Interstate Licensing Compact Work Group
Recommendation of Jan. 15, 2023

Conclusion/Recommendation:
The general consensus among the work group is that there is not a unanimous need nor an urgent nationwide desire for an interstate licensing compact within the profession of optometry at this point in time. However, the work group recognizes that both developing an optometry interstate compact and passing on the opportunity to develop one utilizing a Department of Defense (DoD) grant, could each affect the profession and its doctors for years to come. As such, a long-term, forward-thinking view of these issues is encouraged for everyone considering interstate compacts. The workgroup further acknowledges that some states are potentially interested in a compact for optometry, but this small window of opportunity to apply for DoD grant funding for the development of an interstate licensing compact will soon close.

Our recommendation to Presidents Council is that as soon as possible, each affiliate should vet their interest and potential commitment to participating in an interstate licensing compact for optometry among its leadership. It is further recommended that by the convening of the AOA House of Delegates at Optometry's Meeting in 2023, the AOA have surveyed which affiliates, if any, are strongly committed to forming such a compact, and report those results at the House of Delegates. If there are at least 8-10 affiliates so inclined, the AOA could then convene appropriate stakeholders to more formally investigate the possibility of applying for a DoD grant later this year, provided the risks, benefits and costs of developing and maintaining an interstate licensing compact for those parties is favorable.

Background:
Several years ago during an open forum session at Presidents Council, a discussion was brought up by attendees regarding national licensure and licensure portability. The topic resurfaced at Presidents Council in June 2022, this time more specifically centered around interstate license compacts. Information was provided by Jeanne Perrine, O.D., of Georgia, a Past President of the Georgia Optometric Association and then a sitting member of the Georgia regulatory board of optometry. As a result of the discussion, Presidents Council attendees felt the issue deserved proper vetting, and it was requested that a work group be formed to provide a recommendation back to Presidents Council in January 2023 regarding the subject. In the fall of 2023, a work group of volunteer leaders in optometry, association executive directors, state optometry regulatory board members, and a student representative was formed, consisting of:

Selina McGee, O.D. (OK)
Stacey Meier, O.D. (AZ)
Chelsey Moore, O.D. (IL)
Jeanne Perrine, O.D. (GA)
Adam Sauls, O.D. Candidate @ UABSO (AOSA)
Leigh Ann Vanausdoll (IL)
Rob Wooldridge, O.D. (UT)
Chris Wroten, O.D. (LA)
Wayne Zahka, O.D. (MA)

With administrative support provided by AOA staff member, Adrianne Drollette, and legal clarification provided by AOA general counsel, Mike Stokes, the work group conducted research, developed a series of questions/concerns, and had discussions with the American Dental Association (ADA), who was just finishing an interstate licensing compact for dentists and dental hygienists, and with the Council of State Governments (CSG). CSG is a bipartisan association of the legislatures of each state in the US which searches for common issues on which to work that benefit all states, including having successfully developed numerous interstate license compacts for other professions in a consulting role.

Currently, there are no interstate licensing compacts within the profession of optometry, so licenses for Doctors of Optometry may be obtained: via conventional application to each state regulatory board individually; via reciprocity in states that authorize it; and/or via licensure by endorsement in states that allow for it.

Licensure by Reciprocity is a formal agreement between two states such that any license holder in state A that applies for a license in state B is automatically granted the license by state B, provided they meet any customary, state-specific eligibility criteria and pay the normal license fees to the regulatory board in state B. Similarly, if a doctor licensed in state B applies for licensure in state A, state A automatically grants that license provided normal state-specific eligibility criteria are met and fees are paid.

Licensure by Endorsement is considered on a case-by-case basis in which there is no formal agreement for reciprocal licensure between states. In most instances, if two states have equivalent scopes of practice, and statute/regulations allow, one state board may choose to grant a license by endorsement to an applicant from the other state, but there is no automatic and/or reciprocal agreement that endures beyond that individual case.

