

## ARTICLES

### FROM PIXELS TO PRESCRIPTIONS: THE CASE FOR NATIONAL TELEHEALTH LICENSING & AI-ENHANCED CARE

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#### INTRODUCTION

In the wake of the COVID-19 pandemic, the United States faced stark revelations regarding the vulnerabilities and insufficiencies within its healthcare system. From physician shortages to overextended capacities and disjointed state-centric licensing regulations, the challenges were manifold.<sup>1</sup> In the midst of this turmoil, telehealth—once a peripheral aspect of healthcare delivery—emerged as an unexpected beacon of reform and technological potential.<sup>2</sup> This Article contributes to the discourse on healthcare reform by arguing for a dual approach, which combines the technological promise of telehealth with a comprehensive rethink of the current regulatory framework. It proposes that the federal

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1. Daniel Molager Christensen, *Charlson Comorbidity Index Score and Risk of Severe Outcome and Death in Danish COVID-19 Patients*, 35 J. GEN. INTERNAL MED. 2801, 2802 (2020). In a 2021 study, the American Association of Medical Colleges (AAMC) estimated that there might be a shortage of between 37,800 and 124,000 doctors in the US by 2034. See TIM DALLE ET AL., ASS'N OF AM. MED. COLLS., *THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2019 TO 2034* 3 (2021).

2. Ateev Mehrotra et al., *Rapidly Converting to "Virtual Practices": Outpatient Care in the Era of Covid-19*, NEJM CATALYST (2020). This article delves into the swift shift of outpatient services to online platforms amidst the COVID-19 outbreak. *Id.* It sheds light on the hurdles and prospects that come with this transformation, touching upon the essentiality of tech frameworks, compensation strategies, and patient receptivity. *Id.* The authors underscore telehealth's promise in enhancing healthcare accessibility and diminishing disparities. *Id.*

government should engage with states to enact two specific reforms: first, a mutual recognition of out-of-state medical licenses for the delivery of telehealth services; and second, an expanded scope of practice for non-physician providers, determined by factors including education, training, credentials, outcomes data, and the utilization of emerging technologies such as AI.

Part I of the Article investigates the unexpected rise of telehealth during the pandemic, a consequence of temporary deregulation, and postulates the sustainability of this growth in the post-pandemic era. Part II illuminates how fragmented state licensing schemes and inconsistent scope of practice laws can hinder the growth of telehealth and workforce innovation. Part III places the discussion within the wider legal context by examining recent federal antitrust interventions against state occupational licensing boards. Part IV explores alternative regulatory frameworks such as national licensure systems and interstate compacts.

Part V frames the central proposal of the Article: Congress should employ its spending power to incentivize states, through targeted Medicaid funding bonuses, to recognize out-of-state licenses for telehealth and endorse an expanded scope of practice for non-physician providers. Part VI contemplates the transformative impact on healthcare that could be realized through the proposed reforms. Part VII navigates the complex terrain of federalism and administrative law, ensuring that the proposal stands in alignment with the wider constitutional framework.

In conclusion, the Article posits that while states would maintain authority over in-person medical practice, the proposed changes would significantly enhance telehealth enablement and practitioner scope. The synthesis of telehealth with legal reform offers a promising avenue for expanding access, efficiency, quality, and resilience throughout America's healthcare system. This vision presents not only a response to the urgent demands of a global pandemic but also a proactive step towards a healthcare system attuned to the nuanced demands and opportunities of the 21st century.

#### I. TELEHEALTH COMES OF AGE DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic has spurred significant growth and change within the healthcare system, none more pronounced than the rapid evolution and acceptance of telehealth. This Section explores the multifaceted developments in telehealth, tracing the historical barriers, the unprecedented temporary deregulation, and the subsequent expansion and validation of this critical healthcare delivery model.

The terms telehealth and telemedicine, although often interchanged in common discourse, serve distinct roles within the healthcare ecosystem. Telemedicine refers specifically to services like live videoconferencing and remote patient monitoring, which health insurers have traditionally covered and reimbursed.<sup>3</sup> Telehealth, in contrast, embraces a broader definition that includes

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3. Clemens Scott Kruse et al., *Telehealth and Patient Satisfaction: A Systematic Review and Narrative Analysis*, 7 *BMJ OPEN* 1 (2017).

fundamental modalities like telephone calls and text messaging.<sup>4</sup> This Article adopts the broader term to encapsulate the all-encompassing nature of healthcare delivery through telecommunications technology.

*A. The Longstanding Potential of Telehealth Stymied  
by Restrictive Regulations*

For many years, the healthcare community has recognized the potential of telehealth as a revolutionary means to increase healthcare access, enhance patient outcomes, and decrease overall costs.<sup>5</sup> The theoretical promise was immense, yet the practical realization of this potential was largely stymied; until the extraordinary circumstances of the COVID-19 pandemic, extensive and often overlapping regulatory obstacles severely inhibited telehealth's widespread utilization and broader innovation.<sup>6</sup>

The barriers were multifaceted. Medicare reimbursement rules, which dictated the financial viability of telehealth for many providers, were especially stringent.<sup>7</sup> These rules imposed severe restrictions on the types of technologies that could be used, often prohibiting commonplace devices such as consumer smartphones.<sup>8</sup> Further limitations were placed on the eligible services, providers (typically restricted to rural clinicians), and even the locations where telehealth could be initiated (e.g., requiring patients to travel to pre-approved rural clinics for initial visits).<sup>9</sup>

But federal regulations were just part of the regulatory maze. At the state level, licensing policies added another layer of complexity and potential legal risk, particularly concerning cross-state telehealth services.<sup>10</sup> The net effect of this confusing matrix of federal and state regulations was a significant chilling effect

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4. *See id.*; Shilpa N. Gajarawala & Jessica N. Pelkowski, *Telehealth Benefits and Barriers*, 17 J. NURSE PRACS. 218, 218 (2021).

5. Kruse et al., *supra* note 3.

6. Carmel Shachar et al., *Implications For Telehealth In a Postpandemic Future*, 323 JAMA 2375, 2375-76 (2020).

7. *See id.* at 2375.

8. Julia Shaver, *The State of Telehealth Before and After the COVID-19 Pandemic*, 49 PRIMARY CARE: CLINIC OFF. PRAC. 517 (2022).

9. *Id.*

10. Yvonne C. Jonk et al., *Telehealth Use In a Rural State: A Mixed methods Study Using Maine's All payer Claims Database*, 37 J. RURAL HEALTH 769 (2020). This study analyzes telehealth utilization in a rural setting, emphasizing the hurdles faced in its adoption and execution. The study points out that state-level licensing policies led to uncertainty about the legal boundaries of delivering cross-state telehealth, posing potential legal or payment challenges for providers. *Id.* Additional barriers encompass the intricate task of modifying clinical operations for telehealth, restricted internet access, technology expenses, and the challenge of attracting specialists for telehealth delivery. *Id.* Prior to COVID-19, despite evolving policies and growing interest, this study found the adoption rate for telehealth remained notably low. *Id.*

on the adoption of telehealth.<sup>11</sup> Healthcare professionals, organizations, and even patients were often discouraged from exploring or adopting telehealth solutions.<sup>12</sup>

In retrospect, this regulatory framework can be seen as a product of cautious incrementalism, reflecting legitimate concerns about quality control, fraud prevention, and other issues. Yet, it also can be seen as reflecting a failure to fully appreciate the transformative potential of telehealth and an overestimation of its risks. As we will see, the COVID-19 pandemic would provide both a stark demonstration of telehealth's capabilities and a catalyst for rethinking the legal and regulatory frameworks that had previously constrained it.<sup>13</sup>

### *B. Rapid Deregulation During the COVID-19 Public Health Emergency*

The onset of the COVID-19 pandemic triggered a seismic shift in the regulatory landscape governing telehealth, acting as an urgent catalyst for change. Faced with a sudden and unparalleled public health crisis, regulators found themselves compelled to temporarily waive or relax a thicket of restrictions that had long constrained the growth and innovation of telehealth.<sup>14</sup> This regulatory transformation was sweeping in scope and rapid in implementation. At the federal level, the Centers for Medicare and Medicaid Services (CMS) invoked rarely used emergency powers to expand Medicare coverage of telehealth services across the nation.<sup>15</sup> These changes were profound, disregarding traditional limitations that had previously defined the contours of telehealth's reach such as geography, technology, types of services, and the nature of participating providers.<sup>16</sup>

In parallel, state authorities responded with equal urgency. Governors across the country declared public health emergencies, a move that triggered temporary waivers allowing telehealth services to be delivered across state lines.<sup>17</sup> These waivers circumvented the customary licensure restrictions, facilitating the

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11. *Id.*

12. *Id.*

13. *Id.*

14. JoAnn Volk et al., *States' Actions to Expand Telemedicine Access During COVID-19 Pandemic and Future Policy Considerations*, THE COMMONWEALTH FUND (June 23, 2021), <https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/states-actions-expand-telemedicine-access-covid-19> [<https://perma.cc/MJ7X-44F5>].

15. Press Release, U.S. Ctrs. for Medicare & Medicaid Servs., President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak (Mar. 17, 2020), <https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak> [<https://perma.cc/KMB3-F42N>].

16. Christopher M. Jones et al., *Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the Covid-19 Pandemic*, 10 JAMA PSYCHIATRY 79, 988-91 (2022).

17. Margaret Ziemann et al., *How Governor Directives Changed Health Workforce Flexibility in Response to the COVID-19 Pandemic*, 138 PUB. HEALTH REP. 78S (2023).

provision of care by out-of-state providers in an unprecedented manner.<sup>18</sup>

The cumulative effect of these extraordinary measures was a massive, albeit temporary, deregulation of telehealth, resulting in an exponential increase in its utilization across the healthcare ecosystem. The statistics tell a compelling story of transformation: telehealth visits increased nationally by staggering margins of 50 to 175 times compared to pre-pandemic levels.<sup>19</sup> By the summer of 2020, data revealed that telehealth constituted 10.6% of Medicare primary care visits and 4.3% of all Medicare services, a 63-fold total increase over pre-pandemic levels.<sup>20</sup> Not surprisingly, private insurers echoed this trend, reporting similar explosive growth in telehealth visits among their fully insured clients during the early months of 2020.<sup>21</sup>

This unprecedented shift not only reshaped the provision of healthcare during a time of crisis but also opened a profound dialogue on the future of telehealth by providing empirical evidence of telehealth's capabilities, challenging longstanding assumptions, and revealing the latent demand that had been stifled under prior regulatory regimes. Thus, the rapid, temporary deregulation of telehealth in response to the COVID-19 pandemic will likely be regarded as a critical juncture in the evolution of healthcare delivery, prompting serious consideration of more permanent changes to the legal and regulatory frameworks that govern telehealth.

