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Impact Of The New Jersey COVID-19 Temporary Emergency Reciprocity Licensure Program On Health Care Workforce Supply

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ABSTRACT New Jersey's COVID-19 Temporary Emergency Reciprocity Licensure program provided temporary licenses to more than 31,000 out-of-state health care practitioners. As one of the first COVID-19 hot spots in the US, New Jersey is uniquely positioned to provide insights on enabling an out-of-state health care workforce through temporary licensure to address critical, ongoing concerns about health care workforce supply. In January 2021 we surveyed New Jersey temporary licensees. We analyzed more than 10,000 survey responses and found that practitioners who used the temporary license originated from every state in the US, provided both COVID-19- and non-COVID-19-related care, served a combination of new and existing patients, conversed with patients in at least thirty-six languages, and primarily used telehealth. Findings suggest that temporary licensure of out-of-state practitioners, along with telehealth waivers, may be a valuable, short-term solution to mitigating health care workforce shortages during public health emergencies.

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Health care provider licensing is primarily governed by states, often through boards or committees. Because emergencies sometimes create surges in demand for health care services that existing state workforces may be unable to meet, states may welcome out-of-state practitioners seeking to offer services outside their home state or states of licensure. States eager to boost existing health care provider supply may do so through multi-state licensing compacts or temporary licensing programs. Indeed, emergency health care practitioner licensure has long been a strategy for responding to public health emergencies.¹ Since the beginning of the COVID-19 pandemic, at least forty-five US states have enacted some form of health care practitioner licensure waiver.^{2,3} On March 20, 2020, New Jersey enacted the Temporary Emergency Reciprocity Licensure Program, allowing out-of-state, currently licensed

health care practitioners in good standing to obtain temporary licensure to provide services to New Jersey patients via telehealth⁴ or in person.⁵⁻⁷ The aim of New Jersey's program was to respond to pandemic-related health care workforce demands, especially for hospital staffing and care for underserved populations.

Executive Order 103, signed by Gov. Philip D. Murphy March 9, 2020, authorized the Department of Law and Public Safety's Division of Consumer Affairs, which oversees professional licensure, to "waive, suspend, or modify any existing rule, where the enforcement of which would be detrimental to the public welfare during this emergency."⁶ Subsequently, Executive Order 112,⁸ signed by Governor Murphy April 1, 2020, as well as the enactment of multiple waivers by the Division of Consumer Affairs,⁹ created licensure-based pathways to expanding the health care workforce. Under New Jersey's program, licensing fees and criminal background

checks were waived for eligible applicants. Twenty-three licensing entities participated initially, including the boards for physicians, nurses, and mental health providers.⁷ As of January 2021 the Division of Consumer Affairs had issued more than 30,000 temporary licenses, about 27 percent to physicians, 26 percent to mental health providers, 35 percent to nurses and nurse practitioners, and 2 percent to respiratory care therapists.¹⁰

As one of the first COVID-19 hot spots in the US, New Jersey is uniquely positioned to provide insights on mobilizing an out-of-state health care workforce through temporary licensure to address critical, ongoing concerns about health care workforce supply. In this article we describe the results of a survey sent to recipients of temporary New Jersey licenses during the first nine and a half months of the program. We explore who obtained a New Jersey temporary license, who used that license, and what those who used the license did. Our findings may help inform future professional licensure processes and strategies to address health care workforce shortages.

Study Data And Methods

DATA We conducted a cross-sectional survey of New Jersey temporary licensees, using an instrument developed by officials from the New Jersey Division of Consumer Affairs and researchers from Rutgers University that drew on validated survey questions and theoretical frameworks¹¹ to capture the impact of the program on workforce supply (availability, accessibility, accommodation, affordability, and acceptability). The survey questions are in online appendix exhibit A1.¹² The survey was fielded January 7–21, 2021, by the Division of Consumer Affairs, which emailed the anonymous survey link and two reminder messages to all practitioners ($N = 31,805$) who obtained a New Jersey temporary license between March 20, 2020, and January 6, 2021.¹³ Our analysis was based on 10,449 survey respondents, for a response rate of 33 percent.

