ASSESSING COVID-19 OCCUPATIONAL LICENSING POLICY ACTIONS

CSG The Council of State Governments

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Introduction

As the COVID-19 public health emergency continues to exact a profound toll on American lives and livelihoods, states are utilizing an arsenal of policy options to respond. In this endeavor, occupational licensing policy has emerged as a significant issue for states as they seek to expand the availability of the health care workforce and mitigate existing regulatory encumbrances that have been amplified by economic disruptions.

While occupational licensing policies are structured to protect public health and safety, they also can constrict the supply of workers and inhibit their ability to practice across state lines, an issue particularly magnified by the COVID-19 pandemic. As a result, states have implemented sweeping actions to temporarily amend occupational licensure and related policies, including those regarding scope of practice, telehealth and licensure mobility, to better meet health care and workforce demands.

The variety of temporary state actions and established permanent policy options provide an opportunity for states to consider how they can learn from other states actions and further their resiliency while concurrently reducing long standing workforce barriers. To assist states in these considerations, The Council of State Governments (CSG) has tracked COVID-19 policy actions and the subsequent trends, themes and opportunities for states. Further included in this document are policy options available for states as they assess ways to build resiliency through occupational licensure regulations.

How to Use this Resource

- **LEARN** about the emergency occupational licensing policies that have been implemented in other states and other established policy mechanisms.
- **EVALUATE** the opportunities available for states to further their disaster resiliency and to overall improve pathways to licensure.

Policy Themes

The COVID-19 pandemic has resulted in two primary occupational licensing themed policy problems: workforce shortages and licensure requirements burdens. While both of these policy problems existed before the pandemic, they have been amplified, prompting states to shift focus to the added challenges.

WORKFORCE SHORTAGES

As the initial wave of COVID-19 cases spread across the nation, hospitals and other health care facilities quickly faced risks of workforce strains and shortages, threatening health care providers' ability to provide an adequate response to both COVID-19 related and unrelated health cases. These risks have continued throughout 2020 as states have faced fluctuating numbers of cases and workforce shortages.

The Fitzhugh Mullan Institute for Health Workforce Equity at The George Washington University has continued to provide estimates of the workforce supply and shortages during the pandemic for key health care professions, including intensivists, critical care nurses, hospitalists, respiratory therapists and pharmacists. In its Aug. 7, 2020 snapshot of states at risk for shortages, nearly five months after COVID-19 was declared a pandemic by the World Health Organization, the Mullan Institute estimated that every state was either facing strains or shortages for at least one of the selected occupations.

The uncertainty resulting from the initial wave and subsequent fluctuations of cases highlight the importance of policies that enlarge the healthcare workforce and allow practitioners to practice across a wide geographic area. Among these policies, occupational licensing is one of the immediate levers available for states to meet the increased health care demands.

States use licensing to ensure certain health care practitioners meet a minimum level of competency before they provide services that directly affect the health and safety of the public. Of all licensed workers in the U.S., approximately 25% are health care workers and approximately 65% of all healthcare workers require a license to practice.

To become licensed, health care workers must commonly meet state requirements that involve significant time and training. Further, each state determines their own licensing requirements, meaning a patchwork of regulations exists across the country. These factors, while helping protect the health and safety of the public, can have a constraining effect on the supply and inter-state mobility of health care professionals.

The urgency of the COVID-19 pandemic prompted states to identify ways to quickly increase the supply of the health care workforce without putting the public at an unacceptable risk. The resulting temporary provisions, identified under the Emergency Policies Enacted by States section below, altered state policies to reduce barriers for health care practitioners, including those who possessed qualifications but may have not met the full requirements needed for licensure.

LICENSURE REQUIREMENTS

Occupational licensing involves a number of initial and continuing processes for both the license holder/applicant and the license granting authority, including applications, background checks, licensing examinations, initial and continuing education (CE) and licensing renewals. These processes, as with the case for many business and governmental operations, were disrupted by office closures and stay at home orders. Licensing offices switched to operating remotely while government restrictions affected licensee's ability to meet certain requirements. Notably license applicants and active licensees were affected by the closure of in-person testing facilities and continuing education providers.

Given these circumstances, states have an interest in ensuring workers can continue working in their licensed profession (especially those directly related to the COVID-19 health care response) while not being adversely affected or penalized by licensure requirements.

In response to these added challenges, states have responded by temporarily removing barriers to licensure attainment and maintenance for professions. These changes address the reduced capacities and capabilities of state licensing boards as well as the difficulty for workers meeting licensure requirements, such as obtaining CE credits and paying licensure fees.

Emergency Policies Enacted by States

The emergency policy options available to states to address concerns of workforce shortages and licensure obligations largely involve expanding practice authorizations or lessening their requirements. Due to the urgency of the situation, states were not so much tasked with innovating new policies, but rather relying on innovative thinking in tailoring their existing policies. The following provisions, dated from March 4 to July 19, illustrate how states have utilized and amended these policies in response to the COVID-19 pandemic.