### *C. High Patient and Provider Satisfaction with Telehealth*

The initial expansion of telehealth in response to the COVID-19 pandemic heralded not only a revolutionary change in healthcare delivery but also a significant shift in perceptions among both providers and recipients of care. An examination of surveys conducted in the wake of these changes reveals an overwhelmingly positive response, marking a departure from pre-pandemic hesitancy toward virtual care.<sup>22</sup>

Within the United States, the receptivity to telehealth was echoed in various patient and provider surveys, manifesting high levels of satisfaction with the

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18. Hyunjung Lee & Gopal K. Singh, *The Impact of Telemedicine Parity Requirements on Telehealth Utilization in the United States During the COVID-19 Pandemic*, 4 J. PUB. HEALTH MGMT. & PRAC. 29 (2023).

19. William T. Berg et al., *Clinical Implications of Telemedicine for Providers and Patients*, 114 FERTILITY & STERILITY 1129, 1129 (2020).

20. Press Release, U.S. Ctrs. for Medicare & Medicaid Servs., *New HHS Study Shows 63-Fold Increase in Medicare Telehealth Utilization During the Pandemic* (Dec. 3, 2021), <https://www.cms.gov/newsroom/press-releases/new-hhs-study-shows-63-fold-increase-medicare-telehealth-utilization-during-pandemic> [<https://perma.cc/QN6G-5F25>].

21. See Dee Ford et al., *Leveraging Health System Telehealth and Informatics Infrastructure to Create a Continuum of Services for COVID-19 Screening, Testing, and Treatment*, 27 J. AM. MED. INFORMATICS ASS'N 1871, 1873 (2020).

22. See Kevin Chen et al., *Patient Satisfaction with Telehealth Versus In-person Visits During COVID-19 at a large, Public Healthcare System*, 28 J. EVALUATION CLINICAL PRAC. 986 (2022).

newly accessible virtual care modalities.<sup>23</sup> This sentiment was not confined to domestic borders; indeed, it was mirrored in other nations.<sup>24</sup> A salient example can be found in a large-scale Australian survey conducted contemporaneously with the pandemic.<sup>25</sup> In this survey, 61% of patients conveyed satisfaction with their telehealth visits, while earlier studies of rural Australian telehealth patients revealed a much higher satisfaction rate of 89% and 98%, “suggesting urbanality has a significant impact on telehealth satisfaction[.]”<sup>26</sup> Equally telling was the response from the provider community, with a majority expressing satisfaction with the process of delivering medical care in a virtual environment.<sup>27</sup> Perhaps most revealing in these findings is the substantial proportion of providers have indicated their plans for the continuation of telehealth services beyond the exigencies of the pandemic and even after regulations revert to their pre-COVID status quo.<sup>28</sup> This indication, resonating across national boundaries, provides a strong indication of the substantial latent demand for telehealth, a demand that had been stifled under the restrictive regulatory frameworks of the past.

#### *D. Comparable Quality of Telehealth vs. In-Person Care*

Initial empirical studies conducted during the pandemic on the quality of care delivered through telehealth platforms offer a nuanced and thought-provoking picture. Despite prevailing preconceptions, telehealth’s level of quality is just as high across a broad array of medical domains as traditional in-person care’s; however, in the near future, telehealth will likely remain a secondary option rather than a replacement for traditional in-person care..<sup>29</sup>

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23. *Id.* (“For Care Provider satisfaction questions, video visits generally had higher mean scores than in-person and, in turn, audio-only visits. For Overall Assessment questions, video visits had higher mean scores than in-person and, subsequently, audio-only visits.”).

24. Lucinda Adams et al., *Patient Satisfaction and Acceptability with Telehealth at Specialist Medical Outpatient Clinics during the COVID-19 Pandemic in Australia*, 51 INTERNAL MED. J. 1028 (2021).

25. *Id.*

26. *Id.* at 1033-34.

27. See also Timothy Hoff & Do-Rim Lee, *Physician Satisfaction with Telehealth: A Systematic Review and Agenda for Future Research*, 31 QUALITY MGMT. HEALTH CARE 160 (2022) (concluding that review of studies on physician satisfaction with telehealth was moderate to highly positive, while acknowledging that more research needs to be done on physician sentiment with telehealth post-COVID public health emergencies).

28. See *id.*; see USAFacts Team, *What’s the State of Telehealth after COVID-19?*, USAFACTS (Nov. 22, 2023), <https://usafacts.org/articles/whats-the-state-of-telehealth-after-covid-19/> [<https://perma.cc/E62U-52CV>].

29. See Shaver, *supra* note 8; see, e.g., Centaine L. Snoswell et al., *The Clinical Effectiveness of Telehealth: A Systematic Review of Meta-analyses from 2010 to 2019*, 9 J. TELEMEDICINE & TELECare 669, 672-80 (2021); Kristen M. Johnson et al., *Comparison of Diagnosis and Prescribing Practices Between Virtual Visits and Office Visits for Adults Diagnosed with Sinusitis Within a Primary Care Network*, 9 OPEN F. INFECTIOUS DISEASES 1 (2019).

Several studies, focusing on urgent care scenarios, have drawn particular attention to the lack of statistically significant disparities between telehealth and in-person visits.<sup>30</sup> These studies carefully scrutinize factors such as antibiotic prescribing rates, the employment of medical imaging, return visits to urgent care facilities, and emergency room utilization.<sup>31</sup> The outcomes are noteworthy: telehealth performs on par with in-person care, providing a robust challenge to assumptions about compromised care quality.<sup>32</sup>

This line of inquiry has been extended to other medical fields, with similar findings of equivalent outcomes for telehealth in diverse areas such as prenatal and postpartum obstetric care, dermatology consultations, and more.<sup>33</sup> These preliminary results collectively form a compelling case for the quality of telehealth, arguing against the traditional view that a lack of physical examination and in-person interaction necessarily dilutes the caliber of care.

#### *E. Debunking Restrictive Assumptions through Robust Utilization Data*

The COVID-19 pandemic's unprecedented expansion of telehealth provided an empirical ground to reassess pre-existing restrictive assumptions. By enabling a large-scale temporary deployment of telehealth services, federal and state regulators were able to compile meaningful data to analyze its risks and benefits across a wide spectrum of patient populations and care contexts.<sup>34</sup> A critical data point in this discourse can be traced back to an audit conducted by the Health and Human Services' (HHS) Office of the Inspector General (OIG) in 2018.<sup>35</sup> Analyzing Medicare claims, OIG discovered that a notable 31% did not comply with reimbursement criteria.<sup>36</sup> A further scrutiny revealed that the bulk of these discrepancies were accidental, with issues stemming from nonrural sites (24%), unauthorized sites (3%), and smaller fractions arising from ineligible providers (7%) or unapproved communication methods (2%).<sup>37</sup> Significantly, no deliberate violations were found.<sup>38</sup>

The OIG's analysis not only spotlighted the incidental nature of these breaches but also elucidated potential savings of approximately \$3.7 million that CMS could have realized through tighter oversight.<sup>39</sup> To frame this figure in

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30. See, e.g., Snoswell et al., *supra* note 29; Johnson et al., *supra* note 29.

31. Johnson et al., *supra* note 29.

32. See Snoswell et al., *supra* note 29; Johnson et al., *supra* note 29.

33. Snoswell et al., *supra* note 29, at 672-80.

34. See Shaver, *supra* note 8.

35. GLORIA L. JARMON, OFF. OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., CMS PAID PRACTITIONERS FOR TELEHEALTH SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS (2018).

36. *Id.* at 5 (the sample size of the audit was one hundred claims. Of those one hundred claims, thirty-one did not meet service requirements).

37. *Id.*

38. *Id.* at 6.

39. *Id.* at 5.

perspective, it becomes almost inconsequential when considered against the backdrop of the U.S. healthcare expenditure exceeding \$3.6 trillion in 2018.<sup>40</sup>

These findings challenged the federal government's entrenched perspective that viewed telehealth principally as a rural access remedy rather than a widespread treatment option for a broader beneficiary population.<sup>41</sup> The restrictive regulatory posture, underscored by these findings, offered insights into how telehealth's potential was constrained by assumptions rather than substantive risks.<sup>42</sup> The relationship between innovation and regulation is complex. As scholars in the field of disruptive technology have astutely observed, regulatory barriers can form insurmountable hurdles, stifling technologically superior advancements.<sup>43</sup> These barriers might persist even when disruptive innovations have the potential to become fully competitive within mainstream markets.<sup>44</sup>

The 2018 OIG Report, when revisited in light of the COVID-19 experience, should have been construed as highlighting minimal risks related to Medicare claims. The pandemic's widespread deployment of telehealth brought robust empirical evidence to bear on the issues of clinical quality, utilization patterns, and the real risks and benefits of telehealth.<sup>45</sup> Further, there are legitimate concerns with telehealth facilitating the ease of fraudulent activities such as inflation of time, up-coding complexity of cases, and billing for services that were never delivered.<sup>46</sup> However, the HHS-OIG published a report assessing the level of fraudulent billing during the first year of the pandemic which identified approximately 1700 "high-risk" providers fraudulently billing \$127.7 million in Medicare fee-for-service payments.<sup>47</sup> For many policy observers "the takeaway of the OIG report was that Medicare telehealth fraud was overall proportionally rare."<sup>48</sup>

Thus, the emergence of new data, derived from the deregulatory context of the pandemic, presents a compelling argument for a more nuanced and flexible regulatory framework that accommodates telehealth's potential. It demands an

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40. Micah Hartman et al., *National Health Care Spending In 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending*, 39 HEALTH AFFS. 8, 8 (2020).

41. *See id.*; JARMON, *supra* note 35; Shaver, *supra* note 8.

42. *See* JARMON, *supra* note 35; Shaver, *supra* note 8.

43. Robert Engberg & Peter Altmann, *Regulation and Technology Innovation: A Comparison of Stated and Formal Regulatory Barriers Throughout the Technology Innovation Process*, 10 J. TECH. MGMT. & INNOVATION 85, 85-90 (2015).