ANALYSIS We performed descriptive analyses to describe the impact of the program on health care workforce supply by practitioner type. We created five practitioner groupings corresponding with the largest groups that received the temporary license: mental health providers (alcohol and drug counselors, marriage and family therapists, professional counselors, psychoanalysts, psychologists, and social workers), physicians, nurses (both licensed practical nurses and registered nurses), nurse practitioners (NPs) and physician assistants (PAs), and respiratory care therapists.

The remaining “all other” category included acupuncturists, athletic trainers, audiologists, dentists, genetic counselors, hearing aid dispensers, occupational therapists, opticians, optometrists, perfusionists, pharmacists, and physical therapists. This analysis was conducted using R statistical software. The study was approved by the Rutgers University Institutional Review Board.

LIMITATIONS We note several study limitations. First, the survey had a 33 percent response rate; however, this response rate is on par with prior surveys of practitioners in New Jersey¹⁴ and nationally.¹⁵ Second, the survey may have overrepresented certain practitioner types who received a New Jersey temporary license, such as mental health providers. See appendix exhibit A2 for a comparison of the full temporary licensee pool to survey respondents.¹² Stratified analysis addresses potential bias from the overrepresentation of some practitioner types, although other characteristics of nonrespondents are unknown; care should be taken not to generalize beyond the survey sample. It may be that respondents were more likely to engage actively in care in New Jersey relative to nonrespondents. Third, respondents self-reported how they used their temporary license. Furthermore, there is no clear way to quantify the benefits of the program to New Jersey residents. Such a study would require an all-payer claims database, in which practitioners’ emergency licensure numbers are linked to billed services, and the study must also be able to account for self-paying patients and volunteered time. Fourth, this was a cross-sectional survey conducted in January 2021. We are unable to offer week-to-week insights about care delivered by temporary licensees throughout the pandemic, and we also do not know how the practitioners’ caseloads in New Jersey compared with those in their home states. Finally, the New Jersey program was implemented early in the pandemic, when cases of COVID-19 were concentrated in a few regions of the US, including New Jersey. Program results may have been different in a period when pandemic-related workforce needs were more widespread.

Study Results

Among respondents, 7,552 (72 percent) reported using their temporary license to provide care to at least one New Jersey patient. The remaining 2,897 respondents (28 percent) obtained but did not use a temporary license. The license-using group is the focus of this study, although nonusers are also described. About half (48 percent) of license-using respondents were mental health providers, 21 percent physicians,

16 percent nurses, 7 percent NPs or PAs, 2 percent respiratory care therapists, and 6 percent all other (exhibit 1).

The New Jersey program provided temporary licenses to practitioners from all forty-nine other states. Most were from New York (2,776; 37 percent), Pennsylvania (1,922; 25 percent), Florida (327; 4 percent), Delaware (263; 3 percent), and California (259; 3 percent). These five states accounted for 73 percent ($n = 5,547$) of the license-using respondents. For a complete breakdown of the states in which temporary license-using respondents hold their primary license, see appendix exhibit A3.¹² License-using respondents were mostly non-Hispanic White women ages 40–59 (exhibit 1).

Exhibit 2 shows how license-using respondents used their licenses to care for New Jersey patients. Most were physically located out of state when they treated New Jersey patients (for example, using telehealth), particularly physicians (84 percent), mental health providers (82 percent), and NPs and PAs (62 percent). Nurses (75 percent) and respiratory care therapists (74 percent) were mostly physically located in New Jersey when caring for New Jersey pa-

tients. License-using respondents touched more than 1.4 million lives between March 2020 and January 2021 (data not shown). The average number of New Jersey patients served per month ranged from 1.4 among mental health providers to 409.7 among respiratory care therapists (exhibit 2).

