ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

ISSUE BRIEF

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BARRIERS AND OPPORTUNITIES FOR IMPROVING INTERSTATE LICENSURE RECIPROCITY AND PORTABILITY FOR BEHAVIORAL HEALTH PRACTITIONERS: TECHNICAL EXPERT PANEL FINDINGS

KEY POINTS

- Telehealth holds the promise to help improve access to behavioral health services, but challenges to the widespread use of telehealth services across state lines exist.
- Interstate licensure portability models -- such as compacts and reciprocity agreements -- can help to ease the burden and complexity of requirements associated with providing treatment to persons in more than one state or territory. However, state legislatures, licensure boards, and behavioral health practitioners face several barriers to the widespread adoption of these compacts and agreements.
- According to technical expert panel (TEP) members, compacts and agreements that could garner widespread acceptance and sustainability should focus on a single discipline; have language that applies to both face-to-face treatment and treatment delivered via Internet or phone; and, to the extent possible, be national in scope rather than regional.
- TEP members identified potential opportunities for the Federal Government to support the wider adoption of interstate licensure reciprocity agreements and compacts, including by: providing grants to support coordination across state lines; providing supports to fill infrastructure gaps; and highlighting the benefits of compacts and agreements to both providers and individuals seeking treatment.

INTRODUCTION

Insufficient access to behavioral health care is a significant problem in the United States. Only half of adults with any mental illness (50.6%) received mental health services in 2022.[1] Further, fewer than one in four individuals aged 12 or older (24%) who needed substance use disorder (SUD) treatment in 2022 received treatment during that same time period.[1] Expanding access to behavioral health care services has been an integral component to multiple plans within the U.S. Department of Health and Human Services (HHS) -- including the HHS Roadmap for Behavioral Health Integration[2] and the HHS Overdose Prevention Strategy.[3] Unfortunately, the shortage of behavioral health providers,[4] which is even more pronounced in rural communities,[5] continues to be a barrier to these efforts. Initiatives to expand tele-behavioral health access via interstate licensure portability models show promise for addressing crucial workforce shortages, as such efforts could more efficiently use the existing workforce and better align the geographic availability of services with need.

BACKGROUND

Before the COVID-19 pandemic, telehealth was not broadly leveraged for behavioral health care.[6] Due to insurance restrictions, it was primarily used to provide care for patients who lived in remote areas;[6] some insurers -- including Medicare -- did not routinely allow patients to receive telehealth services in their homes.[7] The COVID-19 pandemic created conditions (e.g., the stay-at-home orders commencing in April 2020), that

restricted access to in-person services, and consequently created an increased need for patients to receive care, while remaining isolated. Therefore, during the COVID-19 Public Health Emergency (PHE), federal, state, and Tribal governments allowed flexibilities and regulatory changes to make it easier to implement and access telehealth services.[8] Among other things, these federal flexibilities allowed Medicare patients to receive behavioral/mental telehealth services in their homes, permitted audio-only telehealth reimbursement for behavioral health services, eliminated the requirement for providers to conduct in-person evaluations of patients prior to prescribing controlled substances via a telemedicine encounter, and permitted health care providers to more easily deliver telehealth services across state lines.[8] Although these flexibilities were originally designed to be temporary and expire at the conclusion of the PHE, many were eventually extended or made permanent.[9,10]

Some flexibilities -- such as those related to delivering telehealth services across state lines -- were not extended. During the COVID-19 pandemic many health care providers were able to deliver limited telehealth services across states lines through states issuing license waivers,[11] HHS issuing a declaration for the Public Readiness and Emergency Preparedness Act (PREP Act),[12] and the Centers for Medicare & Medicaid Services waiving licensure requirements.[13] These measures concluded in May 2023, thus reverting interstate telehealth service delivery to pre-pandemic rules and regulations.