44. *Id.*

45. Asim Kichloo et al., *Telemedicine, the Current COVID-19 Pandemic and the Future: A Narrative Review and Perspectives Moving Forward in the USA*, 8 FAM. MED. & CMTY. HEALTH 1 (2020).

46. *See* Jolie Apicella, *Examining Post-Pandemic Telehealth Fraud Risks*, MED. ECON. (Jan. 10, 2023), <https://www.medicaleconomics.com/view/examining-post-pandemic-telehealth-fraud-risks> [<https://perma.cc/KY3V-L4XV>].

47. *Id.*

48. *Id.* However, the author notes that OIG "set a high threshold" for identifying "high-risk" providers. *Id.*



evidence-based dialogue that moves beyond the traditional reservations and envisions telehealth as an integral part of a dynamic and responsive healthcare system.

*F. Uncorking the Genie: Recognizing Widespread Telehealth as a New Reality*

The temporary deregulation that marked the pandemic's response allowed a synthesis of clinical, utilization, fraud, and abuse data on telehealth services. This empirical collection of evidence serves to debunk many of the longstanding assumptions that regulators have historically relied upon to justify telehealth restrictions, chiefly those premised on quality and program integrity concerns.<sup>49</sup> Indeed, the practical experience with telehealth during the pandemic strongly suggests that it is well-positioned to become a high-value component within the healthcare delivery landscape.<sup>50</sup> However, the realization of this potential requires the formulation of judicious policies that foster the continued growth and development of telehealth services.

One of the most notable endorsements of this new telehealth reality came from the CMS Head, Seema Verma, during the height of the pandemic. Verma's comments capture the zeitgeist of this transformative moment:

I think the genie's out of the bottle on this one. I think it's fair to say that the advent of telehealth has been just completely accelerated, that it's taken this crisis to push us to a new frontier, but there's absolutely no going back . . . [b]ut this, to me, is the most clear example of untapped innovation.<sup>51</sup>

In summary, the unprecedented temporary deregulation prompted by the COVID-19 pandemic has acted as a catalyst, rapidly unleashing telehealth adoption on a massive scale and unveiling its vast disruptive potential.<sup>52</sup>

*G. The Need for Licensing and Scope Reforms to Realize Telehealth's Promise*

In the aftermath of the COVID-19 pandemic, it has become unmistakably clear that telehealth utilization is unlikely to revert to the relatively modest levels observed prior to 2020. The evidence gleaned during this critical period reveals the immense potential of telehealth to enhance access to timely healthcare services across various demographics and regions.<sup>53</sup>

Yet, this potential remains stifled by the archaic and fragmented patchwork of state-based medical licensing regimes and scope of practice policies that

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49. ORG. FOR ECON. COOP. & DEV., THE FUTURE OF TELEMEDICINE AFTER COVID-19 (Jan. 20, 2023).

50. *See id.*

51. Bimal R. Shah & Kevin Schulman, *Do Not Let a Good Crisis Go to Waste: Health Care's Path Forward with Virtual Care*, NEJM CATALYST (Mar. 30, 2021).

52. *Id.*

53. *Id.*

pervade the contemporary healthcare system.<sup>54</sup> These disparate regulations, entrenched in a bygone era, threaten to obstruct the burgeoning digital transformation of healthcare; they constrain the innovative technologies and models of care that have proved both efficacious and popular during the pandemic.<sup>55</sup>

As telehealth stakes its claim as an integral part of the healthcare infrastructure, the onus falls upon lawmakers and policy architects to carefully dismantle these restrictive barriers. The need to modernize the regulatory landscape is not merely a call to streamline bureaucracy but a pivotal step towards fulfilling the promise of telehealth. The forthcoming section will delve into the complex and multifaceted issues surrounding state-based licensing and scope of practice laws, illuminating how these regulatory hurdles may imperil the continued growth and integration of telehealth services in a post-pandemic world.

## II. MEDICAL LICENSING AND SCOPE OF PRACTICE LAWS: THE RESILIENT LEGACY OF OUTDATED BARRIERS

### *A. The Peculiar Persistence of State-Based Medical Licensing*

The tapestry of American healthcare regulation presents a paradox that, while most dimensions of medical practice and oversight have undergone a marked process of nationalization over the past century, the mechanism of medical licensing persists in the jurisdiction of individual states.<sup>56</sup> This anomaly finds its roots in the early 20th century, specifically in the wake of the 1910 Flexner Report, a watershed examination that spurred comprehensive reforms to enhance the quality and uniformity of medical education across the nation.<sup>57</sup> In response to these reforms, physicians strategically capitalized on state medical boards to retain professional sovereignty over licensure and delineation of practice boundaries, thereby effectively insulating these critical aspects of medical regulation from broader public scrutiny and accountability.<sup>58</sup>

This present configuration has not escaped criticism. Detractors argue that state medical boards have devolved into quasi-cartels, disproportionately influenced, if not controlled, by physicians.<sup>59</sup> In contrast, mainstream physician

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54. *See id.*

55. *Id.*

56. Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 202 (1999).

57. Thomas P. Duffy, *The Flexner Report—100 Years Later*, 84 YALE J. BIOLOGY & MED. 269, 269 (2011).

58. *See* PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* (1982).

59. *See* Alexander Hertel-Fernandez et al., *Business Associations, Conservative Networks, and the Ongoing Republican War Over Medicaid Expansion*, 41 J. HEALTH POL., POL'Y & L. 239 (2016); Osea Giuntella, *Why Does the Health of Mexican Immigrants Deteriorate? New Evidence from*

constituencies, such as the American Medical Association (AMA), posit that resistance to broadening the scope of practice for allied health professionals stems not from economic self-preservation but from a genuine concern over the potential erosion of professional jurisdiction and standards of care.<sup>60</sup> Notwithstanding these conflicting perspectives, the fragmented, state-based model endures, its inefficiencies and peculiarities acknowledged yet unaddressed, even in the face of near-consensus regarding its inherent dysfunction. This persistence raises probing questions about the underlying interests and values that continue to shape and stabilize this critical aspect of American healthcare regulation.

*B. Variations in Scope of Practice Laws and the Undermining  
of Workforce Flexibility*

The prevailing variations in scope of practice laws across states have become a prominent and disconcerting feature of contemporary healthcare regulation, creating confusion within the healthcare workforce, and severely restricting the flexibility necessary to leverage allied health professionals in efforts to mitigate physician shortages. The Institute of Medicine's seminal report in 2010, *The Future of Nursing: Leading Change, Advancing Health*, provided a comprehensive examination of the necessary reforms in nursing practice and education to adequately respond to the multifaceted challenges confronting the nation's healthcare system.<sup>61</sup> The report unequivocally concluded that arbitrary differences in scope of practice laws imposed by disparate states constituted a formidable barrier, frustrating efforts to fully capitalize on the unique contributions of advanced practice nurses to expand access to essential services.<sup>62</sup> The recommended corrective measures emphasized the need to standardize and broaden scope of practice policies, ensuring that nurses can practice in diverse care settings to the fullest extent their education, training, and credentials would allow.<sup>63</sup>

The AMA, however, has maintained a consistent and firm stance against the expansion of autonomous practice authority to allied health professionals designated as "non-physician," absent compelling empirical evidence that traditional physician-led models of care delivery are either inadequate or unsafe.<sup>64</sup>

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*Linked Birth Records*, 54 J. HEALTH ECON. 1 (2017); Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1112 (2014).

60. See Hertel-Fernandez et al., *supra* note 59; Giuntella, *supra* note 59; Edlin & Haw, *supra* note 59.

61. INST. OF MED., *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* (2011).

62. *Id.* at 5.

63. *Id.* at 144-45, 148.

64. *AMA Successfully Fights Scope of Practice Expansions that Threaten Patient Safety*, AM. MED. ASS'N (May 15, 2023), <https://www.ama-assn.org/practice-management/scope-practice/ama-successfully-fights-scope-practice-expansions-threaten> [<https://perma.cc/GW9Q-23NF>].

The lingering political skirmishes among healthcare provider factions, each seeking to shape scope of practice policies in their favor, has contributed directly to the existing disparities between states, undermining workforce flexibility, despite the de jure and de facto acceptance of national standards of care in the medical field.<sup>65</sup>

### *C. The Disproportionate Impact on Rural Healthcare Access*

The challenges and constraints imposed by restrictive medical licensing schemes and inconsistent scope of practice limitations are felt most acutely in rural areas, where access to care is already hindered by severe shortages of physicians and other healthcare resources. A demographic reality underscores this concern: nearly one in five Americans reside in rural communities, yet a mere one-tenth of licensed physicians practice within these regions.<sup>66</sup> Certain rural counties face the alarming scenario of having a single practicing physician responsible for the care of over 3,500 residents, falling significantly short of the recommended population-to-provider ratio of 2,000:1, viewed as a baseline for ensuring adequate access to care.<sup>67</sup>

The scarcity of specialist physicians in rural regions further exacerbates this dilemma, often necessitating that patients undertake lengthy journeys to urban centers to obtain the complex care they require.<sup>68</sup> These restrictions on the scope of practice for allied health professionals, wrought by interstate variability, obstruct local workforce innovations that could substantially alleviate rural physician shortages.<sup>69</sup> For example, advanced practice registered nurses (APRNs) and physician assistants (PAs), with their specialized training, frequently fill the void in primary care delivery within rural communities, often under collaborative practice models supervised by remote physicians.<sup>70</sup> However, the prohibitions some states impose on APRNs from managing clinics autonomously, even in the absence of local primary care physicians, result in the closure of rural clinics when collaborating agreements fail to materialize.<sup>71</sup> Eliminating these types of arbitrary variations in permissible care delivery models—models based on identical provider qualifications—could meaningfully alleviate rural access issues

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65. *See id.*

66. Marci Nielsen et al., *Addressing Rural Health Challenges Head On*, 114 MO. MED. 363, 363 (2017).

67. Donglan Zhang et al., *Assessment of Changes in Rural and Urban Primary Care Workforce in the United States From 2009 to 2017*, 3 JAMA NETWORK OPEN 1, 2 (2020); *see* 42 C.F.R. § 5.4 app. A (2024).

68. Zhang et al., *supra* note 67, at 2.

69. *Id.* at 2-4, 7.

70. *Id.* at 3-5.

