Asked Questions (FAQs) 2-5 (June 12, 2019), http://ptcompact.org/portals/0/images/PTCFrequentlyAskedQuestionsV_20190612.pdf.

⁷⁰ *See, e.g.*, Bachtel et al, *supra* note 61 (“the lack of a multistate licensure for advanced practice registered nurses, combined with unnecessary restrictions on APRNs’ scope of practice, has impeded mobilization of the nursing workforce”); Slomski, *supra* note 65 at 1022 (the IMLC does not sufficiently streamline licensure to address the increase in telehealth during the pandemic).

⁷¹ See, e.g., Federation of State Medical Boards (“FSMB”), U.S. States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19 (June 22, 2020) (50 states, D.C., and four territories had waivers; none did not have waivers with respect to out-of-state physicians in-person practice and licensure renewals). The number of states with waivers subsequently decreased; the current document may list fewer states as having issued waivers. See *id.*, <https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensures-requirements-covid-19.pdf> (last visited Nov. 22, 2020). See also FSMB, U.S. States and Territories Modifying Licensure Requirements for Telehealth in Response to COVID-19 (June 22, 2020) (49 states and three territories issued waivers and one state, D.C., and one territory did not with respect to out-of-state physicians, preexisting provider-patient relationships, audio-only requirements). Current document available at <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf>.

⁷² See, e.g., Slomski, *supra* note 65 at 1021. The FSMB compilation of state actions also has many sources that illustrate the variations in state approaches, with many requiring applications and other documentation to obtain temporary licensure. See *supra* note 71.

⁷³ See Interim Final Rule with Comment Period, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 19,230, 19,246 (April 6, 2020) (temporarily relaxing a requirement for direct supervision requirement of nonphysician practitioners when physicians bill Medicare “incident to” their services by allowing supervision using audio/video telecommunications technology).

⁷⁴ Letter from Alexander M. Azar II, Secretary of Health and Human Services, to Governors 2 (Mar. 24, 2020), https://www.ncsbn.org/HHS_Secretary_Letter_to_States_Licensing_Waivers.pdf (recommending that states “[t]emporarily suspend . . . any requirements for written agreements to meet supervision or collaboration requirements, in order to avoid significant delays in the provision of services” and that states “temporarily waive any requirements that the supervising physician be physically co-located with or within a certain geographic distance to the NP or PA who he or she is supervising.”)

⁷⁵ Guidance to States 2 (Mar. 24, 2020), attachment to Letter from Alexander M. Azar II, *supra* note 74, https://www.ncsbn.org/HHS_Guidance_to_States_on_Regulations_on_Healthcare_Workers.pdf.

⁷⁶ See Bachtel et al, *supra* note 61 at 546 (within a month, “all but seven . . . of the 28 states that limit NP practice have partially or fully waived APRN practice agreement requirements with physicians” and “22 states have achieved Full Practice Authority” status for NPs). See also Comment from FTC Staff to CMS, *supra* note 9, at 7-9.