A CALL FOR CHANGE

Removing Barriers to Telehealth Mental Health Treatment for College Students

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Biography

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Disclosure: Dr. Conrad serves as an independent consultant for Physicians Realty Trust and Mind & Match.

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About Ruderman Family Foundation

The Ruderman Family Foundation is an internationally recognized organization that works to end the stigma associated with mental health. The Foundation does this by identifying gaps in mental health resources and programs within the high school and higher education communities as well as by organizing other local and national programming and initiatives that raise greater awareness around the stigma.

The Ruderman Family Foundation believes that inclusion and understanding of all people is essential to a fair and flourishing community and imposes these values within its leadership and funding. For more information, please visit www.rudermanfoundation.org. @rudermanfamilyfoundation, @rudermandfdn, @therudermanfamilyfoundation

For additional mental health resources see https://rudermanfoundation.org/mental-health/

Call the 988 Lifeline 24/7 for confidential support if you or someone you know is in suicidal crisis or mental health-related distress.

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Executive Summary

There are many obstacles to mental health care associated with regulatory restrictions on clinicians delivering services across state lines via audio, video, or other telehealth tools—limitations that adversely affect young people who need a doctor's support while away from their home state for college, work, and travel. The Ruderman Family Foundation commissioned this white paper to examine these barriers to care and propose policy change grounded in research and a thorough understanding of how current medical licensing restrictions limit access to and continuity of care for young adults.

The aim of this project was to assess the scope of the problem and recommend improvements to regulatory practices, insurance policies, health-care plans, clinician knowledge, and patient awareness. Our pioneering research included an inventory of state medical licensing regulations and relevant exemptions. This was followed by a "secret shopper" study to gauge availability of psychiatric treatment for college students and whether existing state medical licensing exemptions meaningfully improve access to care. This research reveals that state telehealth registries and state licensing exemptions are not effective in increasing continuity of care across state lines and make the case for sweeping action.

There could hardly be a worse time for such unnecessary barriers. For decades, the mental health of college students has been declining, and mental health treatment resources have been strained.[1,2] These challenges dramatically worsened during the first few months of the pandemic, when one in four young adults seriously considered suicide and more than half said that they didn't know how to access mental health treatment.[3–5]

To facilitate continuity of care during the pandemic, many restrictions on telehealth, medical licensure, and medical treatment over state lines were loosened, but with the expiration of the public health emergency, these restrictions are progressively taking effect again.[6,7] Restrictions on state medical licensing are uniquely problematic for young adults. The United States has 71 medical boards that each control medical licensure in one geographical region, typically a state or territory. During a telehealth encounter, the care is provided within the jurisdiction of the medical board covering the location of the patient (not the doctor), requiring doctors to have a medical license in the state where the patient is located during each session. The inherent problem with this requirement was amplified during the pandemic, when students stuck at home or in dorms couldn't get services from their doctors out of state. In response, states used emergency authority to relax medical licensing requirements by granting emergency licenses, telehealth registrations, and exemptions. Many of those efforts to expand telehealth and loosen requirements are now in peril. To express their concern, over 230 organizations signed a letter to state governors to maintain and expand licensure flexibilities created during the pandemic.[8] Additionally, three in four doctors support abolishing state medical licenses in favor of a single federal license.[9]

Restrictions on state medical licensing are uniquely problematic for young adults.

Expansion of both mental health treatment and telehealth generally receives bipartisan support.[10,11] The main opposition to loos-

Approximately half a million college students lose access to psychiatric treatment each year due to unnecessary barriers related to state medical licensure.

Three million students attend college outside of their home state, and many are not able to see their existing doctors while away at school, putting them at risk with limited and lack of care.

ening medical licensing restrictions lies in state medical boards and state medical associations. However, even those organizations support so-called commonsense exemptions but emphasize that the exemptions should be implemented at the state level rather than at the federal level.[12,13] Commonsense exemptions include continuity of care for patients who are traveling for short periods of time. Most states do have exemptions that permit physicians to practice telehealth across state lines in specific circumstances, but these exemptions are often inconsistent across states, ambiguously written, confusing to doctors, and cloaked in bureaucracy. The effectiveness of state licensing exemptions has never been studied.

This paper provides a path forward through the tangled landscape of overlapping, inconsistent, and antiquated policies; self-interested regulations; outdated and misleading "ghost networks"; problematic incentives; and gaps in understanding among clinicians, insurers, licensing bodies, and others. This environment is driving doctors out of insurance plans, confusing patients, wasting the time of quality-control bodies, and delaying or denying access to care at a time of peak need. While there are many pressing related questions, such as problems with access among patients with Medicaid, regulation of telehealth startups, and access to reproductive health care across state lines, this paper is focused solely on psychiatric treatment for geographically mobile college students.