An Interstate Licensing Compact is a voluntary agreement between at least 8-10 states that is enacted via identical state legislation to formally allow license holders in one state to obtain licensure to practice in any of the other participating states in the compact, via the compact's application process. State regulatory board authority and autonomy is maintained, but an alternative route to licensure is created. Various interstate compact models exist. For example, the interstate medical compact charges a $700.00 fee which is paid to the compact to fund administrative costs, plus the normal state license fee is also paid directly to the medical board in the state being applied to practice in, with a new license issued to the applicant from that state board. Other models exist in which the compact fees are lower and the original state license is simply recognized by the new state to which the applicant is applying, without a separate, new license being issued (similar to one driver's license being recognized across state lines).

Interstate compacts have been formed or are nearing implementation in a wide number of healthcare and other licensed professions, including medicine, nursing, psychology, dentistry, dental assisting, emergency medical technicians, and others. Once an interstate compact has been officially created, a minimum of 8 to 10 states must pass identical legislation enacting the compact for it to become active. Additional states may join the compact at any time by passing the same legislative language, participating states may drop out by passing new legislation to do

so, and/or the compact's rules may be amended from time-to-time. Compacts are governed by a commission that includes one member from each participating state, all with an equal vote. Disciplinary authority remains with the individual state regulatory boards, and any disciplinary action taken against a licensee from a state participating in the compact is shared among all the state regulatory boards represented by the compact.

It typically costs upwards of $500K to establish the language and develop the framework for a compact, the bulk of which is for legal, consulting and educational fees. Depending on the compact's size and structure, there is an additional cost of up to $1 million for operating costs, ongoing maintenance of information technology networks and databases, and administrative staff to maintain and monitor applications and licenses.

At present time, the Department of Defense (DOD) has made 10 grants available through CSG to cover the cost of legal, consulting, and educational fees incurred in the process of interstate compact development for healthcare professions in which members of the military or their spouses practice, with the goal of increasing the portability of those licenses as members of the military are transferred from state to state. At the time of writing of this memorandum, 7 of the 10 grants have already been awarded, with the remaining 3 grants available on a competitive grant application basis.

The work group developed a robust list of questions concerning interstate compacts, which are attached, along with the answers discovered to the best of its knowledge. Most questions and concerns surrounded accounting for scope of practice differences from state to state, potential opposition (especially if the practice act is opened legislatively), direct and indirect costs to create and operate the compact, and unintentionally promoting any inappropriate use of telehealth that might endanger patient safety. Please refer to the attached list for answers to many of these and other questions that were identified and researched.

FAQ's for Potential Interstate Optometry Compact

1. What is the philosophy behind choosing to form a compact? To increase practice mobility for doctors of optometry, allowing part-time practice in areas of need/emergencies/etc., as well as to avoid potential litigation from doctors of optometry that could undermine the authority of state optometry boards. AOA Attorney Mike Stokes researched the latter and could not find case precedent for that concern at this time.
2. Where will the resource come from to build the language and form the Compact? Model language exists for other healthcare professions who've done compacts; the Council of State Governments would research issues unique to optometry and would make recommendations for the final legislative language, which could then be modified as needed; however, any state participating in the compact must pass identical legislative language to participate in the compact.
3. What will happen if optometry chooses to not form a compact? Potentially nothing? But there is a chance as more and more professions establish compacts that one could be formed without optometry in control.
4. What other professions have done or are in the process of forming compacts?

   Active Interstate Compacts & Number of Participating States (as of June 2022)

   Enhanced Nursing Licensure Compact – 39 states
   Psychology Interjurisdictional Compact – 31 states
   Interstate Medical Licensure Compact – 29 states
   Physical Therapy Compact – 25 states
   Emergency Medical Technician Compact – 21 states
   Audiology & Speech Language Pathology Interstate Compact – 15 states
   Occupational Therapy Licensure Compact – 15 states

   In-Development/Not Yet Active Compacts (as of June 022)

   Advanced Practice Registered Nurses
   Counseling
   Dentistry/Dental Hygiene – about to launch
   Massage Therapy
   Physician Assistants
   Social Workers
5. How will each state contribute? The compact would be set up to be controlled by a board consisting of one representative from each state that participates in the compact (as new states join, they get a seat at the table, as well), with an equal vote for each representative.
6. How will each state ensure they have a voice in the compact? See question 7
7. Who will decide CE requirements? There are no separate CE requirements; the doctor must maintain whatever license they currently have with its requirements (there are no new licenses given through the compact; in other words, if Dr. A is licensed in State 1 and wishes to practice in State 2, and both states are members of the compact, they can apply to the compact and be granted privileges under their existing State 1 license).