About 16 percent of respondents reported that all of their New Jersey patients were new to them. These practitioners were mostly respiratory care therapists (58 percent), nurses (48 percent), and NPs or PAs (33 percent). Only 19 percent of physicians and 10 percent of mental health providers served exclusively new patients. In contrast, 31 percent of license-using respondents reported that none of their New Jersey patients were new to them (that is, practitioners used their temporary license to care solely for existing patients across state lines). These practitioners were mostly mental health providers (42 percent), physicians (27 percent), and NPs or PAs (17 percent). Only 8 percent of nurses and 8 percent of respiratory care therapists reported serving only existing patients (data not shown).

Respondents reported communicating with New Jersey patients in at least thirty-six different

EXHIBIT 1

Demographic characteristics of respondents to a survey of out-of-state health care practitioners who were granted a New Jersey temporary license between March 2020 and January 2021

Characteristics	Mental health providers ($n = 3,592$)	Physicians ($n = 1,587$)	Nurses ($n = 1,232$)	NPs and PAs ($n = 529$)	Respiratory care therapists ($n = 138$)	All other ($n = 474$)
Ethnicity						
Non-Hispanic	90.23%	90.30%	84.09%	91.49%	78.99%	92.41%
Hispanic	7.29	5.17	9.50	5.29	10.14	3.16
Prefer not to answer	2.48	4.54	6.41	3.21	10.87	4.43
Race						
White	76.34	70.26	50.32	73.35	52.90	68.78
Black or African American	11.97	4.66	29.06	13.99	23.19	5.70
Asian	5.54	14.43	9.74	6.81	3.62	17.30
American Indian or Alaska Native	0.72	0.19	1.06	0.76	5.80	0.42
Native Hawaiian or other Pacific Islander	0.17	0.25	0.97	0.19	0.72	0.21
Other	2.14	2.52	3.00	0.57	4.35	2.53
Prefer not to answer	5.35	8.88	8.44	6.24	14.49	6.33
Gender						
Female	80.07	44.05	81.98	82.80	58.70	75.53
Male	17.01	52.30	15.10	13.99	38.41	22.15
Undesignated or nonbinary	1.17	0.25	0.41	0.19	0.00	0.21
Prefer not to answer	1.75	3.40	2.52	3.02	2.90	2.11
Age, years						
18–39	39.20	21.36	42.61	41.59	44.93	55.91
40–59	42.82	51.73	48.46	45.94	45.65	33.97
60+	16.15	23.13	5.76	10.40	4.35	8.65
Prefer not to answer	1.84	3.78	3.17	2.08	5.07	1.48

SOURCE Authors' analysis of survey data from the New Jersey Division of Consumer Affairs. **NOTES** Sample includes survey respondents who reported using the temporary license to care for at least one New Jersey patient. Mental health providers refer to alcohol and drug counselors, marriage and family therapists, professional counselors, psychoanalysts, psychologists, and social workers. Respondents could select multiple options for race; sum could exceed 100 percent. NP is nurse practitioner. PA is physician assistant.

EXHIBIT 2

License usage reported by respondents to a survey of out-of-state health care practitioners who were granted a New Jersey temporary license between March 2020 and January 2021