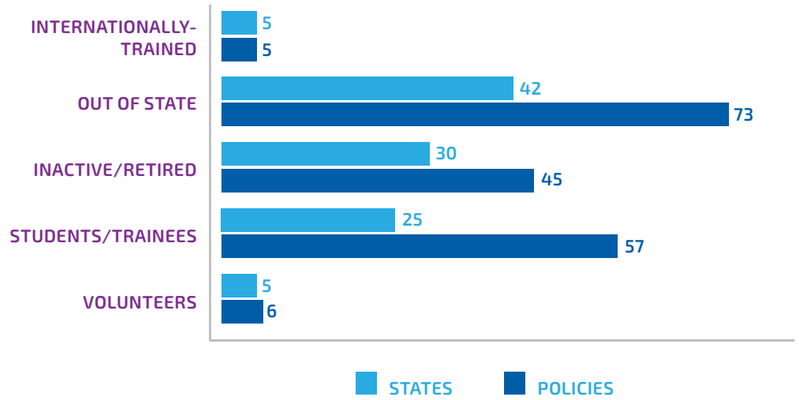
TEMPORARY AND EXPEDITED LICENSURE

Given the increased demand for qualified health care workers, states have expanded temporary and expedited licensing processes for out-of-state, internationally-trained, retired and inactive practitioners, individuals still in-training and volunteers.

Every state has either passed legislation or issued an executive order identifying a targeted set of professions and population groups eligible for temporary licensing considerations during their state's state of emergency. The enumerated professions and population groups varied by state but were commonly centralized around the health care fields, particularly nursing, and licensed out-of-state practitioners. The length of the temporary licenses issued under these orders is most commonly for the length of each state's declared state of emergency.

State Policy Actions | Temporary and Expedited Licensure for:

Out-of-State Practitioners	Internationally-Trained Practitioners	Inactive Practitioners
Retired Practitioners	Students/Trainees	Volunteers



Out-of-State Practitioners

While every state maintains policies that support licensing portability and reciprocity for out-of-state practitioners, there exists great variation among these processes depending on the state, occupation and type of applicant. Over the past two years, states have taken efforts to streamline these efforts by passing universal recognition laws. However, reciprocity provisions typically necessitate a certain amount of processing time by the license granting authority, a critical element during times of disaster.

In response to the urgency of the response to COVID-19, these policies were expanded to streamline credential confirmations, reduce application paperwork and ease background check timelines. Forty-two states have issued emergency orders or passed emergency legislation providing for the issuance of temporary/expedited licenses to out-of-state practitioners, and over 73 provisions were put in place.

- New Hampshire Gov. Christopher Sununu's Emergency Order 2020-04 #15 gives authority to licensed out-of-state medical providers to practice in in the state under a temporary emergency license either in-person or through telehealth services.
- An Alabama State Board of Medical Examiners Emergency Rule allows for temporary licensure for out-of-state physicians, physician assistants and anesthesiologists. These efforts allow individuals to operate in a wider market and are especially impactful in border areas with large cities.
- West Virginia Gov. Jim Justice's EO 23-20 and EO 26-20 have allowed nonresident counselors, marriage and family therapists, speech-language pathologists and audiologists to practice in the state past the statutory limitations on their length of practice.

Internationally Trained Practitioners

Health care workers who have been licensed outside of the U.S., are a part of another population group that has been targeted by states through emergency regulations. While some states have already been working to improve the licensure process for immigrants who obtained training outside the U.S., the pandemic has prompted states to immediately streamline their qualification recognition efforts.

Five states have provisions for internationally traied practitioners.

- New Mexico Gov. Michelle Lujan Grisham's EO 2020-020 allows the New Mexico Department of Health to authorize all nursing professionals licensed in any province or territory of Canada to work in any New Mexico health care facilities during the declared state of emergency. If the New Mexico Department of Health determines that the nursing professional licensed in Canada has the requisite skills and qualifications to practice in New Mexico, they shall provide written authorization to the practitioner that expires after six months. This written authorization releases any Canadian-licensed practitioner from any civil or criminal penalty arising from lack of licensure during the period of the authorization.
- New Jersey Gov. Philip Murphy's EO 112 orders the New Jersey Department of Law and Public Safety's Division of Consumer Affairs to issue a license to any physician who is licensed in good standing in another country, provided that physician submit an application to the Division of Consumer Affairs containing information the director and the relevant licensing board requires.

Inactive and Retired Practitioners

Practitioners who have retired from specified fields of practice or have otherwise let a license lapse have also been targeted by states as populations who are eligible for temporary or expedited licensure. Forty-five such actions have been taken across 30 states. A common provision among the emergency orders and legislation permitting such licensure is a maximum time removed from the profession, typically five years.