8. If I have an OK license with full scope can I perform ~~do~~ laser~~s~~ procedures in Georgia if they are in my Compact? The compact would develop language to allow whatever scope of practice is deemed acceptable by the members, but the expectation would be that lasers would not be part of the scope through the compact, at least not initially, so if a GA doctor wanted to do lasers in OK, even if both states were in the compact, the GA doctor would have to obtain an OK license through the OK board to do lasers, just like they do now); and if an OK doctor obtained privileges to practice in GA through the compact and wanted to do lasers in GA, they would be restricted from doing so by the scope of practice in GA).
9. How does the compact impact each state's Board of Examiners? Each state's Board of Examiners maintains jurisdiction over all doctors practicing in their state; if a compact doctor breaks the law in their state, the Board would still have whatever investigational and disciplinary authority they currently have, but all disciplinary actions must be shared with the other compact member state boards.
10. How will the compact get money to continue to operate? From fees paid by doctors obtaining privileges through the compact.
11. How many states are needed for a compact? Approximately 7-10 to activate a compact.
12. What goes into deciding the language of the compact and which states finish this question
    a. Geography?
    b. Scope?

    Geography and scope don't have to be deciding factors, but it's up to the compact to decide. All states are welcome to join or not join, it is entirely at their discretion, and those participating in the beginning would be involved with CSG in providing suggestions for the language.
13. Can one state begin and other states be added over time? The model compact language can be developed by any number of states, but 7-10 states must pass identical legislation to activate the compact, then other states can do the same and join later.
14. How long will it take to become part of the compact? The process of forming a compact can take years. It becomes active once 7-10 states pass the language. New states are joined as they pass the required legislation.
15. What is the process and language to have a compact? The process would be overseen by the Council of State Governments and could take up to a few years. It is an established process that the CSG has for compact development. The specific language of the optometry compact would be developed during this process.
16. Who and what is the CSG? The Council of State Governments is a nearly 100 year old nonpartisan group made up of the member legislatures of each state, who pay membership dues to fund the organization. The goal of CSG is to find common ground on topics affecting multiple states and try to facilitate efficient resolution of shared issues.
17. What states are currently represented on the national CSG? Each state's House & Senate are members of CSG, with national officer positions elected similar to the AOA Board.

18. Do we have to use CSG? Compacts can be done without CSG, but are expensive and labor intensive; CSG has expertise and for a limited time the Department of Defense is offering grants through CSG to cover the full cost of compact development (~$500K) but professions must use CSG's compact experts to qualify for the grant. The CSG also lends immediate credibility to the efforts.
19. How do legislators typically vote? Most are very familiar with CSG and many already know compacts from other professions and are therefore very open to them because they increase access to care and attract doctors. What pushback will there be? Perhaps from state boards fearing loss of authority and/or doctors who feel competition will come to their area. Who lobbies to get this legislation passed? The state association would undoubtedly take the lead given their expertise in advocacy. Does the language in each state's legislation have to be exactly the same by state? Yes
20. What are the pros if we do? Attract/recruit more applicants to optometry school; protect state board authority; enhance ability for doctors to practice elsewhere.
21. How many and which states have licensure by endorsement and by reciprocity? It is difficult to tell exactly, but most states seem to have one or both means of achieving alternative licensure.
22. How would varying scopes of practice be handled? See above
23. How much do they cost & what are the costs from/for? It's estimated to cost ~$500K to develop an interstate compact. Fees are for consultants, research, language development, attorney's fees, & education of licensees, legislators, and the public. The Department of Defense is currently interested in compact development to ensure their service men and women, and their spouses, can practice wherever they may be moved /stationed during their career, and has set aside grant money for a limited time to cover cost of compact development in its entirety. Currently 7 of the 10 available grants have been awarded. There are also ongoing administrative costs for a few staff and a database, which can cost upwards of $1M total for large professions, which are self-funded by fees paid to the compact. An estimate of ongoing fees for optometry would be provided as part of the groundwork for interstate compact development.
24. Who will pay for it? State associations? AOA? Other stakeholders (e.g. ARBO)? See above
25. How would a group of states go about forming one? See above
26. What role would state associations & the AOA need to play? Education and advocacy
27. What's difference b/t licensure by endorsement, by reciprocity, & by compact? Already answered Why repeat the question?
28. How many states must pass to become active? See above Already answered
29. Can there be additional fees for a compact license, and if so, does the compact keep them, does the state board keep them, or are they shared? Compact fees are what sustains the organization.
30. Are we potentially opening up telehealth to become the wild, wild west if we do a compact? Each state's telehealth rules would govern telehealth delivery in the state, as it does now. Additional safeguards may need to be in place in the compact's legislative language/compact rules.