Typically, providers -- including behavioral health providers -- are licensed or certified to practice by individual states or territories. Although providers may practice in multiple states, they must be licensed by each state in which they practice. Operationally, this means that a provider must be licensed in the state in which the patient is located at the time of the telehealth encounter. Obtaining licensure or certification in multiple states or territories can be burdensome -- each state or territory has its own protocol for licensure which often involves paying a fee, filing an application, presenting credentials, and undergoing a criminal background check. Licensure portability efforts, such as reciprocity agreements and compacts, provide remedies to these complex and burdensome processes and can be leveraged outside of a PHE.

Licensure portability refers to the transferability of a person's professional license from one state to another.

Licensure compacts and **reciprocity agreements** are types of licensure portability models; they are faster pathways for providers to obtain approval to provide services -- including telehealth services -- across state lines.[14,15]

Licensure reciprocity agreements are arrangements between states -- often with shared borders -- in which at least one state recognizes the professional license of a person from the other state.[14]

Licensure compacts are created when any number of states agree upon a uniform standard of care and enact state laws that outline those standards and permit providers licensed in other states who have legally adopted those standards to practice in their state.[15]

Multistate licensure reciprocity agreements and compacts streamline the ability for health care providers to deliver services across state lines.[14,15] There are many different models of licensure reciprocity and portability compacts and agreements; those related to behavioral health are detailed in ***Table 1***. To date, there are no compacts or agreements in effect that are specific to telehealth, or which broadly encompass all behavioral health providers or services. However, there are compacts and agreements which facilitate multistate licensure for psychologists, social workers, counselors, nurses, and physicians -- all of which share several common characteristics: they establish a centralized information repository about practitioners who are licensed in participating states; list basic credentials required for practitioner participation; delineate responsibilities of practitioners and states; define the states' authority to discipline practitioners who violate

their regulations or fail to meet practice standards; and do not supersede state regulatory control or authority over practitioners. Although there are many efforts to improve interstate licensure portability for behavioral health practitioners, many states and eligible providers do not participate. To fully leverage telehealth to improve behavioral health care, we must better understand these barriers and identify federal actions that could increase interstate licensure portability.

Table 1. Existing Efforts in Licensure Portability for Behavioral Health Practitioners

Name	Summary
Interstate Compact for Counselor Licensure	• An interstate compact for licensure portability that facilitates the process through which licensed professional counselors, who are licensed to practice in their home state, can seek the privilege to practice in one or more other states.[16] • Has been enacted in 33 states and is pending in 11 states and the District of Columbia, as of February 2024.[17] It is expected that counselors will be able to apply for participation in the compact in late 2024.[18] • Developed by the American Counseling Association and the National Center for Interstate Compacts of the Council of State Governments (CSG).[19]
Interstate Medical Licensure Compact	• A voluntary, expedited pathway to multistate practice for physicians. • Has been adopted by 35 states and the Territory of Guam as of February 2024.[20] • Provides a streamlined process for multistate licensure by sharing information between state medical boards about physicians who are licensed in their state.[21] • Eligibility requirements for physicians include stipulations about the physicians' State of Principal License, and the required credentials.[20] • Lays out requirements for physicians to apply for and maintain multistate licensure, as well as the responsibilities of the participating states.[20] • Administered by the Interstate Medical Licensure Commission.[20]
Marriage and Family Therapist Licensure Portability Model	• A model intended to promote a pathway to full licensure portability, allowing providers who have a full and unrestricted license in one state to be issued a full and unrestricted license in another state if they meet certain uniform requirements.[22] • Developed by the American Association of Marriage and Family Therapists in 2019.[22]
Model Social Work Interstate Licensing Compact Bill	• A draft bill, designed to improve access to competent social work services by licensed social workers and preserve the authority of state regulatory authorities to protect the health and safety of the public.[23] • Missouri and South Dakota have passed the Social Work Licensure Compact Bill as of February 2024. Twenty-four additional states have introduced legislation. Seven states must enact it for the Compact Commission to be established as the governing body.[24] • Developed by CSG, released by the Association of Social Work Boards.[24]

