



July 20, 2017

Economic Liberty Task Force  
Federal Trade Commission  
600 Pennsylvania Avenue, NW  
Washington, DC 20580

**In Re: Public Comments on License Portability to the FTC's Economic Liberty Task Force**

On behalf of the American Academy of PAs (AAPA), we would like to submit comments to the task force on the topic of license portability as it pertains to the PA (physician assistant) profession. We sincerely appreciate the task force's interest and attention to the issue of license portability. We believe increased license portability for PAs can help to eliminate arbitrary barriers to rapid deployment of PAs in areas of need and expand access to care for underserved populations. The Academy is actively looking for ways to effectively remove anticompetitive restraints that limit consumer access to healthcare. Many of those restraints lie in licensure requirements and procedures.

AAPA is the national professional organization for PAs representing more than 115,000 PAs practicing across all medical and surgical specialties. In addition, AAPA has an affiliate structure with over 100 PA constituent organizations, which include state chapters, federal service chapters, specialty organizations, caucuses, and special interest groups.

PAs are healthcare providers who are nationally certified and state licensed to practice medicine and prescribe medication in every medical and surgical specialty and setting. PAs practice and prescribe in all 50 states and the District of Columbia. PAs are educated in the medical model at Master's level accredited programs. The typical PA program extends over 27 continuous months and is broken into two phases – didactic and clinical. The didactic (classroom) phase consists of courses in anatomy, physiology, pharmacology, physical diagnosis, behavioral sciences and medical ethics. The clinical phase consists of rotations in medical and surgical disciplines including family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine, and psychiatry. Students graduate with approximately 2,000 hours of supervised clinical practice.

PA program graduates are eligible to take the PA National Certification Examination (PANCE) administered by the National Commission on Certification of PAs (NCCPA).<sup>1</sup> Required for PA licensure in all jurisdictions, PANCE functions as the *de facto* PA licensing exam. In order to maintain national certification, PAs are required to recertify by examination as medical generalists every ten years and complete 100 hours of continuing medical education every two years. The recertification examination, the PA National Recertifying Exam (PANRE), is a high-stakes examination that 18 states currently require for license renewal. No other medical profession ties continued licensure to the passage of a recertification exam.<sup>2</sup>

The Centers for Medicare and Medicaid Services (CMS) recently attested to the quality of PA education through a proposed rule published in the June 16, 2016 [Federal Register](#). In justifying a recommended change CMS stated, "PAs are trained on a medical model that is similar in content, if not duration, to that

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<sup>1</sup> There is no direct relationship between AAPA and NCCPA. While AAPA is the national professional society for PAs, NCCPA is the sole certifying organization for PAs in the United States.

<sup>2</sup> *NCCPA Lobbies State Legislatures*, AM. ACAD. PHYS. ASSISTANTS, <https://www.aapa.org/nccpa-lobbies-state-legislatures/> (last visited July 20, 2017).

of physicians. Further, PA training and education is comparable in many ways to that of APRNs (advance practice registered nurses), and in some ways, more extensive.”

The rigorous and comprehensive nature of PA education allows PAs to be extremely versatile providers, with nearly 48% of PAs opting to change specialties at least once during their career.<sup>3</sup> This versatility allows the PA profession to respond to provider shortages and fill gaps where needed.

The Academy has crafted the following responses to the questions posed by the task force.

### **Is obtaining a license in another state a significant barrier to mobility in the PA profession? If licensing is a barrier, what factors contribute to the lack of mobility?**

One of the hallmarks of the PA profession is the adaptability of PAs, who receive a general medical education and are able to practice in a wide range of medical specialties and settings. Another hallmark of the profession is that PAs have always sought to provide care for underserved and hard to serve patient populations. Major barriers to both PA flexibility and caring for the underserved exist in the form of inconsistent, archaic and unnecessary state licensure requirements that limit PA mobility and the ability to be rapidly licensed in multiple states. Some of the more prominent examples of barriers include:

- **Current Certification:** Twenty-two states require a PA to have current certification by NCCPA in order to receive a license.
- **Personal Interviews:** Four states require personal interviews in order to be licensed as a PA.
- **Identification of physician:** Sixteen states require a PA to have a practice agreement with an in-state licensed physician as a condition of licensure.
- **Approval of practice agreement:** Eleven states require a PA to submit a practice agreement for approval by the regulatory agency prior to issuance of a license.
- **Jurisprudence Exam:** Ten states mandate that a PA must pass a jurisprudence examination prior to licensure.
- **Direct board action (approval):** Thirty-three states require PAs seeking licensure to wait until the board has convened and approved applications for licensure.
- **Letters of recommendation:** Nineteen states require some form of letter of recommendation on behalf of a PA prior to licensure.
- **Length of Time Greater than a Month:** Thirty-six states average more than four weeks to issue a PA license.<sup>4</sup>

Requiring these additional steps in the licensure process, which add no public protection value, hinder and impede PAs from multi-jurisdictional licensure and addressing healthcare shortages and needs.