- Georgia Gov. Brian Kemp's EO 3.23.20.02 allows medical professionals with expired licenses to practice.
- Missouri Gov. Michael Parson's EO 20-04 exempts retired physicians from applying for licensure reinstatement before rejoining the field.

In-Training Practitioners

Many states have offered early entry into the field for health care students who are near the end of their education or have completed their courses but cannot take their final exams. Fifty-seven emergency orders or pieces of legislation were issued or passed across 25 states. Common areas of practice covered under these orders are nurses, nurse practitioners and respiratory therapists. These provisions expedite the licensure process for students and recent graduates by waiving or modifying examination, residency and/or supervision requirements while also typically limiting their scope of practice. In states where such provisions are enacted, it is typically up to the hospital staff to determine appropriate scope of practice commensurate with their skills and experience.

- North Carolina Gov. Roy Cooper's EO 130 allows "skilled but unlicensed" students "at an appropriately advanced states of professional study" to provide care.
- Georgia Gov. Brian Kemp's EO 3.23.20.02 gives temporary licensure to nursing graduates who have not yet taken their certification exam.

Releasing Practitioners from Liability

A state requires a license for a profession to protect the health and welfare of the state's residents, and health care professions are some of the most heavily regulated due to the direct link to a patient's physical and mental health. If a health care practitioner makes a mistake that harms a patient, they can be liable for that mistake and a patient can pursue the practitioner, a supervising physician and/or a medical facility for damages. At least 25 states have implemented policies that release volunteers, health care professionals and/or health care facilities from civil liability when they are supporting a state's COVID-19 response. The goal of these immunities is to limit the legal risk personnel and medical facilities encounter for those volunteering their efforts. However, in most of the emergency orders issued, this immunity is not extended to acts or omissions that constitute a crime, fraud, malice, gross negligence and/or willful misconduct.

EXPANDED SCOPE OF PRACTICE

State Policy Actions

- Expand the kinds of patient care practitioners can provide
- Define supervisor roles to match expanded scopes of practice
- Expand authority to order, administer and communicate COVID-19 test results
- Expand prescribing authority

Health care practitioners may face limitations to their scope of practice, or the range of tasks that may be legally performed under a license, including prescribing, diagnostic and other authorities. Scopes of practice are generally set by the states and therefore may vary widely across jurisdictions. Policymakers limit scopes of practice for certain professions, such as physician's assistants, advanced registered practical nurses and pharmacists, to safeguard quality of care where they might anticipate an

Data Disclaimer: The emergency occupational licensure policies presented in this report were collected by CSG over the course of March 4 – July 19. The design of the policy changes varied across states and therefore for the purposes of this report policy actions were counted according to their designed effect. For example, a single state executive order may contain numerous policy actions and therefore were counted in similar multitudes in the report. As states continue to make changes, the number of policy actions reflected in the report also are not intended to be an exhaustive count, but rather a reflection of policy trends and examples so far identified.

enhanced risk from those with lower qualifications performing services typically reserved for higher level professions.

However, in recent years there has been a growing policy trend among states to broaden scopes of practice for some professions in an effort to increase the availability of health care. Proponents for the policy changes cite that there is no evidence that broader scopes of practice result in patient harm. Further, scope of practice limitations are known to have a constraining effect on access to health care. Given these factors and the threat of scope of practice laws furthering shortages already caused by the pandemic, 33 states have temporarily expanded or otherwise modified the scopes of practice for certain professions to broaden the base of health care professionals available to offer services.

Most commonly, state legislation and emergency orders issued in response to the pandemic have expanded the scopes of practice of registered nurses (RN), nurse anesthetists, licensed practical nurses (LPN), advanced practice registered nurses (APRN) and physician assistants (PA) to include many services typically included only in the scope of practice of physicians. Most states that have expanded scopes of practice limit the expansion to the health care facility where a practitioner is currently employed or contracted to work. This restriction supports practitioners performing activities usually outside of their scope by maintaining continuity in supervision, teams and work environments. States that choose this model usually allow supervising health care professionals within facilities to decide how far and for whom scopes of practice are expanded. These supervisors are familiar with the intricacies of scopes of practice, the responsibilities of the different types of certified practitioners and the competencies of the practitioners filling these roles.

- New Jersey DCA Administrative Order No. 2020-06 expands the scope of practice for pharmacy technicians to include ordering, administering and communicating the results of COVID-19 tests.
- Oregon Administrative Rule 847-035-0032, adopted on March 31 and effective on April 1, 2020, allows emergency Medical Services (EMS) personnel to assist with patient care under the direction of a supervising physician.
- Nevada Gov. Steve Sisolak's Declaration of Emergency Directive 011 states that all medical providers in the state are, "authorized to practice outside the scope of their specialization, within the limits of their competency, to the extent necessary to augment and bolster Nevada's health care system during the COVID-19 crisis."