Table 1 (*continued*)	
Name	**Summary**
Nurse Licensure Compact (NLC)	• A compact that allows nurses who reside in participating states and territories to treat patients -- either in person or via telehealth -- in other participating states without having to apply for licensure in the patient's state.[25] • Applies to registered nurses and licensed practical nurses and does not apply to advanced practice registered nurses.[26] • Calls for administrators in participating states to provide uniform data to the Coordinated Licensure Information System. The uniform data include identifying and licensure information about licensed nurses in the jurisdiction. The compact lays out requirements for nurses to apply for and maintain multistate licensure, as well as the responsibilities of the participating states.[26] • Adopted by the State Boards of Nursing in 2015; enacted in 41 states and territories as of February 2024.[27]
Psychology Interjurisdictional Compact (PSYPACT)	• An interstate compact that facilitates the provision of treatment by licensed psychologists across state boundaries.[28] • Enacted in 41 states -- 39 of which have already put the compact into effect -- as of February 2024.[29] • Eligibility requirements for psychologists include that the individual possesses a full, unrestricted license to practice psychology based on a doctoral level degree in at least one PSYPACT participating state.[30]
Uniform Telehealth Act (UTA)	• Would enable states who enact it to regulate and promote the practice of telemedicine across state lines; provides that practitioners including behavioral health practitioners, who are appropriately licensed or certified in their home state may register with any other state that has adopted the act to practice telemedicine if they comply with professional standards and scope of practice laws in the state where the patient is located.[31] • Has special provisions for practitioners to offer specialty second opinions to patients outside of their state; creates protected exemptions from registration for: (1) practitioner to practitioner consults; (2) for continuing care for a previously established practitioner-patient relationship; and (3) for services specific to a specialty assessment, diagnosis or recommendation of treatment.[31] • In July 2022, the Uniform Law Commission approved and recommended the UTA for enactment by all states. Two states and the District of Columbia have since introduced UTA bills; as of February 2024 no states have enacted UTA.[32]

THE TECHNICAL EXPERT PANEL

In October 2022, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) convened a virtual technical expert panel (TEP) to discuss policy options that encourage interstate licensure for behavioral health providers. The panel included experts across various disciplines of behavioral health treatment delivery and who were affiliated with academic institutions, professional associations, and/or behavioral health treatment provider organizations. As a group, the panel represented multiple behavioral health disciplines (e.g., social workers, licensed professional counselors, psychiatrists, and psychologists) as well as experts on the delivery of mental health and SUD services in person and via telehealth. A list of participants is provided in ***Appendix 1***.

The goals of the TEP were to: (1) establish a foundational understanding of the existing barriers to adopting and participating in interstate licensure portability compacts and reciprocity agreements by behavioral health

practitioners, professional organizations, state licensing boards, and legislators; and (2) identify federal actions that could help overcome these challenges and foster both in-person and tele-behavioral health licensure portability. Panelists also provided input on the advantages and disadvantages of multidisciplinary versus single discipline compacts, as well as the merits and limitations of national versus regional compacts.

KEY THEMES AND FINDINGS

Barriers to the Adoption of Interstate Licensure Compacts and Reciprocity Agreements

According to the TEP, there are many barriers and challenges to the adoption and expansion of interstate licensure portability agreements and compacts. These barriers are experienced by diverse stakeholders such as state legislators, licensing boards, practitioners, and professional organizations.