### **To what extent is the increased ability to provide certain services electronically (such as by telehealth or telework) driving greater interest in mechanisms to ease the burdens of multistate licensing?**

A shortage of 35,000-44,000 primary care physicians by 2025 has been predicted by some researchers.<sup>5</sup> The Association of American Medical Colleges has forecast a much more critical projection: a shortage of approximately 45,000 primary care physicians by 2020, expanding to approximately 66,000 by 2025.<sup>6</sup>

<sup>3</sup> AM. ACAD. PHYS. ASSISTANTS, 2015 AAPA NATIONAL SURVEY, (2015).

<sup>4</sup> AM. ACAD. PHYS. ASSISTANTS, CHART: PA LICENSURE PROCEDURES AND NUMBER OF PA LICENSES BY STATE, (updated June 2017).

<sup>5</sup> Jack M. Colwill et al., *Will Generalist Physician Supply Meet Demands of an In-creasing and Aging Population?* 27 HEALTH AFF. 232, 236 (2008).

<sup>6</sup> *The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025*, ASS'N OF AM. MED. COLL., available at [https://www.aamc.org/download/158076/data/updated\\_projections\\_through\\_2025.pdf](https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf) (last visited October 2, 2014). See also, *Physician Shortages to Worsen Without Increases in Residency Training*, ASS'N OF AM. MED. COLL., available at [https://www.aamc.org/download/153160/data/physician\\_shortages\\_to\\_worsen\\_without\\_increases\\_in\\_residency\\_tr.pdf](https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf)

Given these estimates, and the deluge of insured patients due to the enactment of the Affordable Care Act, states continue to examine and implement approaches to ensure that patients have adequate access to care. To that end, the United States is entering a new era of healthcare delivery with a significant expansion in the use of telemedicine. This ability to transmit medical information and provide medical care through a variety of methods to improve patient health and wellbeing is a vital tool that can help meet access to care goals and better assure care coordination. Examples with PAs can be seen in behavioral and mental health and dermatology.

One in five Americans experiences a mental health disorder in any given year and many are unable to get the care they need.<sup>7</sup> Provider shortages, uncoordinated care and patients with multiple health conditions create significant challenges. PAs are on the front lines of this healthcare crisis, witnessing the mental health issues faced by their patients. With a broad medical education grounded in primary care, courses and rotations in behavioral and mental health and authority to prescribe controlled and non-controlled medications, PAs are well prepared to collaborate with psychiatrists to extend care to patients. The use of telemedicine, specifically telepsychiatry by PAs, to treat medically underserved patients in rural areas is invaluable and allows patients to receive care in real time with little to no delay in communication feedback.<sup>8</sup>

Using telemedicine as one of many innovative tools to complement the way in which modern medicine is practiced, allows PAs to evaluate, diagnose and treat patients in a timely and efficient manner. For example, PAs use telemedicine to conduct the initial assessments of children with autism throughout rural areas as members of behavioral pediatrics teams.<sup>9</sup>

PAs take an active role in the utilization of technology in the application of teledermatology, which utilizes “the remote delivery of dermatologic services and clinical information using telecommunications technology.”<sup>10</sup> This is particularly important for patients in rural areas since the most convenient and accessible dermatology practice may be hundreds of miles away, resulting in treatment delays that can put patients at increased risk.<sup>11</sup>

However, to optimally use telemedicine as well as the wide variety of available telecommunication modalities that support it, the current system of health professional licensure and practice regulations must be streamlined so as to not limit both a patient's access and choice surrounding use of these technologies, or the practice of healthcare providers like PAs. Requiring multiple licenses and maintaining separate practice rules in each state is an impediment to the use of telemedicine. Such state-by-state approaches prohibit people from receiving critical, often life-saving medical services that may be available to their neighbors living just across the state line. Since the goal of telemedicine is to increase access to care, states should not impose geographic restrictions and limitations on the provision of care. In addition, states should make it easy for PAs to be licensed in multiple jurisdictions. Reciprocal relationships with neighboring states and multistate compacts whereby a license to practice in one state facilitates licensure in other states for the purposes of reducing barriers to individual providers is ideal.

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(last visited July 17, 2017) (further predicting greater shortages due to funding constraints on postgraduate training for residents and fellows).