71. Ruth Kleinpell et al., *Addressing Barriers to APRN Practice: Policy and Regulatory Implications During COVID-19*, 14 J. NURSE REGUL. 13, 14 (2023) (finding that barriers to APRN practice continue to restrict aspects of patient care and patient access to care, even in states with Full Practice Authority (FPA) and can hinder APRNs from managing clinics independently in rural areas).

while also fostering health sector employment opportunities. More fundamentally, it is the rural residents who bear the harshest consequences of a fragmented state-based medical regulatory model, a model that diminishes incentives for inventive workforce solutions, tailored to meet specific local needs.<sup>72</sup>

*D. The Decline in Rural Hospital Capacity: Amplification  
of Access Challenges*

Over the past two decades, the decline in rural hospital capacity, precipitated by a consistent shortfall of rural physicians, has further exacerbated the already grave challenges of healthcare access within these communities. Since 2010, a staggering number of over 100 rural hospitals across the United States have shuttered their doors, succumbing to relentless financial pressures.<sup>73</sup> Presently, more than 450 additional rural hospitals linger in a precarious state, vulnerable and at imminent risk of closure.<sup>74</sup> A troubling illustration of this trend emerged between 2004 and 2014 when 9% of rural counties nationwide lost access to all local hospital obstetric services.<sup>75</sup> The Medicaid program, responsible for financing nearly half of rural births, makes these closures especially burdensome to lower-income and uninsured women, compelling them to travel greater distances at increased risk when labor commences.<sup>76</sup>

Numerous factors contribute to these closures of rural hospitals, but the tight restrictions on the scopes of practice for allied health professionals, inhibiting their full utilization to fill service gaps, aggravate the underlying revenue pressures. Rural hospitals frequently rely on stable physician staffing to sustain the census levels, service lines, and payer contracts essential to their continued viability.<sup>77</sup> The confinement of advanced skills within inflexible physician-only licensing scopes forces rural hospitals to face daunting choices: recruit elusive doctors, enter into contracts with distant physicians, or reduce service offerings.<sup>78</sup> Each of these paths undermines sustainability.

An alternative, imbued with promise, rests in granting rural healthcare professionals the latitude to practice to the fullest extent of their competencies,

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72. *Id.* at 17-18.

73. Claire E. O'Hanlon et al., *Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation*, 38 HEALTH AFFS. 2095, 2095 (2019).

74. Robert King, *Nearly Half of Rural Hospitals Face Negative Operating Margins as COVID-19 Hits Outpatient Revenue*, FIERCE HEALTHCARE (Feb. 10, 2021, 7:40 PM), <https://www.fiercehealthcare.com/hospitals/chartis-nearly-half-rural-hospitals-face-negative-operating-margins-as-covid-19-hits> [<https://perma.cc/6GZ9-DJ7Z>].

75. Peiyin Hung et al., *Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004–14*, 36 HEALTH AFFS. 1663, 1663 (2017).

76. *Id.* at 1663, 1667-69.

77. *See id.* at 1667-69.

78. *See id.*

a process that necessitates reducing arbitrary variations in licensing restrictions.<sup>79</sup> However, the entrenched barriers of state licensing persistently obstruct the common-sense workforce flexibility that rural communities so urgently need.<sup>80</sup> Fragmented state oversight, therefore, perpetuates a system of disjointed medical regulations that disproportionately diminishes healthcare access for rural populations, leaving them at a disadvantage compared to their urban counterparts who are endowed with greater resources and provider choices.<sup>81</sup>

### *E. The Reverberations of Healthcare Disparities*

Arbitrary variations in scope of practice and telehealth enablement, bred from the state-based licensure model, aggravate healthcare access disparities that afflict rural communities and other vulnerable populations.<sup>82</sup> Lower-income individuals, racial and ethnic minorities, uninsured patients, and other disadvantaged groups concentrated in rural regions and inner cities face compounded barriers stemming from licensure restrictions on telehealth flexibility and care provision by allied health professionals.<sup>83</sup> While the fee-for-service reimbursement policies that prioritize physician procedure volumes over prevention share in the responsibility for inadequate access, unnecessary medical licensing constraints introduce additional obstacles.<sup>84</sup> A systematic elimination of arbitrary scope of practice variations would empower providers such as nurse practitioners and physician assistants to bridge the persistent gaps in primary and chronic care that affect underserved populations. Simultaneously, licensing reforms that allow urban health systems to extend remote telehealth services into rural territories carry the potential to expand access to specialized expertise.<sup>85</sup>

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79. *See id.* at 1669.

80. AM. HOSP. ASS'N., RURAL REPORT: CHALLENGES FACING RURAL COMMUNITIES AND THE ROADMAP TO ENSURE LOCAL ACCESS TO HIGH-QUALITY, AFFORDABLE CARE 6 (2019).

81. *See id.*; King, *supra* note 74.

82. Michael L. Barnett et al., *Trends in Telemedicine Use in a Large Commercially Insured Population, 2005-2017*, 320 JAMA 2147, 2147-49 (2018). The study found that telemedicine visits were more common in areas with greater physician supply and in states with parity laws mandating coverage and reimbursement for telemedicine. *Id.* This suggests that licensure restrictions on telehealth flexibility can impact the availability and utilization of telemedicine services, potentially exacerbating healthcare disparities for disadvantaged populations. *See id.*

83. Cynthia Williams & Di Shang, *Telehealth Usage Among Low-Income Racial and Ethnic Minority Populations During the COVID-19 Pandemic: Retrospective Observational Study*, 25 J. MED. INTERNET RSCH. 1, 1-9 (2023).

84. *See* Barnett et al., *supra* note 82.

85. Blake Sisk et al., *Pediatrician Attitudes Toward and Experiences with Telehealth Use: Results from a National Survey*, 20 ACAD. PEDIATRICS 628, 628-35 (2020). This study concludes that reducing barriers to telehealth adoption, including licensure restrictions, is crucial for promoting equitable access to healthcare for disadvantaged populations in rural regions and inner cities. *Id.* Specifically, policy changes that address payment and billing issues, expand telehealth coverage, and support the use of telemedicine by allied health professionals can help overcome these barriers and

While commercial health insurers have increasingly embraced flexibility in reimbursing telehealth services, Medicare and Medicaid restrictions continue to disproportionately burden low-income elderly and disabled individuals residing in rural areas.<sup>86</sup> A careful alignment of licensing rules with telehealth's capabilities to foster expanded access offers a pathway to mitigate the deeply rooted urban/rural healthcare disparities.<sup>87</sup> However, the realization of such reforms demands overcoming entrenched divides among provider interest groups and modernizing the fragmented state-based regulatory model through judicious and thoughtful policy interventions.

### III. ANTITRUST SCRUTINY OF ANTI-COMPETITIVE STATE LICENSING BOARDS

The growing awareness of the profound impact that occupational licensing restrictions can exert on consumer access, costs, and quality has spurred federal antitrust regulators to increase scrutiny and intervene against state licensing regimes. Such regimes, perceived as improperly suppressing competition without sufficient safeguards for public health and safety, have become focal points.<sup>88</sup> Specifically, the Federal Trade Commission (FTC) has recently concentrated its efforts on challenging overly restrictive telehealth and scope of practice policies promulgated by states, in the absence of empirical evidence demonstrating benefits for consumers and patients.<sup>89</sup> Comprehending the rationale underlying this amplified federal licensing oversight illuminates the context for the reforms elaborated later in this Article.

#### *A. The Battle Against Unwarranted Scope of Practice Restrictions*

In one illustrative instance, the FTC's response to a proposed West Virginia bill that sought to modify nurse practitioner scope of practice requirements included a submission of commentary.<sup>90</sup> The FTC posited that state-based restrictions on nurse practitioner practice should only be as stringent as necessitated by verified patient care and safety concerns.<sup>91</sup> Furthermore, it asserted that unwarranted limitations on scope of practice would likely intensify access challenges, particularly for vulnerable populations in underserved areas.<sup>92</sup> It asserted that unnecessary scope of practice limitations would likely exacerbate

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improve healthcare access for vulnerable populations. *Id.*

86. *See* Williams & Shang, *supra* note 83.

87. *See* Sisk et al., *supra* note 85.

88. KAREN A. GOLDMAN, FED. TRADE COMM'N, OPTIONS TO ENHANCE OCCUPATIONAL LICENSING PORTABILITY, at iv (2018).

89. *Id.*

90. Federal Trade Commission, Comment Letter on West Virginia Senate Bill 516 (Feb. 10, 2016), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf) [<https://perma.cc/69HB-FFWZ>] [hereinafter FTC Comment].

91. *Id.* at 1.

92. *See id.* at 1; GOLDMAN, *supra* note 88.

access problems, especially for vulnerable populations and in underserved areas.<sup>93</sup>

The Commission also maintained that absent definitive evidence of opposing clinical risks to patients, initiatives such as West Virginia's to attenuate scope of practice restrictions in light of provider shortages within the state seemed to be both pro-competitive and advantageous for consumers.<sup>94</sup> Through these and similar advocacy filings, during the past decade the FTC has urged states to refrain from imposing unjustified licensing and scope of practice constraints that impede market competition and erode healthcare access.<sup>95</sup>

### *B. Targeting Anti-Competitive Actions by State Licensing Boards*

Beyond the mere opposition to anticompetitive state policies, the FTC has embarked on enforcement actions aimed at curbing improper competitive restraints enforced by state licensing boards under the influence of private market participants. This issue attained prominence in the landmark 2015 Supreme Court case, *North Carolina State Board of Dental Examiners v. Federal Trade Commission*.<sup>96</sup>

In response to escalating complaints from licensed dentist providers about losing business to non-dentist competitors performing teeth whitening services, the North Carolina State Board of Dental Examiners, comprised of six licensed dentists and one consumer representative, began issuing dozens of cease-and-desist letters.<sup>97</sup> It alleged that the non-dentists were engaged in the unlawful practice of dentistry based on state statutes and pressured mall landlords to evict tenants offering these services.<sup>98</sup> These actions effectively depleted the availability of non-dentist teeth whitening services by 2007, achieving the Board's intended outcome.<sup>99</sup>

In 2010, the FTC responded by filing an administrative complaint against the state dental board.<sup>100</sup> The complaint alleged that the board's efforts to exclude non-dentist competitors from the teeth whitening market constituted an unfair competitive method under the Federal Trade Commission Act and Sherman Antitrust Act.<sup>101</sup> The board sought to deflect these allegations by invoking sovereign state action immunity, contending that it was exempt from federal antitrust laws as a mere state agent acting within its statutory authority.<sup>102</sup>

However, the FTC rejected this defense, determining that the state action doctrine was inapplicable, as the board's anti-competitive conduct was primarily

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93. FTC Comment, *supra* note 90, at 3-5.