TELEHEALTH

State Policy Actions

Expand telehealth services provided by out-of-state or retired practitioners

Mandate insurance coverage for telehealth

Suspend in-person requirements

Expand allowed technology options

Telehealth has experienced rapid growth and expansion during the COVID-19 pandemic. According to McKinsey and Company, in 2019 11% of consumers used telehealth services. In 2020, that number has skyrocketed to 46%.

Defined as the provision of health-related services via telecommunication technologies, 39 states have adopted 74 emergency measures to increase the availability and use of telehealth by reducing existing restrictions and limitations and expanding the medical fields allowed to participate. These actions importantly increase access to health care services and reduce the chance of viral transmission by negating the need for in-person examinations.

There are several policy hurdles associated with the expansion of telehealth during the pandemic. Some state statutes limit the practice of telehealth across state lines, making it illegal for traveling providers to keep up with patients while under stay-at-home orders. Many states also limit the types of telecommunication technologies permissible in telehealth practice, such as prohibiting audio-only technologies, which may adversely impact the accessibility of care for populations with limited broadband and/or computer access. Furthermore, state telehealth statutes frequently require a preexisting patient-provider relationship or an in-person consultation before care may be administered via telehealth. And crucially, requirements for reimbursement of telehealth care by Medicaid and private insurers vary significantly from state to state, creating confusion and uncertainty for patients, providers and insurers.

- Colorado Gov. Jared Polis's EO D 2020 020 broadened the range of acceptable telehealth technologies, mandated insurer coverage of telehealth and permitted out-of-state mental health professionals to treat patients within Colorado.
- Under Ohio Gov. Mark Dewine's EO 2020-01D, state agencies were given broad power to implement procedures and suspend or adopt temporary rules to respond to the pandemic. The State Medical Board of Ohio issued guidance that used this opportunity to suspend enforcement of telehealth-related laws and regulations for the duration of the emergency, provided that practitioners meet minimum standards of care.
- Kentucky Senate Bill 150 (Acts ch. 73) allows remote practice by licensed out-of-state health professionals for the duration of the COVID emergency, among numerous other health care licensing provisions.
- Vermont House Bill 742 (Act 91) allows telehealth practice within the state by retired, out-of-state and recently graduated medical, dental and mental health professionals. The bill also requires insurers to reimburse telehealth services at the same rate as for in-person care and prohibits insurers from restricting patients' access to telehealth.
- Texas Gov. Greg Abbot's March 14th directive allowed the Texas Medical Board and the Texas Board of Nursing to increase patient access to telehealth.

MODIFICATION, SUSPENSION, & WAIVER OF LICENSING REQUIREMENTS

State Policy Actions

Suspend Licensing Exam Requirements

Suspend Internship Requirements

Defer License Renewal Deadlines

Suspend CE Requirements

Occupational license holders must meet a range of prerequisites to achieve their initial license as well as subsequent renewals. These requirements often include the completion and verification of an applicant's education, examinations, internships and sometimes references from supervisors. These processes were threatened for disruption due to the pandemic. In response, states implemented a variety of measures to mitigate these effects while not disrupting the authority of licensed workers to continue practicing.

At the same time as the demand for health care practitioners increased precipitously, schools, testing centers and internship programs that provided required examinations, documents and experiences have either been forced to temporarily shut down or have postponed services indefinitely. Additionally, health care licenses regularly require continuing education credits for renewal, but some states have provisions that required these continuing education credits to be earned in-person. In response,40 states have implemented 108 actions that temporarily modify, suspend or waive licensing requirements.

Some exams for health care practitioners must be taken in person, and so many scheduled tests were

postponed or cancelled due to social distancing requirements for the safety of both students and proctors.

- Waiver requested by the Pennsylvania Department of State and granted by Gov. Tom Wolf allows nursing students who were not able to sit for the licensing exams to apply for a graduate permit that allows them to assist in the COVID-19 response under the supervision of a registered nurse.
- Washington Department of Health Emergency Rule 20-10-014 waives continuing education requirements for retired active nurses, waives clinical experience requirement for nurses with inactive or expired licenses, and allows licensed practical nurse (LPN) students to practice as nursing technicians
- Internships and other supervisor-based requirements became difficult or impossible to fulfill as teaching programs were suspended due to the demand for medical practitioners.
- Iowa's Proclamation of Disaster Emergency of March 22nd, 2020 suspended provisions that required clinical, practical or internship experience to obtain licenses in many professions, including psychologists and pharmacists.