31. Are we restricting future scope in compact in any way/how do we avoid hamstringing the profession in this regard for the future? This would be something that would be discussed and resolved during the creation of the compact.
32. If the compact only allows scope of practice at the most restrictive level between the state in which patients would be seen versus the state in which the doctor actually holds a license, are we giving credence to the argument in the VA that would similarly look to limit scope to the most restrictive available? How can we prevent doing that? In the development process, rules could be put in place to allow for practicing at the highest level or only at the level of the original license. For instance, the PT compact requires certain tests to be completed in order to grant privileges in each state.
33. How easy/difficult is it to change compact rules in the future? The rules process would be managed by the compact's board, with representatives from each compact state.
34. How easy/difficult is it to change compact legislative language in the future? Any changes to something in the legislative language would require each state to pass legislation with the new language. The nurses compact has been around long enough that they have updated their compact and each state has had to pass new language.
35. Can we have someone at the ADA share their thoughts/concerns/experiences in developing their compact? Working on this for the next call.
36. When and how should ASCO/ARBO/AOSA/other stakeholders be brought into the conversation?
37. Is AOA willing to assist with resources if needed? Yes
38. What would the next step(s) be if this workgroup recommends/endorses development of an interstate compact for optometry? To bring this information in the form of a recommendation to Presidents Council in Charleston in Jan. 2023, then hand the reins to AOA and other stakeholders to further vet the issue and potentially apply for the DoD grant to fund its development. The AOA, state leaders, and other stakeholders could provide comment to CSG for compact language development, and once completed, each state interested in participating could decide whether or not to create legislation to pass in order to participate in the compact.
39. Has anyone asked the more difficult states to gain state licensure in (ie. North Carolina, Florida) their thoughts on Compacts? I do not foresee states like this wanting to join a compact? It is up to each individual state to decide whether or not to pursue participation in a compact if one is formed.
40. Also, I have concern that Illinois doctors (or Florida doctors) could/will move their state licensure to another state because of the more tedious CE requirements (Tested CE) which will directly affect state associations? Florida was actually the state that first brought this up at Presidents Council, albeit several years ago now. Ultimately, each state can decide for themselves whether they'd want to participate or not. There would just need to be at least 8-10 states participating to activate the compact after it's been developed. As for CE, each state license would retain their CE requirements.
41. Do we have an estimate of the "fees" paid from doctors obtaining privileges through the Compact to maintain the compact(via other professions "annual fees" to maintain Compacts)? (see above)

42. Can a doctor that is practicing in a Compact state choose not to pay these fees and take part in a compact? Fees are established by the compact. They range from $50 in some professions to $700 in medicine for example. Yes, if a doctor is practicing in a compact state and does not want privileges in other compact states, they are not participating in the compact and will pay no fees.
43. The State Associations will need to bring a Compact to their House/Senate to get legislation passed. Do we have any idea of an estimate of cost? (Especially states looking to scope battles in the future, this would be important). It should be significantly less than most of our legislative battles because the Legislatures are already familiar with interstate compacts and are also members of the association of state governments that would be developing the compact. We will have ADA representatives on a future call to discuss their experiences with this. I do know that some professions with barely active associations have passed their compact language with very little effort. Many states are very welcoming to compacts.
44. "Opening up telehealth": I have worries because certain states may not have good state boards policing telehealth illegal practices and issues currently. Therefore, we are almost encouraging doctors to perform telehealth if the doctor lives in a state where enforcement is not routinely done. There's no doubt compacts could potentially facilitate telehealth in states that don't have good laws and rules on the books to enforce standards of care and to protect patients.