94. *Id.* at 8.

95. See GOLDMAN, *supra* note 88.

96. 574 U.S. 494 (2015).

97. *Id.* at 494.

98. *Id.* at 501.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*



motivated by private dentists seeking to marginalize competitors, rather than by state policymakers' public health objectives.<sup>103</sup> The Commission's ruling underscored that licensing boards influenced by private market participants must justify anti-competitive policies on substantive grounds, rather than relying on sovereign immunity.<sup>104</sup>

Despite losing an appeal before the Fourth Circuit, the state dental board sought Supreme Court review.<sup>105</sup> Yet, in a decisive 6-3 ruling, the Supreme Court too found against the board, concluding that it was not entitled to immunity, given that it was essentially controlled by participants in the dental services market without adequate state supervision.<sup>106</sup> This decision reaffirmed that in the absence of sufficient state oversight, licensing boards controlled by private economic interests must withstand federal antitrust scrutiny of their anti-competitive policies, rather than merely invoking state sovereignty.<sup>107</sup> Consequently, this ruling has far-reaching antitrust implications for professional licensing systems across the nation.

### *C. Implications for Physician-Controlled State Medical Boards*

The Supreme Court's ruling in *North Carolina State Board of Dental Examiners* has reverberated through the medical community. Medical trade organizations, including the AMA, promptly recognized the decision's potential impact on state medical boards, predominantly comprised of licensed physicians along with nominal public representatives.<sup>108</sup> These boards, akin to the North Carolina dental board, are often led by a supermajority of practicing doctors whose private interests may diverge sharply from the public welfare objectives that appropriately balanced regulation seeks to achieve.<sup>109</sup>

Thus, legal observers and commentators discerned that the Court's judgment signals a clear message: these state licensing entities, potentially captured by the profession they regulate, must now defend their anti-competitive policies on substantive merits under federal antitrust law rather than instinctively asserting immunity.<sup>110</sup> Among the medical community, there were calls for states to respond by strengthening supervision over medical boards through measures such as oversight by independent state agencies, sunset provisions necessitating regular re-evaluation of regulations, and equal voting rights for public interests to

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103. *See id.* at 494, 501.

104. *See id.*

105. *Id.* at 502.

106. *Id.* at 495, 515-16.

107. *Id.*

108. Elizabeth A. Mertz, *The Dental–Medical Divide*, 35 HEALTH AFFS. 2168, 2168-75 (2016).

109. Fazal Khan, *The “Uberization” of Healthcare: The Forthcoming Legal Storm Over Mobile Health Technology’s Impact on the Medical Profession*, 26 HEALTH MATRIX: J. L.-MED. 123, 153-55 (2016).

110. *Id.* at 156.

counterbalance physician control.<sup>111</sup> Nevertheless, the willingness of states to voluntarily adopt robust safeguards that would limit the power of self-interested boards to insulate anti-competitive licensing restrictions remains an open question.<sup>112</sup> Absent more substantial transparency and oversight, the current structure, which allows physicians to dominate medical boards, risks perpetuating self-serving licensing barriers shrouded under the guise of state delegation.<sup>113</sup>

#### *D. Intensified Antitrust Scrutiny of State Licensing Policies*

In the aftermath of the Supreme Court's ruling, the FTC expressed its resolve to keenly scrutinize unjustified licensing restrictions that undermine market competition. This commitment was underlined in the FTC's 2018 report on "Options to Enhance Occupational License Portability," wherein the Commission declared its intent to zero in on licensing restrictions likely to harm competition by raising prices, reducing output, or creating barriers to entry.<sup>114</sup> No longer would state licensing boards, controlled by self-interested private actors, be afforded deference from antitrust enforcement.<sup>115</sup> The FTC's stance is that such anti-competitive licensing policies must endure rigorous examination, balancing purported justifications against real-world impacts on cost, access, innovation, and quality.<sup>116</sup>

Through this heightened scrutiny, the FTC is determined to dismantle occupational licensing regimes that serve primarily the private interests of licensed practitioners rather than the broader public interest.<sup>117</sup> In response, some states, such as Louisiana and Texas, have bolstered active supervision over state licensing boards, mandating gubernatorial approval for proposed rules and compulsory review by the state attorney general's office.<sup>118</sup> These measures aim

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111. Victoria E. Kress et al., *A Qualitative Study of Supervisors' Reflections on Providing Sanctioned Supervision*, 34 *CLINICAL SUPERVISOR* 38, 38-56 (2015).

112. See Marc T. Law & Zeynep K. Hansen, *Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis*, 35 *J. HEALTH POLS. POL'Y & L.* 63 (2010). This study examines the characteristics of medical licensing boards and their influence on physician discipline. *Id.* It finds that public oversight and political control overboard budgets do not appear to influence the extent to which medical licensing boards discipline doctors. *Id.*

113. John Alexander Harris & Elena Byhoff, *Variations by State in Physician Disciplinary Actions by US Medical Licensure Boards*, 26 *BMJ QUALITY & SAFETY* 200 (2016) (discussing the significant variation in the annual rate of medical board physician disciplinary action by state in the USA and suggests that state medical boards should consider policies aimed at improving standardization and coordination to provide consistent supervision to physicians and ensure public safety).

114. See GOLDMAN, *supra* note 88, at iv.

115. See *id.*

116. *Id.* at 5.

117. *Id.* at iv.

118. See, e.g., Regulatory Compliance Division, Office of the Texas Governor: Greg Abbott, (last visited Jan. 25, 2024); LA. STAT. ANN. § 37:45 (2023).

to ensure that boards act in accordance with state policy, not merely in pursuit of parochial interests.<sup>119</sup>

Yet, the majority of states have failed to adopt meaningful reforms to rein in the influence of self-interested boards.<sup>120</sup> The anti-competitive status quo lingers, sustained by entrenched professional and political interests, thus highlighting the need for federal inducements to galvanize substantial reforms.

#### *E. The Imperative for Federal Intervention to Drive Substantive Changes*

In conclusion, federal antitrust regulators have unequivocally signaled their intention to stringently review unjustified state licensing policies that undercut market competition, with a special emphasis on telehealth and scope of practice limitations.<sup>121</sup> However, this prospective oversight, on its own, is unlikely to spur comprehensive reforms. The existing, fragmented system of state-based medical licensing continues unabated, despite widespread acknowledgment of its detrimental effects.

The persistence of this system, resistant to change, necessitates either compelling incentives or proactive national action. As delineated in the subsequent section, targeted federal interventions that thoughtfully balance state sovereignty and healthcare quality concerns with the objectives of expanding access, efficiency, and workforce flexibility can serve as a constructive catalyst, igniting the required modernization in a sector that profoundly affects the well-being of the citizenry.<sup>122</sup>

### IV. ASSESSING ALTERNATIVES TO FRAGMENTED STATE-BASED MEDICAL LICENSING

The multifaceted challenges and misalignment inherent in the current fragmented state-based medical licensing systems, juxtaposed with the nationalization of healthcare delivery, have ignited debates and spawned proposals to reform the prevailing model. Although various alternatives aim to modernize the existing framework, each proposition carries its unique limitations that have thwarted transformative changes, notwithstanding widespread recognition of the present deficiencies. This section undertakes a critical analysis of the most promising options and their respective drawbacks.

#### *A. Proposed National System of Medical Licensure*

One of the most sweeping remedies under consideration is the outright establishment of a cohesive national medical license to supplant the current, disjointed array of state-based licenses.<sup>123</sup> The concept centers on a singular

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119. See GOLDMAN, *supra* note 88, at 16.

120. *Id.*

121. *See id.*

122. *See infra* Section IV.

123. Amr H. Sawalha, *Medical Licensure: It Is Time to Eliminate Practice Borders Within the*

medical license that would simplify administrative procedures for providers aspiring to practice in multiple states, promote license portability, enable the formulation of licensure prerequisites specifically designed for telehealth providers, and foster license reciprocity across state lines.<sup>124</sup>

From a theoretical standpoint, the implementation of a national system would bring medical licensing in alignment with contemporary national practice standards, norms, and care delivery paradigms. Nevertheless, the political feasibility of such an ambitious endeavor is shrouded in uncertainty. Anticipated resistance from state licensing boards, legislative bodies, and medical professional associations, deeply rooted in a historical preference for state autonomy in regulating medical practice, presents a formidable barrier.

### *B. Interstate Medical Licensure Compacts*

Over the past two decades, voluntary interstate licensing compacts have surfaced as a pragmatic alternative, seeking to facilitate licensed practitioners' access to multi-state licenses without succumbing to complete nationalization.<sup>125</sup> This approach is driven by a concerted effort to reconcile the preservation of state regulatory control with the reduction of substantial administrative impediments associated with obtaining and sustaining licenses to practice in multiple jurisdictions.<sup>126</sup> Essentially, it seeks to harmonize the polar extremes of full nationalization and the entrenched state-based licensure model.

The pioneering compact in this domain, the Nurse Licensure Compact (NLC), inaugurated in 2000, now spans 38 states.<sup>127</sup> It delineates a mechanism through which a nurse licensed in their home state may practice, whether in person or remotely, in all compact member states without procuring separate licenses.<sup>128</sup> Although the NLC has diminished barriers for over a million nurses, its reach is circumscribed, excluding populous states such as California, Illinois, and Michigan.<sup>129</sup>

In the realm of physician licensing, the Interstate Medical Licensure Compact (IMLC) came into force in 2017 and presently encompasses 37 member states.<sup>130</sup>

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*United States*, 133 AM. J. MED. 1120, 1121 (2020); see Samyukta Mullangi et al., *The COVID-19 Pandemic—An Opportune Time to Update Medical Licensing*, 181 JAMA INTERNAL MED. 307 (2021); Donnie L. Bell & Mitchell H. Katz, *Modernize Medical Licensing, and Credentialing, Too—Lessons From the COVID-19 Pandemic*, 181 JAMA INTERNAL MED. 312 (2021).

124. Sawalha, *supra* note 123; Mullangi et al., *supra* note 123; Bell & Katz, *supra* note 123.

125. See TEX. OCC. CODE ANN. § 304.0015 (2017).

126. See *id.*

127. *Nurse Licensure Compact*, NCSBN, <https://www.nursecompact.com> [<https://perma.cc/48QF-5FJ6>] (last visited Oct. 21, 2023).