License usage	Mental health providers	Physicians	Nurses	NPs and PAs	Respiratory care therapists	All other
Physical location while using NJ temporary license						
Both within and outside NJ	11.83%	9.33%	16.48%	17.77%	16.67%	18.14%
Outside NJ exclusively	82.24	84.05	8.44	61.63	9.42	51.90
Within NJ exclusively	5.93	6.68	75.08	20.60	73.91	29.96
Language spoken with NJ patients						
English only	93.15%	75.17%	51.38%	67.11%	66.67%	70.8% ⁹
Spanish	4.29	19.28	37.74	30.06	22.46	20.25
Other	2.56	5.55	10.88	2.84	10.87	8.86
COVID-19-related (percent of respondents providing)						
COVID-19-related care	79.40%	51.10%	81.66%	59.74%	77.54%	25.53%
Testing	0.14	32.31	41.05	47.47	0.93	12.40
Treating patients in inpatient settings	0.14	15.04	65.71	20.57	94.39	33.06
Treating patients in outpatient settings	1.72	32.92	21.77	30.06	5.61	26.45
Providing or facilitating connections to social services	4.31	9.74	8.75	12.66	0.00	5.79
Providing mental or behavioral health services	98.74	45.25	15.41	40.51	0.93	14.88
Non-COVID-19-related (percent of respondents providing)						
Non-COVID-19-related care	96.52%	87.33%	80.03%	80.91%	86.23%	64.35%
Lab tests	0.14	34.34	25.66	45.33	11.76	10.16
Treating patients in inpatient settings	0.26	16.16	66.02	16.82	93.28	18.03
Treating patients in outpatient settings	7.15	75.11	31.34	66.59	10.92	78.36
Providing or facilitating connections to social services	5.31	12.77	15.01	20.56	0.00	6.23
Providing mental or behavioral health services	98.56	35.21	17.55	37.38	0.84	8.52
Payment sources						
Private insurance	48.80%	36.74%	5.93%	23.63%	3.62%	25.32%
Salary	20.57	27.91	65.18	49.34	66.67	43.67
Patient self-pay	17.59	6.36	0.16	0.76	0.00	5.27
Government programs (Medicare, Medicaid)	4.93	20.54	4.30	10.02	1.45	12.45
Volunteer	2.84	3.40	2.84	2.46	0.00	6.54
Don't know or not applicable	14.50	28.48	25.49	25.52	29.71	21.73
No. of NJ patients served						
Per month average	1.37	30.76	147.45	61.63	409.69	225.08
Standard deviation	3.73	514.55	2,164.73	240.22	2,860.26	3,563.24

SOURCE Authors' analysis of survey data from the New Jersey Division of Consumer Affairs. **NOTES** Sample includes survey respondents who reported using the temporary license to care for at least one New Jersey patient. Mental health providers are defined in the notes to exhibit 1. Respondents could select multiple options for race, COVID-19-related care, non-COVID-19-related care, and payment sources; sum could exceed 100 percent. Sample sizes are in exhibit 1. NP is nurse practitioner. PA is physician assistant.

languages, including each of the state's twelve most common languages: Arabic, Chinese (Mandarin and Cantonese), Haitian Creole, Hindi, Italian, Korean, Gujarati, Polish, Portuguese, Russian, Spanish, and Tagalog (including Filipino) (data not shown). Mental health providers were least likely to converse with their New Jersey patients in a language other than English, with 93 percent reporting using only English (exhibit 2). For all other practitioner categories, one-quarter or more of respondents conversed with patients in a language other than English. Spanish was the next most commonly spoken language, used by about one-third of nurses (38 percent) and NPs and PAs (30 percent). Among nurses, the next most commonly spoken languages were Haitian Creole (7 per-

cent) and Tagalog (6 percent). Among NPs and PAs, 3 percent spoke with patients in Haitian Creole. Among respiratory care therapists, 7 percent spoke with patients in Chinese. In the "all other" provider category, 7 percent spoke with patients in Hindi (data not shown for languages other than Spanish).

The majority of respondents (65 percent) provided both COVID-19-related and non-COVID-19-related care to New Jerseyans. About 4 percent provided COVID-19-related care only, and 29 percent provided non-COVID-19 care only (data not shown). Most of the license-using respondents reported getting paid via private insurance (35 percent) or salary (34 percent). About 10 percent reported having self-paying patients, 3 percent reported volunteering their time, and

21 percent did not know how they were being compensated (calculations based on exhibit 2). It should be noted that respondents could report more than one type of payment source.