Licensing bodies have faced problems with existing licenses as well. As licenses approached their expiration dates some practitioners were not able to complete required continuing education credits in a timely manner. More importantly, health care practitioners were already strained by unprecedented workloads, and an interruption in their ability to legally treat patients could cause critical delays in medical care. To avoid this, many states extended licenses past the expiration dates they were originally constrained by. Other states have suspended the requirement that continuing education credits must be earned in-person, allowing licensees to take continuing education credits via live videoconferencing or simulation, while other states have suspended all CE requirements for some occupations.

- Kansas Gov. Laura Kelly's EO 20-19 extends all licenses issued to individuals until 90 days after the termination of the state of emergency.
- The Vermont Office of Professional Regulation changed their CE policy to allow licensees to request a renewal extension of up to 180 days to earn missing continuing education credits, and nurses may now earn continuing education credits from online courses in lieu of in-person continuing education opportunities.
- Maryland Gov. Larry Hogan's March 12 EO extended "all licenses, permits, registrations and other authorizations issued by the State of Maryland" until 30 days after the termination of the declared state of emergency.
- Connecticut Gov. Ned Lamont's EO 70 authorized the Department of Public Health to suspend all license renewal requirements during the state's state of emergency.

108 MODIFICATION OF LICENSURE

181 TEMPORARY LICENSURE

74 TELEHEALTH

44 SCOPE OF PRACTICE MODIFICATION

407 TOTAL ACTIONS

Lessons Learned

LOCALIZED DISASTERS VERSUS NATIONAL DISASTERS

Common emergencies that affect the U.S. like severe storms, wildfires and flooding may require out-of-state licensed professionals, including emergency management technicians and nurses, to assist an affected state in meeting its increased health and safety demands. States have a number of policy options at their disposal, such as interstate compacts, to assist with the transfer of these professionals and their credentials to another state where they do not maintain a residence or place of work.

These policies, however, work best when the disaster is localized to one state or region where unaffected states more likely have the capacity to send emergency volunteers. In contrast, the COVID-19 pandemic quickly spread to all 50 states meaning states did not readily have the ability to assist each other as they normally would for fear of their own potential or realized need. Therefore, at the onset of the pandemic, states were spurred to take other measures to increase the health care workforce supply.

For example, the Emergency Management Assistance Compact is designed for states to quickly and efficiently request aid during a state of emergency. However, during the early days of the pandemic states quickly found that requests for additional health care workers were unable to be fulfilled due to the scope of the emergency.

A further complicating factor is that the danger to emergency and health care responders during a pandemic lasts much longer than most disasters. While the physical damage of an earthquake, tornado or hurricane and the ensuing recovery may be prolonged, the responding emergency responders are relatively safe from immediate danger shortly after the disaster incident. In comparison, health care workers are at a continued risk of contracting the virus themselves during the pandemic, threatening the workforce supply even further.

The COVID-19 pandemic has shown that in addition to the current single-state/regional disaster model, the federal government and every state need contingency plans in case aid cannot be received from outside sources. For more common disasters, states can still rely on one another and the federal government for efficient disaster response and recovery efforts, but in response to a nationwide or global disaster, plans that emphasize self-sufficiency must be developed.

OPPORTUNITIES FOR POLICY CHANGE

COVID-19 has prompted states to refocus their efforts on building resiliencies for the continued effects of the current pandemic as well as look at ways to prepare for future disasters. Among these considerations, states should focus on how to best structure their licensing policies to afford flexibility and limited interruption to services provided by credentialed workers. Such policy changes may also assist states in furthering their larger occupational licensing reform efforts to benefit licensed workers during normal operations.

Strategies to Improve State Resiliency

The COVID-19 public health emergency provides states an opportunity to strengthen their resiliency against the persistent public health risks wrought by the current pandemic as well as

future disaster events. Building resiliency through occupational licensing regulations can additionally provide the benefit of addressing other state policy goals, such as improving licensure portability. The following policy options and considerations are presented here for states as they continue to navigate the effects of the pandemic and seek ways to improve their occupational licensure and related policies.

Telehealth Policies

The renewed focus on telehealth during the COVID-19 pandemic provides states an opportunity to capitalize on these policy advancements and make further regulation changes to facilitate the increased use of telehealth technologies. In doing so, states will not only increase their resiliency but also enhance access to health-care services.

There are other policy areas that must be considered to expand the use of telehealth, such as the need to increase access to broadband services to unserved and underserved populations. However, for the purposes of directly supporting licensed health care providers' ability to practice telehealth, one of the most impactful things a state can do is improve policies that provide better pathways for license holders to practice across states lines.