<sup>7</sup> AM. PSYCHIATRIC ASS'N. WORDS MATTER: REPORTING ON MENTAL HEALTH CONDITIONS.

<https://www.psychiatry.org/newsroom/reporting-on-mental-health-conditions>. (Accessed July 16, 2017).

<sup>8</sup> Telepsychiatry in rural Iowa: Making Mental Health Services Available. PA Professional. April 2011.

<sup>9</sup> AM. ACAD. OF PHYS. ASSIST., PHYSICIAN ASSISTANTS AND TELEMEDICINE: OPPORTUNITY FOR RURAL COMMUNITIES (2012) (on file with the author).

<sup>10</sup> *Teledermatology*, AM. ACAD. OF DERMATOLOGY, <https://www.aad.org/members/practice-and-advocacy-resource-center/practice-arrangements-and-operations/teledermatology> (last visited Nov. 16, 2014) (defining teledermatology). See also Sharon Rounds, *Innovative Approaches to Healthcare Delivery at the Providence VA Medical Center*, 93 MED. & HEALTH R.I. 6, 6-7 (2010) (discussing PA utilization of teledermatology in the Dermatology Section of the Providence VA Medical Center and provision of teledermatology services to VA facilities in rural Maine.).

<sup>11</sup> Karyn B. Stitzenberg et al, *Distance to Diagnosing Provider as a Measure of Access to Patients with Melanoma*, 143 ARCHIVES OF DERMATOLOGY 991, 997 (2007), available at <http://archderm.jamanetwork.com/article.aspx?articleid=654325&resultClick=3> (last visited July 16, 2017). The farther that patients travel to reach their diagnosing providers, the more advanced their stage at diagnosis is likely to be. Although we do not yet have survival data, it is reasonable to surmise that differences in Breslow thickness at diagnosis could translate into differences in overall survival.

## **What are the advantages and disadvantages of the mechanisms that interstate licensure compacts and model laws use to ease licensing requirements across state lines, such as mutual recognition, endorsement, and expedited licensure?**

Like any type of unified action, there is the potential for both advantages and disadvantages in an interstate compact and model law. However, it is important to point out that the disadvantages are not only far outweighed by the advantages, but they are also rendered moot if the compact or model law is ideally created and executed. The potential disadvantages are the time, effort and capital required to initiate a compact and there is no guarantee that once in place, it would eliminate all relevant barriers. The Interstate Medical Licensure Compact, for example, was introduced as a resolution in the 2012 Federation of State Medical Boards (FSMB) House of Delegates (HOD), and then moved quickly through various stages to the point of launch in 2014 of the actual legislative language.<sup>12</sup> This was incredibly rapid for such a complex undertaking, however applications for compact licenses were not actually accepted until April 2017,<sup>13</sup> nearly five years after the 2012 FSMB HOD. The length of time from concept to execution creates the potential for some items in the compact to be outdated before they are implemented.

This problem has been demonstrated in the nursing compact. A state is only a member if it adopts identical legislative language as the other compact member states. With the initial nursing compact it was realized that it no longer reflected a sufficiently modern approach, and thus a whole new compact was launched and all member states were required to pass new legislation.<sup>14</sup> Additionally, a compact has the potential to implement barriers, rather than remove them. An example of this would be if the model legislation for a compact incorporated a requirement that was antiquated and hindered, rather than streamlined licensure.

Mutual recognition, endorsement and expedited licensure can all facilitate consumer access to healthcare providers. In addition, requiring high standards for multi-state licensees, as is required by the Interstate Medical Licensure Compact, has the potential to create a safer licensee workforce. This is described in an article from the Journal of Medical Regulation, which outlined the requirements for a physician to be eligible for participation in the compact and stated, "In short: Physicians who participate in the Compact will have the strongest possible track record of safe and responsible medical care."<sup>15</sup> It goes on to say that the information sharing agreements between states "make it possible to better track and investigate physicians who have been disciplined or are under investigation."<sup>16</sup> This demonstrates that one of the advantages to this Compact, and the mechanisms it utilizes leads to a safer pool of providers.

## **How effective are compacts and model laws in reducing barriers to entry in licensed occupations, enhancing mobility of licensees, increasing the supply of licensees, and promoting competition among service providers?**

The effectiveness of compacts in reducing barriers to entry, enhancing mobility of the licensees and increasing the supply of licensees, as well as promoting competition, rests on the type of compact (mutual recognition - nurses v. individual; state license model - physicians) and the number of member states. Compacts that utilize a mutual recognition model, allow licensees to be licensed in a home state, and practice in any of the member states so long as they meet certain criteria. This allows for a rapid deployment of licensees.<sup>17</sup> The Interstate Medical Licensure Compact, an individual state license model,

<sup>12</sup> Blake T. Maresh, *The Interstate Medical Licensure Compact: Making the Business Case*, 100 J. MED. REG. 8, at 19 (2014).