The time has come for productive, sustainable solutions. The following approaches may be effective in expanding access and facilitating continuity of care for young adults:

Instituting a national continuity of care exemption for young adults until age 26.
This would ensure that college-age students who travel across state lines for limited periods of time for academic, professional, or travel opportunities are guaranteed access to their clinicians. Congress passed a similar exemption for sports teams traveling across state lines.

Challenging state medical board interference with an established doctor-patient relationship as an anticompetitive practice that causes injury to consumers.
The Federal Trade Commission (FTC) has already gone on record in favor of less restrictive alternatives to individual state licensing requirements.

Requiring health plans to reimburse patient encounters across state lines to protect continuity of care for young adults until age 26.
Recent amendments to the Employee Retirement Income Security Act of 1974 (ERISA) have already expanded protections for events such as job loss as well as access to mental health services under the Mental Health Parity Act.

Issuing a mandate to recognize commonsense exemptions and protect the continuity of care until age 26.
Historically, mandates by the Centers for Medicare & Medicaid Services (CMS) have influenced norms in the provision of care and accordingly paved the way for providers to follow. A working group in Congress could determine which federal agencies have the authority to enforce commonsense exemptions for specific circumstances, such as rare diseases, on a national level. If the working group concludes that no federal agency currently has such authority, a committee could determine the best-suited agency and draft legislation that designates responsibility for enacting national commonsense exemptions.

Expanding health-plan provider networks and combating ghost networks.
The Biden administration recently announced a proposal that would make it easier to access in-network mental health care by putting pressure on health plans to expand their provider networks and out-of-network coverage.

PART
ONE

A National Crisis of Student Mental Health

While the mental health of college students has declined, treatment resources have become increasingly strained. During the pandemic, both trends dramatically worsened, and restrictions designed to curb the spread of COVID-19 exacerbated existing challenges.[2,3] Even as students have regained much of their pre-pandemic freedoms and coping strategies, mental health concerns among young adults persist at higher rates.

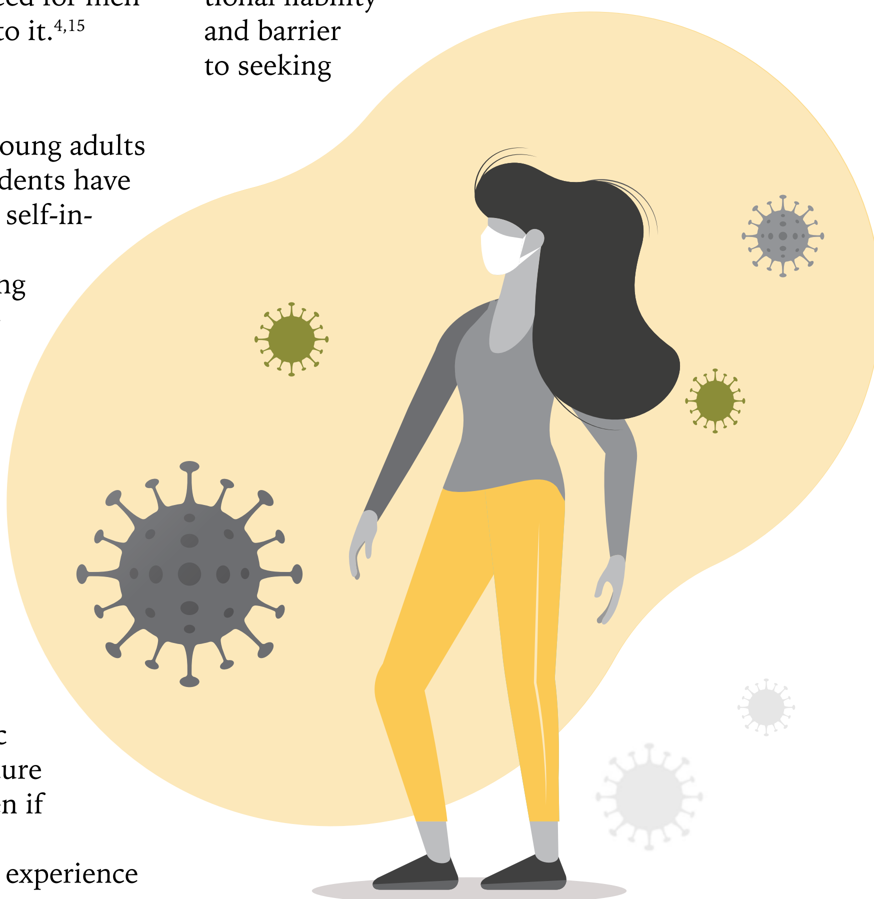
As of June 2023, 47% of young people ages 18 to 29 were experiencing symptoms of anxiety or depression.[17] Compounding the crisis, the deficit of mental health treatment access is significantly higher among young adults than any other age group and almost twice the national average of 11%.[17] Sixty-one percent of young adults say that they face obstacles to treatment, with 20% reporting a need for mental health treatment but no access to it.[4,15]

