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Resolving Roadblocks to Activating Additional Physicians

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The COVID-19 pandemic is creating acute shortages of healthcare providers in crisis areas. Although research has highlighted that both pharmacists and nurse practitioners can play a greater role in assisting with the crisis,[1] doctors nevertheless remain the most highly trained health professionals and are sorely needed. The governors in Michigan and New York have made public pleas for more doctors to come to those states and assist with the crisis.[2] Recent research has highlighted emergency occupational licensing reforms enacted in states to combat the crisis.[3] However, several additional roadblocks prevent retired, out-of-state, and aspiring physicians from responding to critical needs.

In this piece, we highlight the roadblocks that insurance companies and the licensing process continue to present to physicians trying to respond to the crisis. To alleviate these challenges, we make the following recommendations:

1. Many insurers have not yet agreed to even *begin* credentialing physicians holding out-of-state licenses; Medicare is not credentialing physicians with out-of-state licenses either, unless those physicians have current Medicare privileges. Insurance companies should follow Medicare's example immediately.
2. State licensing boards should have a mandate to process licenses expeditiously, with a set maximum processing time, to ensure adequate supply of physicians in their state.
3. States should continue recognition of out-of-state physician licenses as a permanent reform.

INSURANCE COMPANIES SHOULD ALLOW CREDENTIALING FOR ALL LICENSED PHYSICIANS

Given President Trump's declaration of a federal emergency, the Stafford Act waives the requirement that doctors hold licenses in the state where they are providing services for the purposes of Medicare, Medicaid, and the State Children's Health Insurance Program.[4] In addition, Medicare recently updated guidance to waive the requirement for in-state licenses, as long as the providers are registered under Medicare elsewhere.[5] Although these reforms are both important steps, barriers remain for providers coming out of retirement and for new physicians who have not yet registered under Medicare. Both of these groups are still required to obtain an in-state license and then undergo Medicare credentialing.

As of April 1, many private insurance companies we have contacted have not agreed to even *begin* the credentialing process for physicians who do not hold in-state licenses.[6] Private insurance companies may wish to take extra precautions to make sure that quality standards are maintained. It is not clear, however, that delaying this process would improve quality standards set by both the state and hospital credentialing process.

The current stalemate puts hospitals in a potential financial bind: they can hire new or previously retired physicians but will be unable to bill insurance companies for any care provided by these physicians. Thus, the care provided by this group of providers becomes a strictly loss-making charitable measure. From a financial standpoint, this is not sustainable.

To alleviate these challenges, we recommend that Medicare immediately begin credentialing licensed physicians regardless of previous Medicare enrollment, in accordance with the Stafford Act. Private insurance companies should be strongly encouraged to follow this example.

STATE LICENSING SHOULD BE ACCELERATED

In addition to the credentialing barrier created by insurance, medical licensing is a lengthy process, usually taking three to nine months, depending on state.[7] Much of this work is redundant and includes verification of medical training, background checks, and other state licenses. Generally, this process must be repeated for each new state license obtained.

Accordingly, the present state of emergency has not significantly affected the length of time for processing a state license, which is crucial for insurance credentialing, as described earlier.[8] Reactivation of a license also remains a time-consuming process in many states (although others have adopted or are investigating various emergency measures to streamline this process).[9] Thus, retired or out-of-state doctors trying to help out with the pandemic may still face a wait of several months.

Verifying diplomas and board scores, as well as monitoring for malpractice, are important roles of medical boards. However, many boards have gone far beyond this core mandate, thereby contributing to processing delays.[10] In part, this expansion has been enabled by state boards' mandates to protect consumers from the incompetent practice of medicine; yet no countervailing mandate exists to protect the health of the public by ensuring an adequate supply of healthcare providers.

In addition to their present mandate for consumer protection, state licensing boards should have a mandate to ensure adequate and flexible physician supply via expeditious processing of license applications. This recommendation is not only valid for times of crisis, it should also be extended indefinitely to ease persistent shortages in primary care.

INTERSTATE MEDICAL LICENSING RECOGNITION SHOULD BE CONTINUED

As already noted, the physician licensure process presents redundancies for new physicians as well as physicians licensed in good standing seeking to practice in a new state. Some authorities have recognized this redundancy and have offered new services as a result. Federation Credentials Verification Service (FCVS) serves as a storehouse of physician credentials.[11] The Uniform Application also retains application information that can be reused for multiple state medical boards.[12] Although these services are welcome additions, neither is fully effective at reducing redundancy or shortening processing times.