<sup>13</sup> Press Release, Federation of State Medical Boards, FSMB Congratulates Commission on Launch of Interstate Medical Licensure Compact (April 7, 2017) (on file with author).

<sup>14</sup> *Enhanced Nurse Licensure Compact (eNLF) Implementation*, NATIONAL COUNCIL OF STATE BOARDS OF NURSING, <https://www.ncsbn.org/enhanced-nlc-implementation.htm> (last visited July 18, 2017).

<sup>15</sup> Donald H. Polk, *Sensible Regulatory Guidelines for a New Era of Telemedicine: How the FSMB is Leading*, 100 J. MED. REG. 5, at 7 (2014).

<sup>16</sup> *Id.*

<sup>17</sup> Am. Med. Ass'n, Issue Brief: Interstate Medical Licensure Compact 6 (2017). (Specifically the chart comparing the RN Compact, the APRN Compact and the Interstate Medical Licensure Compact).

while in its infancy, should facilitate rapid physician licensure in multiple jurisdictions and increase the mobility and supply of licensees.

It is important to point out that PAs, unlike nurses or physicians, are generally regulated by a profession different from its own. Physicians are almost universally licensed by medical boards consisting of physicians. Nurses (whether RNs or APRNs) are almost always licensed by nursing boards comprised of nurses. PAs are generally regulated by physician-dominated boards that may be out of touch with best practices in PA licensing. Development of a compact for PAs may aid boards in evaluating their current processes and adopting more appropriate systems that can enhance competition and increase access.

As with any organized effort involving various entities, compacts, even successful ones, have both positives and negatives. For example, the nursing compact has purportedly clarified the authority to practice for many nurses providing telehealth, simplified and streamlined the financial burden and process of multiple licenses (which increased mobility), improved access to care, enhanced disaster response, and vastly improved data sharing among participant states.<sup>18</sup> Even with these potential advantages, the compact encountered difficulty in various forms, which the Health Resources & Services Administration (HRSA) stated as “Control/Loss of Authority, Lack of Uniform Standards, Costs/Loss of Revenue, Strike Breaking, and Perception vs. Actual Experience/Lack of Independent Evaluation.”<sup>19</sup>

The potential for a compact to bring states with restrictive licensing and scope laws up to speed could have a major impact on the number of qualified providers in that state, and thus could greatly expand access to care. In states that are more restrictive in regulating PA practice, there is difficulty retaining the PAs that are trained and educated there. A prime example of this is the state of Kentucky, which is the only state that does not allow PAs to prescribe controlled substances.<sup>20</sup> Additionally, Colorado, which requires a physician to be onsite for the first six months of practice with a newly graduated PA, has noted that new graduate PAs fail to remain in or choose to come to the state.<sup>21</sup>

### **How does an interstate licensure compact differ from a model law used to streamline licensing across state lines? What factors influence the choice of an interstate compact or a model law to ease cross-state licensing requirements?**

Both an interstate compact and a model law can streamline the licensure process. The differences lie within the function of each. A compact streamlines the process by allowing for an expedited process for those who are already licensed within a member state. So long as the licensee meets the requirements of the compact, he or she does not need to start the process up from scratch. This has its limitations in that the laws and the regulations may be different in the participating states within the compact.

A model law, in contrast, promotes consistency since each state that adopts it has the same provisions and parameters regulating the licensure and practice of that profession. This would make the actual practice from state-to-state more uniform, but does not on its own address the length of time it takes to become licensed.

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<sup>18</sup> HRSA, Health Licensing Board Report to Congress, at 18 (2010).

<sup>19</sup> Id. at 19.

<sup>20</sup> *Legislator Seeks Measure Permitting Physician Assistants to Prescribe Controlled Substances*, KENTUCKY HEALTH NEWS (Oct. 12, 2016), <http://www.kyforward.com/legislator-seeks-measure-permitting-physician-assistants-to-prescribe-controlled-substances/>. (“Ben Swartz, the executive director for the Kentucky Academy of Physician Assistants, tells IL that this difference makes it harder to hire physician assistants, and changing the law would ‘bring parity in line with the two professions’ and ‘level the job market’ in Kentucky,” Sonka reports. “He adds that because Kentucky lags behind the rest of the country on this law, physician assistants in Kentucky often leave to find work in other states where they have full prescription authority, even though their training is more thorough than that of nurse practitioners.”)