Barriers among State Legislators and Licensing Boards

TEP members highlighted important barriers and challenges that -- in their experience -- limit more widespread acceptance and adoption of behavioral health licensure compacts and agreements, among state legislators and licensing boards. The TEP noted that concerns of state legislators and state licensing boards are often related to their duties to protect the health of the people in their jurisdictions. Concerns that were mentioned during the TEP meeting were largely focused on oversight, logistics, and financing:

- **Difficulties vetting and holding providers accountable across state lines**. Several panelists noted that widespread adoption of interstate licensure portability compacts and reciprocity agreements have been hampered by concerns among licensing boards about their abilities to properly regulate out-of-state practitioners who are providing care to residents within the board's state. Panelists noted that compacts and agreements should address the needs of licensing boards to: (1) properly vet out-of-state providers to practice within their state and remain informed about the quality of care provided within their state; (2) sanction out-of-state **providers** for poor performance; and (3) ensure out-of-state providers adhere to all rules within their state (e.g., consulting a prescription drug monitoring program when required). Panelists emphasized that state licensing boards need to have the capacity and ability to receive and track patient reports of **inadequate** care provided by all practitioners who are practicing in their state.
- **Varying provider authorities across states/territories and subdisciplines**. Several panelists noted that cross-state differences in the authorities granted to practitioners can be a challenge to the adoption of interstate licensure portability compacts. For example, some states allow licensed psychologists to prescribe medications, whereas others do not. This variation in prescribing abilities adds complications to arranging compact agreements, since the authority to prescribe depends on the state in which the practitioner is practicing (i.e., the state where the patient/client is located when receiving treatment, not the state where the practitioner is physically located).
- **Varying credentialing standards across states/territories and subdisciplines**. Panelists mentioned that differences in licensing or credentialing standards can prove to be a significant challenge to interstate compacts, especially when one state has more lenient licensing requirements than other states. For example, many -- but not all -- states require that psychologists have a doctoral degree from an American Psychological Association-accredited program. State licensing boards that have such a requirement may be reluctant to allow psychologists whose education does not meet this standard to practice in their state.
- **Uncertainty in funding for licensing boards**. As states continue to join compacts, providers may have less of a need to pay individual state licensing boards for individual state licenses. State licensing boards could face a decrease in annual income, due to lost licensure application fees. Therefore, the

cost of multistate licensure must be carefully considered, in order to ensure financial sustainability of licensing boards.

Practitioners and Professional Organizations

Identified concerns among practitioners and professional organizations were often related to the practitioners' time and financial burden of gaining licensure in more than one state. Specific concerns that were mentioned during the TEP include the following:

- **Administrative burdens due to variations in credentialing**. Several panelists mentioned that practitioners and professional associations are reluctant to participate in interstate compacts, due to the increased burden on the practitioners to meet credentialing requirements of other states, such as continuing education requirements.
- **Lack of efficiencies in obtaining licensure/certification in multiple jurisdictions**. Panelists also noted that practitioners and professional organizations may be reluctant to support a licensure portability compact or reciprocity agreement in which there are little to no efficiencies in the actual cost and time burdens associated with the application processes (including background checks, fingerprinting, needed credentials, and the navigating the registration process) for licensing/certification in multiple states.
- **Union buy-in for several specialty areas**. Several panelists also noted that for professional disciplines that are unionized, such as nursing, union buy-in is critical to the adoption of interstate licensure compacts by practitioners and professional organizations.

TEP discussions revealed the importance of balancing the needs of state regulators and licensing boards, as well as professional associations and individual practitioners. Many of the identified challenges stem from the variations between credentialing requirements and scope of practice authorities granted across states and jurisdictions within a given discipline.

Opportunities to Improve the Adoption of Interstate Licensure Compacts and Agreements

In addition to barriers and challenges, panelists discussed several opportunities to improve the adoption of licensure reciprocity and portability agreements. Panelists shared bold ideas, such as tying compact adoption with an increased Medicaid Federal Medical Assistance Percentage, and allowing licensed (in at least one state) Medicare providers to deliver telehealth services to any Medicare beneficiary in any state. Although these bold ideas were identified as potentially impactful, panelists determined that such ideas would not likely be operational in the near future. Detailed below are several key considerations and federal actions that panelists agreed could feasibly facilitate the adoption of interstate licensure compacts and reciprocity agreements.