In addition, there are other policies states can consider. For the past two-years, CSG has worked with a collection of state leaders tasked with identifying common strategies can take to improve the health of states. The recommendations from the task force regarding telehealth policies include:

- Allow originating sites for telehealth visits to include a patient's home, school or workplace
- Reduce restrictions around the types of providers allowed to treat patients through telehealth
- Enact telehealth policies that are technology neutral and allow for asynchronous technologies, remote patient monitoring and store and forward services
- Enact telehealth legislation that considers the applicability of the written word (e-mail and text) particularly in behavioral health interactions
- Support telehealth applications to train and provide professional development opportunities to health care providers
- Enact policies that provide parity in reimbursement for telehealth providers under both private insurance and Medicaid

Online Licensing Systems

States have long been working to modernize their licensing process and operations through a more robust online presence. The COVID-19 pandemic however has escalated the need and priority of these efforts as state licensing authorities switched to remote operations to limit in-person interactions.

By digitizing certain licensing processes, such as initial and renewal applications, states are provided a layer of resiliency while also improving licensee/license granting authority interactions. Online systems also may provide states key insights into the supply, and potential shortages, of licensed workers and other gaps between state policy intentions and reality.

Features for online licensing systems:

- Paperless initial and renewal applications
- Paperless licenses
- Online continuing education credits

- Online fee payment
- Incorporating occupational surveys into licensing process

Improving Licensing Portability

States may particularly improve their resiliency to meet health care demands by implementing policies that support interstate licensure portability. A key issue experienced by states, and exacerbated by occupational licensure laws, was the lack of qualified health care professionals. Any efforts to improve licensure recognition should therefore be a foremost consideration. While allowing inactive, retired or in-training practitioners can certainly improve the supply of the workforce, having an active and currently licensed practitioner from another state removes less of the unknown that inherently comes with allowing unlicensed workers to practice. Out-of-state licensed practitioners can also be instrumental in assisting with routine health issues, either in-person or through telehealth, to allow in-state practitioners the ability to focus on the crisis at hand.

Interstate Compacts

Interstate compacts are legally binding agreements among states created to achieve a common purpose or policy goal. In recent years, interstate compacts have been formed to assist with licensure portability for certain occupations. For these professions, interstate compacts facilitate the mutual recognition of licenses and allow practitioners with a compact privilege to freely practice in compact member states.

During times of increased need, licensed professionals who have received a compact privilege are able to quickly deploy to other compact states, either in-person or via telehealth, without an added administrative process by the state that may otherwise prove difficult or time intensive to implement. Further, since interstate compacts are well established policies with standard processes and procedures, it significantly decreases the learning curve that practitioners and regulators may otherwise experience when having to navigate new and temporary regulations with varying expiration dates. Interstate compact privileges are also able to benefit states both during declared emergencies and normal operations, increasing their utility to workers.

As of August 2020, there were seven active occupation specific licensure compacts, with other occupation stakeholder groups currently in the process of formulating additional compacts. Of the seven current licensing compacts, 42 states participating in at least one. Further, the Emergency Management Assistance Compact, which has been adopted in all 50 states, contains provisions to recognize out-of-state licenses during gubernatorial declared emergencies as well coordinate the efficient distribution of emergency resources.

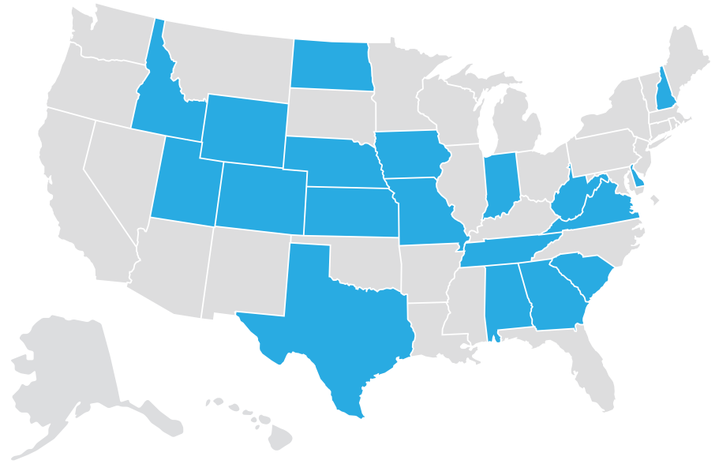
For states to participate in a compact they must do so through legislation. This means that while states may not have been able to quickly join compacts during the onset of the pandemic, those were currently compact members were able to enjoy the added resiliency. While official data is not available at the time of publishing, many of the compacts listed below reported increased use of compact privileges during the COVID-19 Pandemic.

It is also important to note that interstate compacts increase their value through increased state participation, and therefore unless a compact has representation from all states, additional licensure recognition policies may be necessary to maintain full inclusivity of the national pool of licensed workers.