<sup>21</sup> AM. ACAD. PHYSICIAN ASSISTANTS, *Survey of Colorado PAs on Regulatory Restrictions: August 2016*, (unpublished results on file with author) (Of Colorado PAs surveyed who graduated in the last 5 years, 67% of respondents report that CO’s restrictions in state law and regulations to some extent hindered them from obtaining a PA position, changing jobs as a PA, or hindered them once you had made the change. 44% report that the restrictions and regulations at least moderately hindered them from obtaining a PA position, changing jobs as a PA, or hindered them once you had made the change. 6.7% report that the restrictions and regulations prevented them from obtaining a job).

AAPA first adopted Model State Legislation for PAs in 1991 and has updated the Model multiple times to reflect new improved licensing procedures and changes in PA practice and has started the process of updating the Model once again to implement a new and more progressive policy on state regulation of PAs adopted by AAPA in May of 2017.<sup>22</sup> If AAPA's Model State Legislation was passed in all states PA utilization would be greatly improved, enhancing consumer access and choice and leading to increased innovation in practice. Additionally, it would eliminate numerous administrative and antiquated barriers regarding PA scope, and remove licensure procedures (such as those highlighted in the answer to the first question) that serve no public protection interest. In spite of improvements to healthcare regulation and patient care that can be achieved through the passage of model laws, their pursuit and enactment can be a long and arduous process due not only to the different local and political realities of each state but also to opposition from providers who feel threatened by the changes in state law sought for implementation. For example, although nurse practitioners have made concerted efforts to advance their model legislation for 20 years, less than half of the country has adopted it.<sup>23</sup>

**What factors contribute to a successful compact or model law for easing licensing requirements across state lines? Are interstate licensure compacts or other mechanisms more suitable for some occupations than others?**

As noted above, two factors that contribute to the success of the compact are the type of compact and the number of member states. The factor that contributes to a successful model law is its incorporation of best practices. The success of a compact or model law, at least as far as it pertains to healthcare-related professions, is measured by whether access to care has been expanded, while the care being provided has improved. Interstate licensure compacts are more suitable for professions whose regulation is a matter of public health and safety, including but not limited to PAs, advanced practice nurses, registered nurses and physicians. Compacts also facilitate the ability of health professionals to rapidly respond to emergencies across state lines. This would include, but is certainly not limited to, those clinicians who are often at the forefront of patient care, including PAs, advanced practice nurses, registered nurses and physicians.

**To what extent does the effectiveness of a compact or model law depend on harmonization of state requirements for licensing? Do compacts and model laws tend to increase the substantive or procedural standards to obtain a state license? If there is an increase in standards, does that limit licensee participation or otherwise reduce the effectiveness of a compact or model law in easing licensing requirements?**

The effectiveness of a compact or model law is almost completely dependent on harmonization of state licensing requirements. In theory a state could have additional licensing requirements, but this would defeat the compact or model's intent.

Compacts have the potential to either increase or decrease substantive or procedural standards. Ideally they describe and adopt best practices and level set. If the commission managing the compact does an insufficient job of forming a consensus on licensure requirements and procedures, states may be hesitant to join the compact for fear of the safety of their residents. This has the potential to add extraneous requirements (see the Interstate Medical Licensure Compact's requirement for board certification).<sup>24</sup> Conversely it may lead states to review their own processes and incorporate licensing best practices.<sup>25</sup>

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<sup>22</sup> AM. ACAD. OF PHYSICIAN ASSISTANTS, GUIDELINES FOR STATE REGULATION OF PAs, *available at* [http://news-center.aapa.org/wp-content/uploads/sites/2/2017/06/Guidelines\\_for\\_State\\_Regulation\\_2017-A-07-FINAL.pdf](http://news-center.aapa.org/wp-content/uploads/sites/2/2017/06/Guidelines_for_State_Regulation_2017-A-07-FINAL.pdf).

<sup>23</sup> STATE PRACTICE ENVIRONMENT, AM. ASSOC. NURSE PRACTITIONERS, <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment> (last visited July 20, 2017).

<sup>24</sup> INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION, INTERSTATE MEDICAL LICENSURE COMPACT, at 3 (2016). Available at: <https://imlcc.org/wp-content/uploads/2016/01/Interstate-Medical-Licensure-Compact-FINAL.pdf>. See definition of physician as including the stipulation, "(4) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists."

<sup>25</sup> HRSA, HEALTH LICENSING BOARD REPORT TO CONGRESS, at 11 (2010). Discussing "Uniform Core Licensure Requirements."

If the compact or model indeed includes best practices and accepted professional standards and requirements it should not have a negative impact on licensees.