128. *Id.*

129. *Id.*

130. *A Faster Pathway to Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT, <https://www.imlcc.org/a-faster-pathway-to-physician-licensure/> [<https://perma.cc/PW7R-3KLA>] (last visited Oct. 9, 2023).

It, too, offers a streamlined route for qualified physicians to secure licenses for practice in multiple participating states. Nonetheless, significant constraints mar the efficacy of the IMLC model.<sup>131</sup>

While an estimated 80% of physicians licensed in IMLC-participating states satisfy the basic criteria for qualification (e.g., no disciplinary history, clean criminal background check), a mere fraction of one percent have actually pursued licenses via this process.<sup>132</sup> The lukewarm uptake reflects persistent complexities: applicants must first obtain a license in their state of principal licensure (SPL), secure a Letter of Qualification (LOQ) from the SPL state medical board, and adhere to a plethora of requirements, including additional criminal background checks and the payment of a \$700 fee.<sup>133</sup> After completing these steps, physicians must still separately apply and meet distinct requirements for every individual state where they want to practice outside their SPL, and further applications and fees are required for each new state license.<sup>134</sup>

While marginally easing the process, the IMLC system retains considerable burdens and its utility would be significantly enhanced with participation from large states like California, Texas, and Florida, an evolution that has yet to transpire.<sup>135</sup> Consequently, although a marked improvement over the existing arrangement, the IMLC, in its current form, leaves ample room for enhancement and adaptation to the evolving landscape of national healthcare delivery.

### *C. Proposed National Medical License Reciprocity*

In light of the persistent inadequacies of the current models, certain experts and scholars have advocated for the abandonment of the incrementalist paradigm in pursuit of a radical and permanent nationwide license reciprocity.<sup>136</sup> This model would mandate that medical licenses become reciprocal across all states, enabling a practitioner licensed in one jurisdiction to practice automatically in any other without the necessity for additional licenses.<sup>137</sup> Proponents of this approach contend that universal license reciprocity would optimize healthcare access and efficiency by dismantling protectionist impediments to provider

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131. *Id.*

132. Andis Robeznieks, *Interstate Medical Licensure Numbers*, AMA (Oct. 11, 2019), <https://www.ama-assn.org/practice-management/digital/interstate-medical-licensure-numbers> [<https://perma.cc/8XT4-HCZG>]; Frédéric Michas, *Total Active Physicians in the U.S. as of May 2023, by State*, STATISTA (June 29, 2023), <https://www.statista.com/statistics/186269/total-active-physicians-in-the-us/> [<https://perma.cc/95KU-H6SG>] (reporting there are 1,077,115 professionally active physicians in the US as of May 2023).

133. *A Faster Pathway to Physician Licensure*, *supra* note 130.

134. *Id.*

135. *Id.*

136. Sawalha, *supra* note 123, at 112; *see also* Mullangi et al., *supra* note 123; Bell & Katz, *supra* note 123.

137. Sawalha, *supra* note 123; Mullangi et al., *supra* note 123; Bell & Katz, *supra* note 123.

mobility.<sup>138</sup> Patients across the nation would benefit from unhindered access to telehealth services delivered by licensed out-of-state providers.<sup>139</sup> Moreover, active practitioners could transition between states without confronting the bureaucratic entanglements and consequential delays in patient care associated with relicensing.<sup>140</sup>

Nevertheless, the quest for meaningful medical license reciprocity across states faces formidable political obstacles. The practice of medicine continues to be tightly regulated by states, and the restrictions imposed through medical school accreditation and residency funding have enabled physicians to retain elevated incomes, prestige, and a consequential role in shaping state policies—even though their relative affluence and influence may have waned since the 1980s.<sup>141</sup>

Because state medical boards and professional associations have wielded significant power to thwart perceived threats to physician autonomy and control over medical practice, they have consistently resisted ceding the perceived advantages of state-based licensure, rendering voluntary reciprocal arrangements both unlikely and fragmented.<sup>142</sup> For example, the initial concept of the Interstate Medical Licensure Compact, envisioning true reciprocity, was diluted due to opposition from state medical boards.<sup>143</sup> Absent compelling incentives or definitive national intervention, substantial reciprocity reforms seem remote and improbable.<sup>144</sup>

#### *D. Expedited License Portability Processes*

A faction of reform proponents has urged states to introduce, at the very least, expedited license portability processes to facilitate physicians' relocation between states.<sup>145</sup> Such a mechanism would expedite license transfers and approvals, curtailing the delays that can disrupt care and deter interstate mobility.<sup>146</sup> Additionally, licensure barriers that restrict physician movement undermine

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138. Sawalha, *supra* note 123; Mullangi et al., *supra* note 123; Bell & Katz, *supra* note 123.

139. Sawalha, *supra* note 123; Mullangi et al., *supra* note 123; Bell & Katz, *supra* note 123.

140. Sawalha, *supra* note 123; Mullangi et al., *supra* note 123; Bell & Katz, *supra* note 123.

141. Derek Thompson, *Why America Has So Few Doctors*, ATLANTIC (Feb. 14, 2022), <https://www.theatlantic.com/ideas/archive/2022/02/why-does-the-us-make-it-so-hard-to-be-a-doctor/622065/> [<https://perma.cc/6Q4B-HP64>]; Mark Schlesinger, *A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession*, 80 MILBANK Q. 185, 187-91 (2002).

142. Christopher G. Roy, *Patient Safety Functions of State Medical Boards in the United States*, 94 YALE J. BIOLOGY & MED 165, 165-73 (Mar. 31, 2021).

143. *See* Thompson, *supra* note 141; *see* Schlesinger, *supra* note 141, at 187-91.

144. Roy, *supra* note 142, at 165-73.

145. Shirley Svorny, *Liberating Telemedicine: Options to Eliminate State-Licensing Roadblocks*, CATO INST. (Nov. 15, 2017), <https://www.cato.org/policy-analysis/liberating-telemedicine-options-eliminate-state-licensing-roadblock> [<https://perma.cc/45J3-53AL>].

146. *See id.*

patient access and continuity of care.<sup>147</sup>

However, the current state of affairs often involves protracted wait times for license approvals in new jurisdictions, repetitive documentation requirements, and inconsistent application rules.<sup>148</sup> Although enhanced data sharing on disciplinary matters could quicken verification checks, tangible progress would require overcoming bureaucratic inertia and the perceived benefits that some states believe slower license portability affords in competitively recruiting physicians.<sup>149</sup> Once more, significant advancements appear unlikely without external incentives that can surmount entrenched resistance.

#### *E. The Political Resilience of a Functionally Obsolete System*

The prevailing, disjointed system of state-based medical licensing, although functionally archaic and indefensible, remains politically tenacious, owing to deep-rooted interests obstructing reform.<sup>150</sup> The incongruity between state-based licensure and the progressively nationalized character of American healthcare—evident from the Medicare and Medicaid Act (1965) to the Affordable Care Act (2010)—underscores this dysfunction.<sup>151</sup>

The stubborn perpetuation of fragmented medical licensing, despite near-consensus regarding its inadequacies, is likely attributable to physicians' lingering influence at the state levels, where they encounter fewer competitive threats. To breach this impasse and ignite substantive reform, compelling incentives or authoritative national action may be necessary. While less ambitious alternatives like interstate compacts can effectuate incremental enhancements, they fail to address the fundamental disorder of fragmented state oversight.

A decisive shift away from the cumbersome and inefficient navigation of fifty discrete state medical licensing systems appears indispensable, albeit challenging in the face of prevailing political realities. The subsequent section will delineate targeted federal policy interventions that hold the potential to proactively modernize medical licensing and scope of practice regimes, by strategically realigning state-level incentives.

### V. INCENTIVIZING MUTUAL RECOGNITION AND COMPETENCY-BASED SCOPE OF PRACTICE REFORMS THROUGH MEDICAID

Confronted with significant political impediments that states encounter in voluntarily initiating sweeping reforms, the federal government possesses the capacity to act as a catalyst. It may achieve this by promoting targeted policies that harmonize concerns over state sovereignty and healthcare quality with the imperative of augmenting access, efficiency, and workforce flexibility. Specifically, Congress should employ its spending power to prompt states to

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147. *See id.*

148. *Id.*

149. *See id.*

150. *See discussion supra* Parts II-III.

151. *See discussion supra* Parts II-III.

implement two distinct reforms: (1) mutual acknowledgment of out-of-state medical licenses solely for the provision of telehealth services across jurisdictional boundaries; and (2) enlargement of scope-of-practice eligibility for non-physician healthcare providers, commensurate with their education, training, credentials, outcomes data, and proficiencies enhanced by emerging technologies such as artificial intelligence (AI).

*A. Medicaid as a Vehicle for Encouraging State-Level Reforms*

The Constitution furnishes Congress with the prerogative to levy taxes and allocate funds for the common welfare, thereby bestowing broad latitude to incentivize states to enact preferred health policies by predicating federal financing on policy alterations.<sup>152</sup> Supreme Court precedent has validated that Congress may deploy fiscal inducements to stimulate state-level reforms that it might not directly enforce upon sovereign states.<sup>153</sup>

In order to employ federal grants as incentives for state policy transformations, associated stipulations must: (1) foster the general welfare; (2) be unequivocal; (3) correlate sensibly with federal undertakings or programs; (4) not mandate unconstitutional actions; and (5) not traverse the boundary from encouragement into coercion.<sup>154</sup> The Court has found that the threat of losing all federal Medicaid funding coercively compelled state expansion of Medicaid under the Affordable Care Act (ACA), contrasting this with the 5-10% of federal highway fund losses at issue in *South Dakota v. Dole*, where states preserved autonomy.<sup>155</sup>

This legal foundation authorizes Congress to deploy small, non-coercive Medicaid funding supplements over baseline state allocation levels to incentivize licensing and scope reforms. With average federal Medicaid outlays constituting more than 25% of expenditure in state budgets, Congress wields considerable influence to stimulate state alterations through modest bonus payments.<sup>156</sup> Because states would not forfeit any funds for resisting reforms, this method avoids eliciting the argument of unconstitutional coercion of state policymaking—a reasoning underpinning the Supreme Court’s invalidation of the original Medicaid expansion plan integral to the ACA.<sup>157</sup>

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152. U.S. CONST., art. I § 8 cl. 1. (“The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States.”).