Key Considerations

- **Efforts should focus on individual disciplines as opposed to being multidisciplinary**. Panelists largely agreed that interstate licensure reciprocity compacts and portability agreements should be written specifically for a single professional discipline (e.g., nursing) rather than trying to cover multiple disciplines (e.g., nursing, psychologists, social workers, etc.) within one behavioral health compact. Panelists' reasoning was largely based on logistics and professional buy-in. Panelists began by describing the complexities of bridging the needs of multiple states for just one professional compact. For example, even for a single discipline, states vary in the language and terms used for licensure and certification requirements. These variations include significant nuances in how educational attainment and degree types, supervision requirements and scope of practice within each behavioral health discipline are described. In some cases, different terms and language are superficial, (e.g., alternative

credential titles for equivalent education and training achievements). In other cases, they reflect meaningful differences in training and experience standards, and how and by whom services can be provided. Such variations present substantial challenges for state legislators, state licensing boards, professional associations, and practitioners to come to consensus on appropriate terms and language for a licensure compact. Panelists went on to explain that these complexities would be compounded by adding several professional disciplines together in one compact. Attempting to bridge the specification requirements of several disciplines would require satisfying the needs of more stakeholders and, in the view of the panelists, would likely result in a compact that is not specific enough to meet the needs of any one discipline. There is also the logistical issue of determining which agency or agencies would be responsible for overseeing a multidisciplinary compact. According to the panelists, there is not currently an appetite for a multidisciplinary compact and efforts to expand compacts should instead support existing single disciplinary agreements.

- **Efforts should not be exclusive to telehealth or in-person care**. Multiple panelists also expressed that compacts and agreements should be written in ways that are applicable to both in-person and virtual care. As one panelist noted, "Telehealth is just another form of routine health care, and efforts to advance telehealth-only compacts would suggest that telehealth is something 'different' than normal in-person care."
- **To the extent possible, efforts should be national -- as opposed to regional -- in scope**. Panelists noted that whereas much cross-state telehealth occurs regionally, regional compacts (i.e., those focusing on a small number of adjacent states) would not meet the current level of need, and a national approach is needed. Where compacts do not exist, reciprocity agreements across state lines may be suitable to address the issue of regional care.

Federal Actions to Improve Adoption of Compacts and Agreements

Finally, panelists identified several federal actions that could potentially facilitate more widespread adoption of licensure portability efforts to support interstate behavioral health service delivery. The panelists' ideas focused on ways in which the Federal Government could support the development of efficient and effective systems of multistate licensure and certification that balance the needs of states, licensing boards, practitioners, and patients.

- **Provide grants to develop infrastructure and processes to support coordination across state licensing boards**. Several panelists expressed a need for technological infrastructure to streamline application and credentialing protocols. Such technology would help remove redundancies and reduce the burden on both practitioners and licensing boards by centralizing and streamlining the collection and maintenance of state-level licensing data (e.g., education and supervision credentials, criminal background checks). Panelists shared that federal financial support -- in the form of startup or improvement funds -- could help to develop or improve these data tracking systems, including background checking systems, web-based clearinghouses, and licensure databases. In addition to reducing redundancies in obtaining and issuing licensure, the development or improvement of these systems would enhance the state licensing boards' capacity to regulate and monitor the status and performance of practitioners licensed in other states who are practicing in their state.
- **Provide grants to support ongoing evaluation of interstate licensure compacts, infrastructure, and related quality improvement efforts**. Several panelists pointed out that the development and improvement of infrastructure systems is not an end unto itself. Ongoing monitoring and evaluation will be needed to maintain systems that continue to be effective and efficient in a changing world. The panelists suggested that the Federal Government could support these efforts by providing grants to support the evaluation over time of licensure application systems and web-based clearinghouses/licensure databases that are developed.