**To what extent do centralized databases of applicants' credentials, criminal background checks, and disciplinary information contribute to the effectiveness of an interstate licensure compact? Do centralized databases make it more likely that the compact will be accepted by licensees and employers of licensees?**

The primary function of a state medical (or PA) board is to protect patients through assuring their proper licensing and regulation.<sup>26</sup> An "effective interstate medical licensure compact must include a cooperative system of information-sharing and rapid adjudication of disciplinary issues between states."<sup>27</sup> Patient protection commences with the licensure process which is intended to ensure that practitioners have the requisite education and training, and that they conform to recognized standards of professional conduct in the provision of patient care.<sup>28</sup> As a result, the existence of information-sharing agreements between states that facilitate the ability to better document, catalog and evaluate providers who are under investigation or who have been disciplined makes a centralized database of applicants' credentials,<sup>29</sup> criminal background checks and disciplinary information more attractive to these regulatory bodies.

As the national membership organization for PAs, while we cannot definitively say that centralized databases will make a compact more acceptable to licensees or their employers, it is certainly true that such repositories are not novel concepts to PAs or their employers. For example, PAs, health systems (and physicians) can and do currently benefit from the Federation Credentials Verification Service (FCVS) offered by the FSMB. FCVS is a uniform process for state medical boards to obtain a verified, primary source record of a PA's (or a physician's) core medical credentials. FCVS obtains primary source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows providers to establish a confidential, lifetime professional portfolio which can be forwarded, at their request, to any state medical board that has established an agreement with FCVS, hospital, healthcare or any other entity. Hospitals and insurance providers can also use the FCVS profile in their credentialing process. This can decrease the amount of time it takes to process applications. Similarly, PAs are also subject to the National Practitioner Data Bank (NPDB), a workforce tool that prevents practitioners from moving state-to-state without disclosure or discovery of previous damaging performance. Established by Congress in 1996, this web-based repository of reports contains data on medical malpractice payments and certain adverse actions related to healthcare practitioners, providers, and suppliers.

Centralized databases are often required for compact formation and function and already widely utilized by licensees and employers.

**What factors influence a state's decision to enter into a compact or adopt a model law? Are some states more willing to become part of a compact or model law than others? How effective are compacts and model laws that are not universally adopted? How can organizations that develop and administer compacts and model laws foster their adoption by more states?**

A state's decision to adopt a compact or model law is typically influenced by several factors, including but not limited to, the desire to articulate best practices and policies regarding the regulation of a profession, the need to achieve regulatory efficiency, a commitment to assuring that patients have access to timely,

<sup>26</sup> Letter from AAPA to FTC (July 5, 2017) (on file with AAPA). With the exception of five states, which have separate PA boards with plenary regulatory authority (Arizona, Iowa, Massachusetts, Rhode Island and Utah), PAs are regulated by medical boards.

<sup>27</sup> FEDERATION OF STATE MEDICAL BOARDS, COMMENTS ON FEDERAL TRADE COMMISSION (FTC) WORKSHOP, EXAMINING HEALTH CARE COMPETITION (2014) available at [https://www.ftc.gov/system/files/documents/public\\_comments/2014/04/00131-89853.pdf](https://www.ftc.gov/system/files/documents/public_comments/2014/04/00131-89853.pdf) (last accessed July 16, 2017).

<sup>28</sup> FEDERATION OF STATE MEDICAL BOARDS, *The Role of the State Medical Board*, available at [https://www.fsmb.org/Media/Default/PDF/Advocacy/role\\_of\\_state\\_medical\\_boards.pdf](https://www.fsmb.org/Media/Default/PDF/Advocacy/role_of_state_medical_boards.pdf) (last accessed July 16, 2017).

<sup>29</sup> Donald H. Polk, *Sensible Regulatory Guidelines for a New Era of Telemedicine: How the FSMB is Leading*, 100 J. MED. REG. 5, at 7 (2014).

safe, high-quality care and local realities that require an immediate solution to a healthcare problem. Unhappily it is also influenced by political pressure, not uncommonly, as noted by the FTC, by active market participants. Since a compact requires several states to uniformly adopt the same language, some states may choose to adopt a model law for purposes of flexibility and immediacy. Even in those instances where states participate in interstate licensure compacts, regulations regarding a profession's scope of practice and level of autonomous practice may vary significantly across jurisdictions. This scenario precludes effective and optimal utilization and minimally improves access to care.