A meeting occurred on September 22 at 9:30 am at the Grand Hyatt Hotel to discuss questions and concerns surrounding the idea of licensing compacts. In attendance were Executive Directors Wayne Zahka, O.D. (MA), Stacey Meier, O.D. (AZ), and Leigh Ann Vanausdoll (IL).

QUESTIONS:

1. Why do we need legislation? Each state currently has a policy for "reciprocity". Why can't we simply have each state in the compact update their policy so they are identical?
2. If legislation is needed
    a. Who pays for the legislation? Each state would be responsible for passing the bill authorizing the compact, if they would like to be a part of it. Therefore each state would shoulder the burden for any costs in passing the language.
    b. What happens if you leave the compact; do you have to pass legislation to remove yourself from the compact? Unclear, this would be a question for CSG.
    c. NOTE: NURSES HAVE BEEN ATTEMPTING TO PASS A COMPACT LAW IN MASSACHUSETTS FOR 8 YEARS AND HAVE NOT HAD SUCCESS TO DATE. Some states are much more open to compacts than others.
3. What are the parameters and limitations of the compact's authority? Each state's Board of Examiners maintains jurisdiction over all doctors practicing in their state; if a compact doctor breaks the law in their state, the Board would still have whatever investigational and disciplinary authority they currently have, but all disciplinary actions must be shared with the other compact member state boards.

4. What are the border regulations? Can an OD located in one contact state care for a patient in another compact state via Telehealth? Telehealth guidelines and regulations need to be well defined in the compact. Yes, this would be worked out in the compact language as well as in each state's telehealth law.
5. What if an OD has a patient complaint filed against them
    a. What jurisdiction handles the complaint? State Board or Compact Board?
    b. Is every state in the compact notified of the complaint? Yes.
6. What if an OD is actually punished or sanctioned in one state
    a. Is every state in the compact notified of the punishment/sanction? Yes.
    b. Can the compact further punish or sanction? Yes I believe so.
7. What information is shared between compact states? Background checks and any disciplinary information, anything else is decided by the compact language.
8. What happens if a compact state increases (or decreases) scope of practice? Rules can be changed/updated by the compact board.
9. What is the procedure if an OD permanently changes his primary address to another state? Unclear, we can find out.
    a. Does the original home state license stay valid even though s/he is no longer in the state? This already occurs on a frequent basis. Many doctors maintain their licenses after leaving a state. Some maintain licenses in states in which they've never practiced. As long as they continue to pay the state fees and meet the state's requirements for licensure e.g. CE requirements, the licenses remain valid.
    b. Does the new state automatically issue a license to the OD? Depending on how the compact is structured, a new license could be issued from the new state, or the new state could acknowledge the original license (similar to a driver's license).
    c. What is the process? See above
10. Is there an impact on health care costs, either positive or negative? Compacts could increase access to healthcare, thereby improving healthcare outcomes. There would be additional fees incurred by doctors wishing to get licensed through a compact.
11. What are the fees? Established by the compact. Any fees are paid by the OD.
    a. Initiation fee? See above
    b. Yearly membership fee? See above
    c. How much and who is responsible for the payment? See above
12. What are the rules/procedures concerning differential of CE requirements state to state? Depending on the structure of the compact, an OD would follow the CE rules for the state where they hold their primary license, or alternatively it could be structured such that CE requirements for each state must be met.

PROS:

1. It is appealing to have a license that is accepted in multiple states. We see this especially true for OD's living in border towns, new graduates, young OD's and OD's nearer to retirement age.
2. It is easier to market, as it has more appeal.
3. It is easier to move and change the state in which locate your primary address
4. Possibly aids in disaster relief and emergency situations
5. Possibly expands access to care in rural areas and seasonal areas

CONS:

1. Association members will balk at spending membership dollars for legislation that doesn't directly impact them
2. Legislation is tedious. It takes a lot of time and money. (See 2C in the Questions section above)
3. There may be a fear of too many OD's entering a state.
4. There will be State revenue loss due to decreased licensing
5. There is a CE differential from state to state (See Question 12 above)
6. Telehealth Issues- Need precise regulations and policing of policy