153. *South Dakota v. Dole*, 483 U.S. 203 (1987).

154. *Id.* at 203-04.

155. *Id.* at 204.

156. Elizabeth Williams, Robin Rudowitz, & Alice Burns, *Medicaid Financing: The Basics*, Kaiser Family Foundation, KFF (Apr. 13, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/> [<https://perma.cc/NK6S-Q7PK>].

157. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 575-85 (2012).



### *B. Mutual Recognition of Out-of-State Medical Licenses for Telehealth*

Congress should first mobilize Medicaid financing to endorse mutual recognition of out-of-state medical licenses expressly for the administration of telehealth services across state lines. Under this construct, any medical professional licensed in one state would be qualified to deliver telehealth care to patients situated in any other state, irrespective of whether the provider possesses a license in the patient's domicile state. This mechanism would attain nationwide license portability for telehealth services analogous to the provisional pandemic practice liberties while sustaining state jurisdiction over in-person care. Such telehealth licensure reform would bifurcate medical practice into two facets: (1) conventional state-based licensure for the physical in-person care of patients within the licensing state's confines; and (2) a de facto national licensure facilitating the remote delivery of telehealth services to patients throughout the country by qualifying for a license in a single state.

This balanced schema derives inspiration from the interjurisdictional practice model applied to licensed attorneys, who can dispense legal services virtually nationwide regardless of bar affiliations through mutual recognition, while physical practice within courtrooms continues to necessitate individual state bar admissions. Adapting this framework to telehealth medical services would capacitate national practice while honoring state dominion over in-state care.

### *C. Competency-Based Scope of Practice Expansion for Non-Physicians*

The next frontier in healthcare reform that Congress should explore through the mobilization of Medicaid incentives is the widening of scope of practice eligibility for allied health professionals. This category includes nurse practitioners (NPs), pharmacists, physician assistants (PAs), and others, in a manner commensurate with their respective education, training, credentials, and empirical clinical outcomes data.<sup>158</sup> Such expansion necessitates a recognition of their enhanced diagnostic and treatment capacities, particularly when augmented by leading-edge artificial intelligence (AI) technologies like machine learning, natural language processing, computer vision, and large language model chatbots like ChatGPT.<sup>159</sup> This approach emphasizes competencies, not traditional hierarchies, aiming for efficiency and effectiveness in care delivery rather than maintaining outdated delineations designed to protect physicians from competition.

*1. Evidence-Based Justifications for Expanded Practice.*—Multiple studies attest to nurse practitioners delivering primary care of quality and outcomes comparable to physicians.<sup>160</sup> Still, only 26 states and the District of Columbia

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158. INST. OF MED., COMM. TO STUDY THE ROLE OF ALLIED HEALTH PERS., *ALLIED HEALTH SERVICES: AVOIDING CRISES* (1989), <https://www.ncbi.nlm.nih.gov/books/NBK218850/>[<https://perma.cc/5U95-JALA>].

159. Thomas Davenport & Ravi Kalakota, *The Potential for Artificial Intelligence in Healthcare*, 6 *FUTURE HEALTHCARE J.* 94, 96 (2019).

160. See Chuan-Fen Liu et al., *Outcomes of Primary Care Delivery by Nurse Practitioners:*

sanction full NP practice authority.<sup>161</sup> Pharmacists, too, have shown potential in managing routine chronic conditions and preventative health services, but licensure limitations frequently impede their ability to work to their full capabilities.<sup>162</sup> Targeted expansions that phase in increased practice independence, anchored in rigorous scientific proof of provider proficiencies, would likely enhance both efficiency and care quality for time-sensitive medical conditions.<sup>163</sup>

2. *The Integration of Emerging Technologies.*—These scope reforms must also encompass the ability of allied health professionals to employ emerging technologies like AI diagnostic support tools, which empirically surpass human constraints.<sup>164</sup> The responsible evolution of scope of practice to “enhance medical professionals’ capabilities and improve patient treatments” demands continuous oversight of the safety and effectiveness of these technologies.<sup>165</sup>

3. *The Convergence of Expanded Scopes, AI, and Telehealth.*—The proposition of this Article is a comprehensive synergy of expanded scopes of practice grounded in competencies, fortified AI assistance, and telehealth supervision access to maximize workforce agility and productivity. While states would continue to regulate medical practice under their “police power,” the Medicaid-based initiative offers an avenue to persuade states to diminish unnecessary physician monopolies over technical skills that many allied

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*Utilization, Cost, and Quality of Care*, 55 HEALTH SERV. RES. 178 (2020); Mary O. Munding et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A Randomized Trial*, 283 JAMA 59 (2000).

161. David Mitchell & Moiz Bhai, *Nurse Practitioner Reform: Full Practice Authority in Pennsylvania*, COMMONWEALTH FOUND. (Dec. 5, 2022), <https://www.commonwealthfoundation.org/research/nurse-practitioner-reform-full-practice-authority-pennsylvania/> [<https://perma.cc/6T6A-SX7T>].

162. See Patti Gasdek Manolakis & Jann B. Skelton, *Pharmacists’ Contributions to Primary Care in the United States Collaborating to Address Unmet Patient Care Needs: The Emerging Role for Pharmacists to Address the Shortage of Primary Care Providers*, 74 AM. J. PHARM. EDUC. 1, 5-6 (2010).

163. See Liu et al., *supra* note 160, at 66-68; see also Munding et al., *supra* note 160, at 66-68.

164. U.S. GOV’T ACCOUNTABILITY OFF., GAO-22-104629, ARTIFICIAL INTELLIGENCE IN HEALTH CARE: BENEFITS AND CHALLENGES OF MACHINE LEARNING TECHNOLOGIES FOR MEDICAL DIAGNOSTICS (2022) (“Several machine learning (ML) technologies are available in the U.S. to assist with the diagnostic process. The resulting benefits include earlier detection of diseases; more consistent analysis of medical data; and increased access to care, particularly for underserved populations. GAO identified a variety of ML-based technologies for five selected diseases—certain cancers, diabetic retinopathy, Alzheimer’s disease, heart disease, and COVID-19—with most technologies relying on data from imaging such as x-rays or magnetic resonance imaging (MRI). . . . These advances could enhance medical professionals’ capabilities and improve patient treatments but also have certain limitations. For example, adaptive technologies may improve accuracy by incorporating additional data to update themselves, but automatic incorporation of low-quality data may lead to inconsistent or poorer algorithmic performance.”).

165. *Id.*

professionals are competent to perform.<sup>166</sup>

4. *Preserving State Authority Over In-Person Medical Practice.*—This nuanced approach allows states to maintain control over the regulation of in-person medical practice. It aims to rectify dysfunction in telehealth enablement and scope of practice stemming from inconsistencies across state lines. By tying enhanced licensure recognition and scope of practice eligibility explicitly to telehealth services, the proposal avoids undue federal interference in state oversight of in-person care.

*D. Impact on Healthcare Access, Efficiency, Quality, and Resilience*

The intentional alignment of state policies through congressional incentives serves the general welfare under constitutional mandates.<sup>167</sup> Similarly to how Congress intended Medicaid expansion to increase healthcare access for lower-income populations under the Affordable Care Act, Medicaid funding incentives can “nudge” states to reduce outmoded restrictions on telehealth providers and

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166. The police power is the inherent power of the state to regulate behavior and enforce order within its territory for the betterment of the health, safety, morals, and general welfare of its inhabitants. *Chi., Burlington & Quincy Ry. Co. v. Illinois*, 200 U.S. 561, 592 (U.S. 1906). Under the Tenth Amendment to the United States Constitution, the powers not delegated to the Federal Government are reserved to the states or to the people. U.S. CONST. amend. X. This means that the states have the power to regulate healthcare, subject to certain limitations imposed by the Constitution. *See Barsky v. Bd. of Regents of Univ. of State of N.Y.*, 347 U.S. 442, 449 (1954) (“It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state’s police power.”). The police power of the states to regulate healthcare is broad and has been upheld by the courts in a number of cases. For example, the Supreme Court has upheld state laws requiring vaccination, *Zucht v. King*, 260 U.S. 174 (1922), quarantine, *Compagnie Francaise de Navigation a Vapeur v. Bd. of Health of State of La.*, 186 U.S. 380 (1902), and licensing of health care professionals, *Hawker v. New York*, 170 U.S. 189 (U.S. 1898). However, the police power of the states is not unlimited. *See Buchanan v. Warley*, 245 U.S. 60, 75 (U.S. 1917) (noting that “the police power, broad as it is, cannot justify the passage of a law or ordinance which runs counter to the limitations of the federal Constitution”). The states cannot regulate healthcare in a way that violates the Constitution, such as by infringing on individual rights or by discriminating against certain groups of people. *See S. Ry. Co. v. Virginia ex rel. Shirley*, 290 U.S. 190, 196 (U.S. 1933) (“The claim that the questioned statute was enacted under the police power of the state, and therefore is not subject to the standards applicable to legislation under other powers, conflicts with the firmly established rule that every state power is limited by the inhibitions of the Fourteenth Amendment.”). Additionally, the states must comply with federal laws that regulate healthcare, such as the Affordable Care Act and ERISA. *See District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 127 (U.S. 1992) (holding that the latter pre-empted a District of Columbia law requiring that employers who offer health insurance to their employees provide equivalent coverage for injured employees eligible for workers’ compensation benefits).