Medical practice is dynamic and changes rapidly to adapt to modern technologies and innovative ways people deploy health professionals in the field. Admittedly, all states have different political and healthcare climates. However, standardization in medical regulation can enhance appropriate and flexible professional practice while at the same time allowing states to improve access to care. Legislators whether at the state or federal level, and other policy and decision makers must have some knowledge of a wide variety of issues given the nature of their responsibilities. However, these individuals often recognize that they are not the experts regarding a particular issue for which subject matter expertise is required. To that end they understand and appreciate the value in adopting thoughtful and carefully crafted best practices from those who are considered the experts in regulation.

Some states are more willing to enact a model law given the urgent need for a prompt remedy to a healthcare crisis. For example, as states across the country continue to examine ways in which to address their healthcare workforce shortages, it is only logical for them to examine the policies and model law of the national organization for PAs, a profession created over 50 years ago in response to a perceived shortage and maldistribution of physicians for viable solutions. Even in those instances in which states do not fully adopt all aspects of the AAPA model law for PAs, states still benefit from the provisions that are ultimately incorporated within their state laws and regulations. These benefits can include streamlining licensure requirements, processes and procedures to allow PAs to quickly get to work and assuring that PAs can practice to the top of their license, education, training and experience through the incorporation of optimal team practice provisions, among several others.

Organizations that develop model laws can foster their adoption by more states through continued engagement with their state and specialty professional membership organizations, applicable professional regulatory boards, and consumer organizations. In addition, the development of resources to include fact sheets, media campaigns, issue briefs, answers to frequently asked questions, white papers, and articles that are readily accessible to members of the public can also assist in the adoption of model laws.

### **What, if anything, can or should the federal government do to encourage adoption of compacts and model laws that promote license portability across state lines?**

The federal government understands fully the shortage of healthcare providers that exists and thus should explore ways to incentivize states to adopt and participate in interstate compacts and model laws that maximize deployment of providers like PAs. HRSA, a division of the Health and Human Services department, is a branch of the federal government. Each year, HRSA offers grants, for use to support initiatives designed to improve patient health for those who are medically underserved or face barriers to needed care because they are economically vulnerable or geographically isolated in the United States.<sup>30</sup> Program areas include primary healthcare, HIV/AIDs and healthcare workforce among several others.<sup>31</sup> In 2015, HRSA awarded the Federation of State Medical Boards (FSMB) a grant to support state medical and osteopathic boards in their efforts to establish a commission to administer the Interstate Medical Licensure Compact.<sup>32</sup>

<sup>30</sup> HRSA Agency Overview *available at* <https://www.hrsa.gov/about/budget/hrsabudgetoverview-2018.pdf> (Last visited July 18, 2017); See also About HRSA *available at* <https://www.hrsa.gov/about/index.html> (Last visited July 18, 2017)

<sup>31</sup> *Id.*

<sup>32</sup> Press Release, Federation of State Medical Boards, **Federal Grant Awarded to Support State Medical Boards in Developing Infrastructure for Interstate Medical Licensure Compact**, *available at*

A similar grant could be awarded to PA-licensing boards with the goal of increasing patient access to care through an interstate licensure compact for PAs, to address statutory and regulatory barriers to multistate PA licensure and to assure that PAs are able to utilize telemedicine technologies for the practice of medicine. If such an endeavor is to be successful, continued and increased discretionary and mandatory funding which HRSA currently receives for its multiple programs will be required. Mandatory funding is slated to expire at the end of fiscal year 2017 for several key programs including the National Health Services Corps which offers financial and other support to primary care providers and sites in underserved communities.<sup>33</sup> Also as the need for HRSA programs continues to grow, increased discretionary funding will be required to continually invest in programs that keep patients healthy.<sup>34</sup>

Further, there have been studies that show states could save millions of dollars over time by removing barriers to PA practice.<sup>35</sup> The federal government could conduct a more in-depth review and study to incentivize states to reduce barriers. Finally, more involvement and encouragement from legislators, as was done by several U.S. Senators with FSMB regarding the Interstate Medical Licensure Compact, would go a long way in encouraging states to adopt compacts as a way to streamline licensure and reduce barriers.<sup>36</sup>

**How effective are state-based initiatives at improving the portability of licenses for military spouses? Are such portability measures more effective for some professions than others? What mechanisms have states used (e.g., endorsement, temporary licensure, expedited licensure, etc.) to assist military spouses, and which have been the most effective?**

It's unclear if state-based initiatives to improve the portability of licenses for military spouses are effective.<sup>37</sup> This is due in part to the fact that the laws are inconsistent, only apply when they are triggered by certain circumstances and do not apply to all professions.<sup>38</sup> States also do not extend the same licensure privilege to military spouses. For example, some laws issue a temporary or courtesy license, others provide for expedited licensure and still others allow for licensure reciprocity.<sup>39</sup> Thus it remains to be seen which mechanism is the most effective.