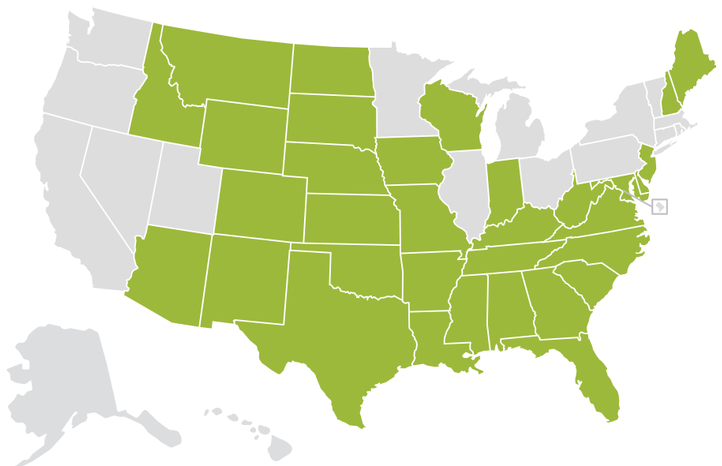
The following are profiles and state adoption numbers for the licensing compacts that were particularly instrumental for states during the pandemic.

The Emergency Management Assistance Compact (EMAC) is the cornerstone of the nation's mutual aid system. EMAC assists during governor-declared states of emergency by allowing states to send personnel, equipment and commodities to assist with response and recovery efforts in other states. States can also transfer services (such as shipping blood from a disaster-impacted lab to a lab in another state) and conduct virtual missions (such as GIS mapping). EMAC establishes a firm legal foundation for sharing resources between states: once the conditions for providing assistance to a requesting state have been set, the terms constitute a legally binding agreement. The compact solves the problems of liability and responsibilities of cost and allows for credentials, licenses and certifications to be honored across state lines. Since ratification in 1996, all 50 states, Washington, D.C., Puerto Rico, Guam, the U.S. Virgin Islands and the Northern Mariana Islands have become EMAC members.

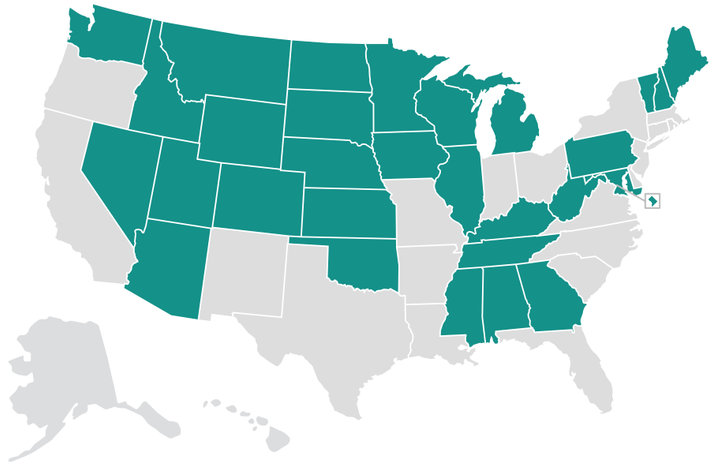
The EMS Compact facilitates the cross-state deployment of emergency management personnel by employing a mutual recognition model, meaning licensees with residence in a compact state are granted a privilege to practice in any other compact state. The compact was activated in 2020 and, as of August, includes 18 participating states.



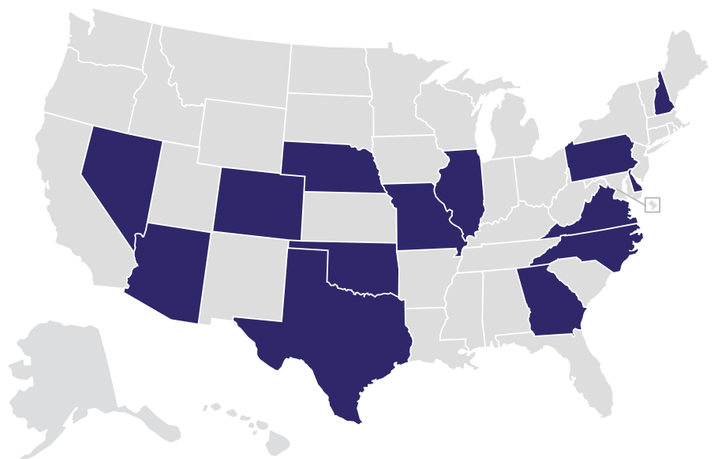
The Enhanced Nurse Licensure Compact (eNLC), adopted in 2019, strengthens the original Nurse Licensure Compact and pursues the same objectives: to encourage interstate cooperation in regulation of the profession, to provide opportunities for interstate practice and to reduce redundant licensing requirements. The compact utilizes a mutual recognition approach, whereby individuals may apply within their home compact state for a multistate license that functions much like a driver's license. As of August 2020, 34 states are signatories of this compact.