For many respondents, telehealth was the main modality for care delivery. Exhibit 3 shows the percentage of license-using respondents who used telehealth (defined as telephone, video, or e-visit) for all of the care they delivered to New Jersey patients compared with those who used telehealth more than half of the time, half of the time or less, and none of the time. Most mental health providers (83 percent), physicians (64 percent), and NPs or PAs (51 percent) used telehealth all of the time. Exhibit 4 shows that the majority of telehealth time was on video for mental health providers and the “all other” category. Respiratory care therapists reported that about 40 percent of their telehealth time was audio only.

There were 2,897 respondents (28 percent) who reported receiving but not using their temporary license (data not shown). The most frequently cited reasons included that they could not find new patients, could not find a job, and were prepared to “follow” existing patients to New Jersey but the need did not arise. An additional reason was personal circumstances, including that they took another job, family emergencies, and COVID-19-related travel restrictions. A another reason concerned matters related to the temporary license, including timing (for example, received the license only re-

cently), that they no longer needed it (for example, obtained a New Jersey plenary license), and that they experienced start-up issues (for example, had trouble affiliating with New Jersey provider organizations or did not know how to bill).

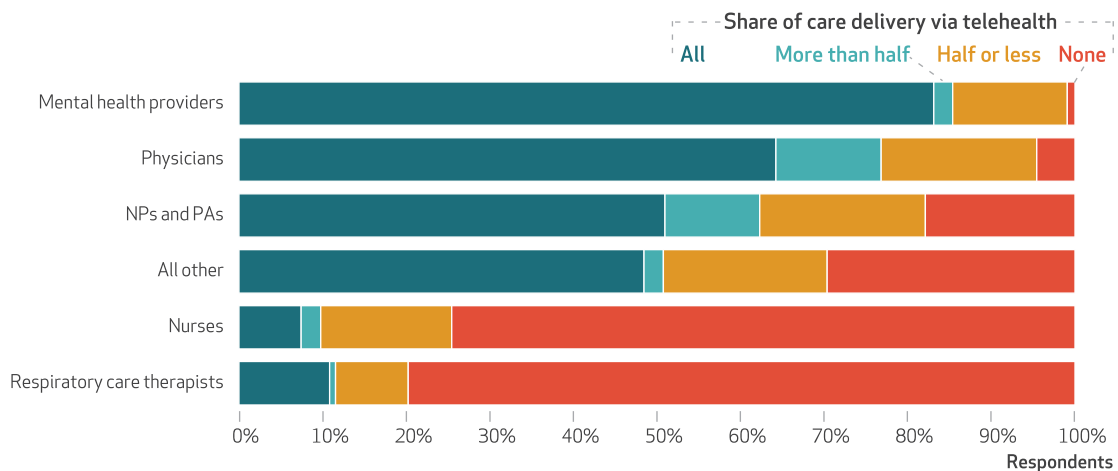
Discussion

From a public health perspective, it was imperative for states such as New Jersey to increase service capacity by setting up a temporary emergency reciprocity licensure program to remove administrative barriers for supplemental health care providers. Since the beginning of the pandemic, at least forty-five US states have enacted some form of a temporary licensure waiver.^{2,16} To the best of our knowledge, our study is the first to report data from a state temporary licensure waiver. This unplanned experiment demonstrates the importance of regulatory flexibility enabling rapid response in an emergency. Because New Jersey was one of the early COVID-19 hot spots in the US, this survey offers insight into some of the impacts of temporarily licensing out-of-state health care workers to address health care workforce supply during a public health emergency.