Physician licensing requirements are generally uniform across states.[13] The redundancy in obtaining licenses to practice in additional states is hard to justify from a public health standpoint. Recognizing out-of-state licenses is certainly sensible in a pandemic, but many parts of the United States faced a shortage of medical professionals even before this crisis. Current reciprocity efforts have attempted to address this need but do not go far enough, covering only a minority of cases, such as physicians living on the edge of one state and commuting to another.[14] To further alleviate this need now and into the future, states should make permanent the Stafford Act's recognition of out-of-state licenses to minimize the duplication of labor that has allowed license processing to become so heavily encumbered.

The United States faces a medical crisis not seen since the 1918 flu pandemic. The crisis has only exacerbated existing problems with the provision of physician care. Policymakers have been quick to respond, but barriers remain, and we believe the solutions offered in this piece will help alleviate the strain today and help moving into the postcrisis world.

ABOUT THE AUTHORS

Peter Wei is a radiologist who trained at Duke University and graduated residency from SUNY Upstate Medical University. He is a coauthor of *Learning Medicine: An Evidence-Based Guide*. As a young physician eager to do his part to help battle the COVID-19 pandemic, he hopes that smarter healthcare policies will allow the country to make the best use of its healthcare professionals.

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NOTES

1. James Broughel and Yuliya Yatsyshina, "Relax Pharmacy Regulations to Help with COVID-19 Testing and Treatment" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, March 2020); Matthew D. Mitchell, "First, Do No Harm: Three Ways That Policymakers Can Make It Easier for Healthcare Professionals to Do Their Jobs" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, March 2020).
2. Katelyn Burns, "Governors Plead with Other States for More Health Care Workers to Fight Coronavirus," *Vox*, March 31, 2020.
3. Ethan Bayne, Conor Norris, and Edward Timmons, "A Primer on Emergency Occupational Licensing Reforms for Combating COVID-19" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, March 2020).
4. Bruce M. Altevogt et al., rapporteurs, *Medical Surge Capacity: Workshop Summary* (Washington, DC: National Academies Press, 2010).
5. Centers for Medicare & Medicaid Services, *2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)*, March 2020, https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf.
6. To ensure that our information was up to date, we placed calls to the three largest private insurance companies in New York (Anthem, United, and Humana) and confirmed that they are still requiring in-state licenses. We presumed that the biggest insurers in the state with the most COVID-19 cases would be the most likely to change policies. We also placed calls to BlueCross in Texas and Nebraska and confirmed that all the major New Hampshire insurers require in-state licenses.
7. "How Long Does It Take to Get a Physician License In Each State?," *Nomad*, October 16, 2018.
8. Amy Paturel, "Retired Doctors Want to Return to Work to Fight COVID-19. Here's What They Need to Know," *AAMCNEWS*, April 8, 2020.
9. Federation of State Medical Boards, *States Expediting Licensure for Inactive-Retired Licensees in Response to COVID-19*, April 2, 2020, https://www.fsmb.org/siteassets/advocacy/pdf/states-expediting-licensure-for-inactive-retired-licensees-in-response-to-covid19.pdf.
10. Steven L. Simas, "Physician Residents Beware – Problems during Your Residency Could Prevent You from Obtaining Your Medical License in California," Simas & Associates, September 6, 2018.
11. "Federation Credentials Verification Service," Federation of State Medical Boards, accessed May 5, 2020, https://www.fsmb.org/fcvs/.
12. "Uniform Application," Federation of State Medical Boards, accessed May 5, 2020, https://www.fsmb.org/uniform-application/.

13. “State Specific Requirements for Initial Medical Licensure,” Federation of State Medical Boards, accessed May 5, 2020, https://www.fsmb.org/step-3/state-licensure/.

14. Interstate Medical Licensure Compact (website), accessed May 5, 2020, https://imlcc.org/. For findings on the similar Nursing Licensure Compact, see Christina DePasquale and Kevin Stange, “Labor Supply Effects of Occupational Regulation: Evidence from the Nurse Licensure Compact” (NBER Working Paper No. 22344, National Bureau of Economic Research, Cambridge, MA, June 2016).