167. *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588 (2012) (holding that the Affordable Care Act’s individual mandate requiring most Americans to obtain health insurance or pay a penalty was a valid exercise of Congress’s taxing power under the Constitution).

allied health professionals.<sup>168</sup> This calibrated approach promises to optimize healthcare accessibility, efficiency, quality, and resilience. By eliminating arbitrary geographic barriers and deploying a diversified array of competent medical professionals, costs can be managed more prudently. The rural and underserved communities, often marginalized in the healthcare landscape, stand to benefit substantially from this nuanced policy shift.<sup>169</sup> Inevitably any proposal to increase federal healthcare spending raises the hackles of fiscal hawks. However, the substantial projected savings and accessibility enhancements from telehealth and allied health professionals justify the investment.<sup>170</sup>

A critical analysis of existing research lends further credence to the proposed policy, with empirical data corroborating telehealth's ability to enhance the management of chronic illnesses at a more manageable expense.<sup>171</sup> Facilitating a wider spectrum of capable practitioners to function at the zenith of their abilities would create a more balanced distribution of responsibilities by lowering costs and mitigating the pressures on beleaguered physicians. The resulting alleviation of physician shortages would promise a more responsive healthcare system, with shorter waiting times and wider accessibility. Although physicians' apprehensions regarding potential displacement by AI are not without merit, an adeptly managed distribution of clinical responsibilities could ameliorate the current healthcare crisis marked by physician exhaustion and burnout.<sup>172</sup> These legitimate concerns can be constructively addressed through judicious state licensing laws, mandating the presence of qualified human oversight in AI-assisted medical decision-making (i.e., "keeping the human in the loop").<sup>173</sup>

The policy's proactive stance towards the augmentation of healthcare

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168. See RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

169. Liu et al., *supra* note 160; see also Munding et al., *supra* note 160.

170. Liu et al., *supra* note 160; see also Munding et al., *supra* note 160.

171. Kanesha Ward et al., *Visit Types in Primary Care with Telehealth Use During the COVID-19 Pandemic: Systematic Review*, 10 *JMIR MED. INFORMATICS* 1 (2022) (examining the use of telehealth during the COVID-19 pandemic, with both patients and clinicians reporting benefits such as improved convenience, focused discussions, and continuity of care); see also Rashid L. Bashshur et al., *The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management*, 20 *TELEMEDICINE & E-HEALTH* 769, 795 (2014).

172. Scott W. Yates, *Physician Stress and Burnout*, 133 *AM. J. MED.* 160, 160-63 (2020). This article discusses the causes and consequences of physician burnout and proposes solutions to increase physician work satisfaction. *Id.* The 2018 Medscape survey found that 56% of physicians who reported burnout cited excess bureaucracy, long working hours, lack of respect from colleagues, increasing computerization of practice, insufficient compensation, and a lack of clinical autonomy as contributing factors. *Id.* at 161. The use of scribes (whose functions can be automated by AI) in primary care has been shown to decrease the time spent on EMR documentation tasks and improve physician work efficiency and satisfaction. *Id.* at 162.

173. Suzanne Bakken, *AI in Health: Keeping the Human in the Loop*, 30 *J. AM. MED. INFORMATICS ASS'N* 1225, 1225-26 (2023) (highlighting five papers focused on AI that provide key lessons about the importance of keeping the human in the loop).

capacity and accessibility through telehealth and the careful delineation of professional scope portends a resilient system equipped to respond to unforeseen public health emergencies and natural catastrophes.<sup>174</sup> The fusion of heightened telehealth adaptability with an empowered cadre of allied health professionals paves the way for enduring solutions, ensuring rapid and reliable access to essential services in times of crisis.<sup>175</sup>

Though the precise fiscal implications of the proposed telehealth and professional scope incentives remain shrouded in uncertainty, the sheer magnitude of the potential benefits warrants congressional appropriation in the vicinity of one to two percent of annual Medicaid expenditures to subsidize state-level incentives. As of 2021, federal Medicaid funding stood at an impressive \$734 billion, constituting 17% of the \$4.3 trillion National Health Expenditure (NHE).<sup>176</sup> A nominal increase of two percent in Medicaid spending (approximately \$15 billion) would elevate Medicaid's share to 17.5% of total NHE.<sup>177</sup> A two percent increase in Medicaid spending (approximately \$15 billion) would nominally increase Medicaid to 17.5% of total NHE. Yet, the anticipated systemic savings and the unlocking of telehealth capabilities, together with the full deployment of allied health professionals, argue convincingly for this fiscal outlay.

In addition, the utilization of Section 1115 Medicaid waivers permits states to explore and experiment with groundbreaking approaches to healthcare delivery and financing, inclusive of AI and telehealth applications.<sup>178</sup> These waivers empower states to act as experimental laboratories, piloting innovative programs tailored to specific populations or health conditions.<sup>179</sup> Such a fertile collaboration between technological advancement and adaptive policy constructs an ecosystem ripe for innovation that is poised to potentially revolutionize the healthcare terrain, enhancing the quality and accessibility of care for the entire nation.

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174. Bokolo Anthony, Jr., *Use of Telemedicine and Virtual Care for Remote Treatment in Response to COVID-19 Pandemic*, 44 J. MED. SYS. 132 (2020).

175. Nachiket Gudi et al., *Telemedicine Supported Strengthening of Primary Care in WHO South East Asia Region: Lessons from the COVID-19 Pandemic Experiences*, 7 BMJ INNOVATIONS 580 (2021) (discussing the potential role of telehealth in augmenting health system capacity, particularly in strengthening primary care during health emergencies, and highlighting the need for resilient primary healthcare systems and the role of telehealth in expanding access to care); see also Nancy E. Morden et al., *Receipt of Medications for Chronic Disease During the First 2 Years of the COVID-19 Pandemic Among Enrollees in Fee-for-Service Medicare*, 6 JAMA NETWORK OPEN 1 (2023) (mentioning the need for regulatory and reimbursement reforms to expand telehealth and suggesting that expanding telehealth could help address disruptions in effective treatment during public health emergencies).

176. *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID (Sept. 6, 2023, 4:57 PM), <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet> [<https://perma.cc/SRB2-7WTZ>].

177. *Id.*

178. Social Security Act § 1115, 42 U.S.C. § 1315.

179. *See id.*

## VI. ADDRESSING FEDERALISM AND ADMINISTRATIVE AUTHORITY CONCERNS

*A. The Constitutional Scope of Congressional Power*

It may be argued that using Medicaid incentives to drive state-level telehealth and scope reforms raises federalism concerns about national government overreach into state affairs. This criticism, while resonant with historical debates concerning the delicate balance of power within our federal system, can be countered by recognizing that Congress would merely be wielding its clearly demarcated constitutional authority to expend for the general welfare.<sup>180</sup> Far from imposing mandates coercively upon the states, this proposal aims to foster voluntary alignment with national objectives through fiscal inducements. States that prefer the status quo can simply opt out, mirroring the choice offered to states in the subsidized expansion of Medicaid coverage under the ACA.<sup>181</sup>

The grounding for this perspective can be located in Justice O'Connor's discerning opinion in *New York v. United States*, where the principle was affirmed that Congress possesses the fiscal instruments necessary to "urge a State to adopt a legislative program consistent with federal interests."<sup>182</sup> Under this legal framework, tailored Medicaid incentives aimed at augmenting healthcare access through telehealth and scope reforms would not transgress the prohibition against federal commandeering of state legislation.

*B. The Regulatory Authority of CMS*

Detractors might also dispute that telehealth and the scope of medical practice are beyond the regulatory purview of CMS, the agency entrusted with the stewardship of Medicaid. However, CMS has broad responsibility to ensure Medicaid provides sufficient access to quality care efficiently, which empowers it to issue guidance encouraging beneficial reforms.<sup>183</sup> Through demonstration waivers and conditional funding, CMS has legal avenues to collaborate with states to spearhead modernizations in licensing and scope of practice that are responsive to technological advancements like telehealth and AI.<sup>184</sup> This approach has been used to expand Medicaid coverage options and test reforms improving

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180. See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519.

181. Leisha C. Elmore et al., *Impact of Medicaid Expansion Under the Affordable Care Act on Receipt of Surgery for Breast Cancer*, 3 *ANNALS SURGERY OPEN* 3, 1 (2022); see also Jordan H. Rhodes et al., *Heterogeneous Effects of the ACA Medicaid Expansion on Hospital Financial Outcomes*, 38 *CONTEMP. ECON. POL'Y* 81, 83 (2019) (reporting that states that opted out of Medicaid expansion fell behind in providing access to vulnerable populations in urban and rural settings).

182. 505 U.S. 144, 166 (1992).

183. Julie M. Donohue et al., *The U.S. Medicaid Program: Coverage, Financing, Reforms, and Implications for Health Equity*, 328 *JAMA* 1085 (2022); Colleen M. Grogan et al., *Rhetoric and Reform in Waiver States*, 42 *J. HEALTH POL., POL'Y & L.* 247 (2017).

184. Donohue et al., *supra* note 183; Grogan et al., *supra* note 183.

outcomes.<sup>185</sup> Collectively, CMS possesses the legal authority to work in conjunction with the states to modernize licensing and scope of practice reforms that incorporate the latest technologies like telehealth and AI.<sup>186</sup> In essence, the purpose of this proposal is to confront the pressing challenges inherent in the U.S. healthcare system. These challenges correspond to the three cardinal objectives, colloquially referred to as the “triple aim” within healthcare: namely, the accessibility of care, the cost of treatment, and the quality of medical services.<sup>187</sup>

#### CONCLUSION

The COVID-19 pandemic laid bare significant lacunae in the United States’ healthcare architecture, simultaneously unveiling the disruptive potential inherent in telehealth and astute reforms. The exigencies of the crisis call for the intelligent modernization of a landscape marred by fragmented state-based medical licensing and inconsistent practice limitations.

This Article posits that cautious federal intervention, incentivizing precise state-level modifications, is a promising avenue to spur intelligent modernization. Congress, by deploying Medicaid resources, should champion two particular reforms: first, the mutual recognition of out-of-state medical licenses specific to the provision of telehealth services, and second, an enlargement of practice eligibility for allied healthcare professionals, in accordance with competencies ascertained through education, credentials, outcomes data, training, and the utilization of emerging technologies.

While states would retain complete control over the regulation of in-person medical practices, these innovations would alleviate the telehealth-related inefficiencies and obstacles to workforce agility engendered by inconsistent cross-jurisdictional policies. The consequence would be enhanced access for patients to a wider selection of licensed providers via telehealth, coupled with the possibility for states to authorize more significant independent practice rooted in competencies. Such reforms could herald a new era of expanded access, efficiency, quality, and resilience within the healthcare system of the United States.

This Article has advanced a judicious path for federal intervention, using Medicaid incentives to stimulate precise state-level adaptations. By harmonizing medical regulations with contemporary technological competencies and workforce capabilities, Congress has the potential to trigger innovations that honor the memory of those lost in the pandemic by erecting a healthcare system apt for the future. The poignant lessons of COVID-19 concerning the avenues and imperatives for reform must not be consigned to oblivion. They form the blueprint for a commitment to future generations and the promise of a system that enhances life itself.

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185. Donohue et al., *supra* note 183; Grogan et al., *supra* note 183.

186. Donohue et al., *supra* note 183; Grogan et al., *supra* note 183.

187. Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 759 (2008).