The New Jersey Temporary Emergency Licensure Reciprocity Program was designed to respond to pandemic-related health care workforce demands, especially for hospital staffing and care for underserved populations. Our findings suggest that the New Jersey program in-

EXHIBIT 3

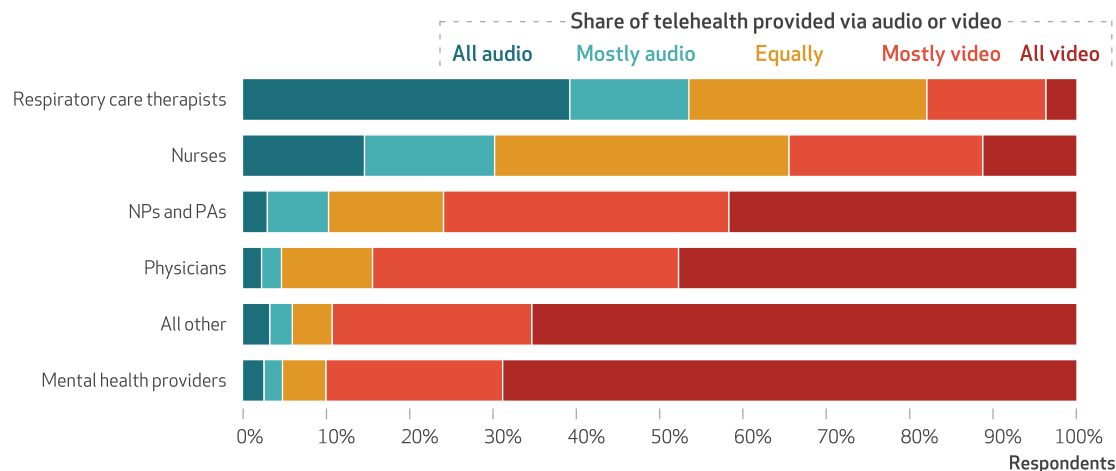
Percent of out-of-state health care practitioners who were granted a New Jersey temporary license using telehealth for care delivery, by share of prevalence and type of practitioner, March 2020–January 2021



SOURCE Authors’ analysis of survey data from the New Jersey Division of Consumer Affairs. **NOTES** Sample includes respondents to a survey of out-of-state health care practitioners who were granted a New Jersey temporary license between March 2020 and January 2021 and who reported using the temporary license to care for at least one New Jersey patient. Mental health providers are defined in the notes to exhibit 1. NP is nurse practitioner. PA is physician assistant.

EXHIBIT 4

Audio and video use to deliver telehealth by out-of-state health care practitioners who were granted a New Jersey temporary license, by mix and type of practitioner, March 2020–January 2021



SOURCE Authors' analysis of survey data from the New Jersey Division of Consumer Affairs. **NOTES** Sample includes respondents to a survey of out-of-state health care practitioners who were granted a New Jersey temporary license between March 2020 and January 2021 and who reported using the temporary license to care for at least one New Jersey patient. Mental health providers are defined in the notes to exhibit 1. NP is nurse practitioner. PA is physician assistant.

creased the state's health care workforce supply during the pandemic. Temporary licenses enabled care continuity across state lines and increased the supply of services for New Jersey patients, especially for mental and behavioral health—an asset at a time when demand for these services was rising steeply.¹⁷ The increased workforce supply likely also aided hospital staffing, with more than 1,000 respondents providing inpatient care, and also expanded care for underserved populations, with at least 670 respondents caring for Medicare or Medicaid patients. Respondents also communicated with patients in more than thirty-six languages, improving health equity.

COVID-19 federal and state telehealth waivers, which maintained obligations to meet standards of care¹⁸ but relaxed telehealth requirements related to the originating site and treatment of only established patients, also helped expand the temporary licensees' reach. Our findings indicate high use of telehealth among emergency licensees, particularly mental health providers. This is consistent with reported high adoption rates of telemental health across the country.¹⁹ A study of national private claims data found that from June to October 2020, 46 percent of behavioral health visits were virtual, compared with 0.4 percent the previous year, whereas 22 percent of medical visits were virtual in the same period, compared with 0.3 percent the year prior.²⁰ A systematic review reported that telehealth use, particularly for mental health, was widely

accepted by providers and patients during the pandemic.²¹ These factors, alongside the waivers, may have resulted in an environment conducive for mental health providers to seek out-of-state licensure. This flexibility may be especially important in states that share health care delivery markets with neighboring states. Here the flexibility suggested the potential to reduce travel burdens for patients and health care practitioners.