The Interstate Medical Licensure Compact (IMLC) seeks to improve access to health care by providing a streamlined process for physicians seeking licensure in multiple states. IMLC utilizes an expedited licensure method where practitioners have the option to seek licensure in multiple states through a compact facilitated process. As of August 2020, 29 states, Washington, D.C., and Guam are signatories of this compact.



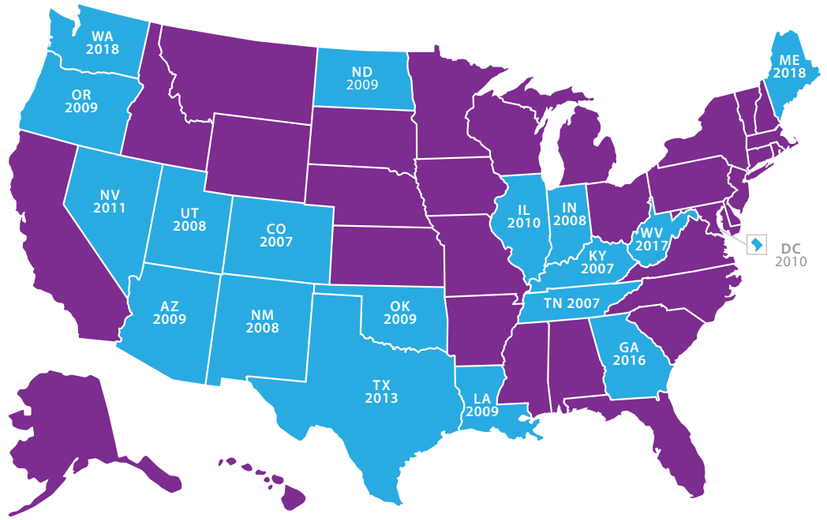
The Psychology Interjurisdictional Compact (PSYPACT) was developed to help manage the proliferation of telepsychology, as well as a greater general concern among stakeholders regarding barriers to temporary practice across state lines. PSYPACT authorizes a licensed worker's privilege to practice in compact member states through two distinct forms: practitioners licensed under the compact can choose to exercise their privilege to practice in remote states through telepsychology and/or a temporary authorization (30 days in one calendar year) to physically practice in remote states. As of August 2020, there were 12 signatories of this compact.



Further resources regarding interstate compacts may be found on CSG's occupational licensing website https://licensing.csg.org/compacts/.

Uniform Emergency Volunteer Health Practitioners Act

The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) is model legislation that provides a pathway for states to recognize out-of-state licensed practitioners during a declared emergency who have registered with a public or private registration system. UEVHPA legislation is also designed to provide civil liability protection for volunteers who are authorized to practice. Since 2007, 18 states and the District of Columbia have adopted the UEVHPA model legislation.



Considering the Permanency of Emergency Policies

For states that made emergency policy changes through executive order, legislation or administrative rulemaking there exists the opportunity to consider which of these temporary policies might be well suited to become permanent. Idaho, through Executive Order 2020-13, has already established the authority and process for its state agencies to adopt emergency regulations permanently.

For states to maintain a judicious approach during these considerations, further study should be conducted to assess the performance, benefits and any issues related to these policies as part of a consideration to make the temporary changes permanent.

States may consider the use of an independent committee to conduct these assessments and issue non-partisan recommendations for state regulators to consider. Further, because of the relatively small sample size that may exist for some of these policies, states would do well to also connect and learn from other state's experiences on similar policies to garner a better understanding of potential risks to public health and safety.

Emergency Occupational Licensing Policy Plans

The immediacy of COVID-19 prompted states to quickly adopt temporary policy amendments to their occupational licensure policies. With the prospect of a continued resurgences in COVID-19 cases as well as additional pandemic scale events a possibility, states have the opportunity to assess which temporary policies it may wish to refine and include in its emergency plans

To accomplish this assessment, states may compare and contrast the temporary policy changes made across states. In doing so states may consider how to better structure and scale temporary emergency policies for subsequent disasters.

A state's evaluation may include looking at both the differences in policies made and not made. For example, a state may consider the structure of temporary licensing policies in comparison to their own as well as look at examples from states that may have expanded their policies to additional populations groups.

To assist states in this endeavor, CSG has collected each state's occupational licensing related COVID-19 action (made through executive order and legislation) and categorized by the policy type (temporary licensing, scope of practice, telehealth, interstate compacts, reducing licensing attainment and maintenance burdens). This resource can be found on CSG's occupational licensing website https://licensing.csg.org/covid-policy-responses/.

Conclusion

The COVID-19 pandemic has prompted states to focus on ways to build their resiliency. Structuring occupational licensing policies to serve this purpose is one the most significant actions a state can take to ensure a robust health care workforce while also limiting the economic effects that licensing may impose. In particular, policy changes made to improve a state's licensing portability and use of telehealth by licensed professionals have benefits that extend well beyond times of disaster and therefore should in particular be a priority for states.

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