**What lessons have been learned from efforts to improve license portability for military spouses? To what extent might these lessons be extended to streamlining cross-state licensure for all licensees?**

Military spouses seek new employment every one to three years, on average, and more often than civilians, based on when their enlisted husbands or wives are deployed to posts in a new state.<sup>40</sup> In addition, one-third or 35% of military spouses have careers that require a professional license, thus necessitating re-credentialing with each move across state lines.<sup>41</sup> Although there have been efforts throughout the country to improve, streamline and expedite professional licensing regulations of military spouses, more work remains to be done. According to the National Military Family Association, even with

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[https://www.fsmb.org/Media/Default/PDF/Publications/Compact\\_Commission\\_Grant\\_July071715A.pdf](https://www.fsmb.org/Media/Default/PDF/Publications/Compact_Commission_Grant_July071715A.pdf) (Last accessed July 16, 2017)

<sup>33</sup> Friends of HRSA Sign-on Letter on FY18 Appropriations available at [https://www.aapa.org/wp-content/uploads/2017/03/Friends\\_of\\_HRSA\\_FY18\\_Appropriations\\_sign-on-letter.pdf](https://www.aapa.org/wp-content/uploads/2017/03/Friends_of_HRSA_FY18_Appropriations_sign-on-letter.pdf) (Last visited July 18, 2017)

<sup>34</sup> Id.

<sup>35</sup> Rod Hooker and Ashley Muchow, *Modifying State Laws for Nurse Practitioners and Physician Assistants Can Reduce Cost of Medical Services*, 33 NURSING ECONOMIC\$ 88 (2015).

<sup>36</sup> Letter from Senators Barrasso et al to Humayun Chaudhry and James Gifford, Federation of State Medical Boards (Sept. 25, 2015). Available at: [http://www.fsmb.org/Media/Default/PDF/Publications/Senate\\_Letter\\_Sept2015.pdf](http://www.fsmb.org/Media/Default/PDF/Publications/Senate_Letter_Sept2015.pdf).

<sup>37</sup> The Pew Charitable Trusts Military. Spouses Struggle to Stay Careers, Despite State Laws *available at* <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/12/13/military-spouses-struggle-to-stay-in-careers-despite-state-laws> (last visited July 18, 2017).

<sup>38</sup> Id.

<sup>39</sup> Id.

<sup>40</sup> White House Fact Sheet, July 2016, *available at* <https://obamawhitehouse.archives.gov/the-press-office/2016/07/02/fact-sheet-first-lady-michelle-obama-and-dr-jill-biden-announce-all-50>.

<sup>41</sup> Id.

the enhancements states have made, the rules are not uniform and are often complex.<sup>42</sup> In addition, regulatory agencies responsible for implementing the rules are often unaware of their existence or how to apply them.<sup>43</sup> As a result, these efforts illustrate that consistency and a better understanding of the licensing regulations are needed to continue the efforts to improve license portability for military spouses. These lessons are certainly not limited to this group or type of licensees. All regulators and licensees benefit when laws and rules are concise, consistent and easy to navigate and understand.

**Are there some occupations for which it would be better to reduce or eliminate licensing requirements, rather than develop an interstate licensure compact or model law to ease licensing requirements across state lines? What factors would influence this analysis?**

The answer to the question of whether there are occupations for which it would be better to reduce or eliminate licensing requirements lies at the intersection of public protection and free enterprise. Nowhere is this more evident than in the realm of healthcare. For example, PAs could benefit greatly in many states by the rationalization of licensure procedures and unnecessary requirements.

There are some professions within healthcare that have sought to become licensed who could simply be credentialed at the facility level. In these instances, human resources practices could substitute for licensure. The decision on which occupations do or do not require licensure should be influenced by the degree of oversight provided and autonomous decision making required.

The Academy applauds the steps taken by the FTC's leadership to more deeply examine the issue of license portability through the Economic Liberty Task Force. Maximizing license portability for PAs has the potential to enhance the ability of PAs to increase consumer access and choice and to enhance innovation. We appreciate the opportunity to comment on this important topic.

Sincerely,

A large rectangular area of the document is redacted with a light gray background, obscuring the signature and any handwritten notes.

Tillie Fowler, JD  
Senior Vice President  
Advocacy and Government Relations

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<sup>42</sup> Amy Bushatz, Push to Ease Licensing for Military Spouses Remains Patchwork by State *available at* <http://www.military.com/daily-news/2016/07/05/push-ease-licensing-military-spouses-remains-patchwork-state.html>.

<sup>43</sup> Id.