A few findings were unexpected and worth noting. Our study revealed that there were two main uses of the temporary licenses: nurses and respiratory care therapists who came into New Jersey to help with COVID-19-related hospital care during the pandemic, and physicians and mental health providers who provided telehealth across state lines for COVID-19 and non-COVID-19 patients. How the New Jersey program was used thus differed by practitioner type. We also found that 29 percent of license-using respondents provided non-COVID-19 care. Although the program was designed as part of the COVID-19 response, it also expanded access to non-COVID-19 care. These findings should be considered in any future licensure reform, as they demonstrate how a single policy or program affects practitioners differently, particularly those who need to deliver care in person versus those who can use telehealth. To increase understanding of the impact of emergency licensure, including the benefits and costs associated with lifting licensing restrictions, we encourage more study

This unplanned experiment demonstrates the importance of regulatory flexibility enabling rapid response in an emergency.

of state emergency licensure programs, using findings from this study as a framework and conducting repeated surveys and interviews, where possible.

As of June 1, 2022, New Jersey temporary licenses for physicians, nurses, mental health providers, and respiratory care therapists remained active. However, temporary licenses for other practitioner types expired June 30, 2021. A New Jersey plenary (that is, regular) license is required for continued care provision, although it is unclear how many temporary licensees are obtaining plenary licensure. The extent to which temporary license holders convert to plenary licenses (in states offering such an option) is another area of interest for policy analysis.

In addition, New Jersey established other temporary health care workforce provisions, including programs for temporary emergency graduate licensure, retiree license reactivation, and federally deployed providers.^{8,9} The New Jersey Board of Nursing also partially implemented the Nursing Licensure Compact in March 2020, which enabled nurses residing in compact states who held an active multistate license to practice in

New Jersey. The Nursing Licensure Compact was fully implemented in New Jersey November 15, 2021.²²

Health care workforce supply remains a challenge in New Jersey and elsewhere. In November 2021 Shereef Elnahal, then president and CEO of University Hospital, a safety-net hospital located in Newark, New Jersey, said, “University Hospital is projecting a 17.5 percent overall turnover rate this year, an all-time high. ...We are very concerned about staffing.”²³ Across the US, pre-pandemic health care workforce shortages²⁴ were exacerbated by COVID-19 because of burn-out, attrition, and early retirement.²⁵ A recent report suggests that current workforce pipelines will not meet market needs.²⁶ Licensure policy may simultaneously secure public safety and support health care access goals, especially as telehealth uptake increases for services that do not require physical proximity. However, because such access gaps are common in other states as well, enabling out-of-state practitioners to work in one state can cause supply problems in others. The zero-sum nature of interstate licensure may limit its value as a solution for addressing access gaps and suggests the need for further labor-market evaluation of health care provider supply, using a national lens.

Conclusion

Temporary licensure of out-of-state practitioners, along with telehealth waivers, may be a valuable, short-term solution to mitigate health care workforce shortages during public health emergencies. Other provisions, such as temporary emergency graduate licensure, retiree license reactivation, interstate licensure compacts, and federally deployed providers (for example, the National Guard), may also be worth examining for their impacts on the health care workforce supply. We urge further study and discussion of state professional licensure programs to inform emergency and nonemergency health care workforce policy development. ■

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Attorney General. The authors thank colleagues at the Division of Consumer Affairs and Rutgers University for initial review of the survey instrument and findings, as well as survey participants for sharing their experiences using temporary New Jersey licenses.

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