- **Create resources which support the technological aspects of telehealth care provision**. Panelists noted that the practice of health care in a virtual environment presents additional challenges to both practitioners and patients/clients, and behavioral health care is no exception. Both the practitioner and the patient/client must navigate the technological challenges of connecting and communicating via phone or Internet, while also compensating for the loss of cues and connections that are more available during a face-to-face encounter. There was widespread agreement among panelists that additional resources are needed to support the provision of in-service training to practitioners to facilitate overcoming these challenges to ensure comparable quality of virtual versus in-person care.
- **Send supporting letters to states and state licensing boards**. Finally, panelists noted that states and licensure boards could be encouraged to participate in interstate licensure portability compacts and reciprocity agreements if the Federal Government were to directly communicate the benefits of such models, and encourage states to adopt these agreements. This could be done by sending letters that herald the positive aspects of these compacts to legislators and licensing boards of states that are debating whether to adopt a licensure reciprocity or portability compact.

DISCUSSION

The behavioral health workforce shortage is an ongoing challenge that requires continued efforts to address. Telehealth and workforce mobility offer opportunities to improve access of behavioral health care in underserved communities, but professional licensing and certification requirements -- which are specific to each state -- can impede a practitioner's ability to practice in multiple states. Licensure portability models, reciprocity agreements, and compacts provide mechanisms for overcoming some of those challenges. Across disciplines that provide behavioral health care, several licensure compacts or agreements are currently in place or being developed.

Panelists in the TEP identified several barriers to more widespread adoption of these compacts and agreements. Such barriers include the responsibilities and burdens placed on state licensing boards for regulating care, protecting health care consumers, and monitoring practitioners operating in their states. The panelists also noted the burdens that state licensure and certifications systems place on behavioral health practitioners, such as understanding and meeting state licensure requirements for all states in which they practice.

There was consensus among panelists about the key characteristics that licensure portability efforts should have, in order to foster acceptance among stakeholders. Specifically, compacts should focus on individual disciplines rather than being multidisciplinary. Further, compacts should have language that is inclusive of both telehealth and in-person care; and to the extent possible, be national rather than regional in scope.

The TEP identified several opportunities for the Federal Government to improve interstate licensure portability. The TEP established that several challenges could be solved by improving technology and data systems (e.g., to allay concerns about provider quality and safety) or streamlining economically inefficient processes (e.g., universal criminal background checks); to do this, the Federal Government could administer grants to facilitate the development, maintenance, and ongoing evaluation of coordinated or universal databases that serve both state licensing boards and individual practitioners. In addition, the Federal Government can facilitate use of tele-behavioral health across state lines by providing resources to improve the technological aspects of telehealth care provision. Finally, TEP panelists indicated that federal letters of support, which communicate the benefits and importance of interstate licensure portability, to state legislatures and state licensing boards, would be helpful.

APPENDIX 1: MEMBERS OF THE TECHNICAL EXPERT PANEL

Deborah Baker, JD -- American Psychological Association (APA)

Tim Cesario, MS, LCADC -- International Certification & Reciprocity Consortium

Varun Choudhary, MD, MA, DFAPA -- Talkspace

Eric Fish, JD -- Federation of State Medical Boards

Chris Fore, PhD -- Indian Health Service (IHS) Telebehavioral Health Center of Excellence

Karen Goodenough, PhD, MSW, LGSW -- National Association of Social Workers

Morris Kleiner, PhD -- University of Minnesota Humphrey School of Public Affairs

Lynn Linde, EdD -- Center for Counseling Practice, Policy, and Research

Daniel Logsdon -- National Center for Interstate Contacts at the Council of State Governments

Ateev Mehrotra, MD, MPH -- Harvard Medical School

Jean Moore, DrPH, FAAN -- School of Public Health, State University of New York (SUNY) at Albany

James Puente, MS, MJ, CAE -- National Council of State Boards of Nursing (NCSBN)

Roger Smith, JD -- American Association for Marriage and Family Therapy.

ASPE Representatives -- Tisamarie Sherry, Laura Jacobus-Kantor

RTI Representatives -- Lissette Saavedra, Kathryn Batts.

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