A Cohort at Risk

The acute mental health needs of young adults is not new; for decades, college students have had increasing anxiety, depression, self-injury, and suicide, which is now the second leading cause of death among that age group.[1,18] Factors that contribute to this rising rate of mental health problems may include increasing societal expectations for academic achievement, financial stressors, social media use, and more students with severe mental illness attending college.[19,20] Severe mental illness and psychotic disorders typically emerge during late adolescence and early adulthood, and illness severity, academic and professional outcomes, premature mortality, and risk of suicide worsen if left untreated.[21,22]

Certain vulnerable populations experience higher rates of mental health symptoms and lower rates of access to mental health treatment. Nearly half of LGBTQ youth seriously considered attempting suicide in 2022.[23,24] One-half of bisexual college students and more than a third of trans students report a prior suicide attempt.[20,25] LGBTQ youth of color report higher rates of suicidal thoughts and depression and lower rates of access to mental health treatment than their white peers.[26] Other barriers to treatment include poverty, living in rural areas, and limited English proficiency.[27–29]

Students are legally granted the rights to privacy and medical decision-making when they turn 18, although their maturity may not be on par with those responsibilities, which can create an additional liability and barrier to seeking



Establishing care with a doctor, mental health provider, or psychiatrist is often time-consuming, frustrating, and burdensome.

mental health support.[30] Establishing care with a doctor, mental health provider, or psychiatrist is often time-consuming, frustrating, and burdensome. College students who are still developing organizational, time management, and planning skills may not be able to successfully navigate confusing processes and systems.[31,32]

Severe mental health symptoms may further interfere with their ability to pursue access to care. Students with poor motivation due to depression may have trouble with the effort required to gather information about their health insurance and make many phone calls. Students with social anxiety may avoid the potential awkwardness of interacting with new people. Students with untreated ADHD may lose information or forget tasks. Yet as this paper and research will attest, even high-functioning students with private health insurance or the financial resources to pay out-of-network costs face challenges finding psychiatric treatment due to the limited number of psychiatrists accepting new patients.

Impact of COVID-19 on College Students

In the early months of the pandemic, college students reported a greater increase in anxiety, depression, and suicidality than any other age group.[33] CDC data showed that among people ages 18 to 24, 63% reported depression or anxiety, 25% reported increased substance use, and 25% seriously considered suicide during June 2020.

College students in particular were affected by losses of experiences, milestones, relationships, and community, and their most common coping strategies—socializing and exercise—were restricted.[34,35] The trauma of campus evacuation, sometimes involving losing personal belongings or being forced out of college dormitories without anywhere else to stay, was associated with worsening mental health.[36] During a stage of development when feelings of acceptance and belonging are critical to emotional well-being, adolescents and young adults experienced acute loneliness and isolation.[37,38]

The quality of learning deteriorated as well. Schools, professors, and students struggled to adjust to online modalities, and college students experienced a higher risk of long-term educational and professional impact because these interruptions occurred during a critical time in their trajectory.[39] Although the restrictions associated with the pandemic have been lifted, mental health symptoms persist: as of June 2023, 47% of young people ages 18 to 29 were experiencing symptoms of anxiety or depression.[17] Compounding the crisis, the deficit of mental health treatment access is significantly higher among young adults than any other age group. While 11% of all adults report that they need mental health treatment but don't receive it, this is reported by 20% of young adults 18 to 29 years old.[17] The systems that should be supporting this age group seem to be buckling under the pressure.

PART
TWO

Barriers to Care

In addition to the increasing demand for mental health services and the shortage of providers facing all patients, young adults have more difficulty accessing treatment on and off campus. The array of obstacles to care include frequent relocation, changes in insurance, the lack of or limitations of school counseling centers, disconnects between pediatric and adult systems, maturity level, and the challenges of learning to navigate complex health-care systems.[31,32] In addition, because most health insurance plans have a significant shortage of providers, scheduling an appointment with a mental health provider often requires five phone calls, while scheduling an appointment with a psychiatrist often requires nearly twice that number.[40–42] With limited access and resources, college students in need of mental health care face numerous hurdles.

Inadequate Campus Resources

Three in four colleges report that they do not have adequate psychiatric services on campus to meet the needs of their students.[1] The availability of on-campus mental health treatment resources are influenced by many factors, including the college's size and financial resources, the presence of an academic medical center, and the college's location.[2,43] Fifty percent of colleges do not offer any psychiatric services on campus.[1] Students who are not able to continue care with their childhood providers back home or the campus counseling center are left to find a psychiatrist in the community.

When the pandemic began and students were evacuated from campus, the steep rise in mental health demands taxed an already tenuous system, and the existing inadequate resources were further stretched.[1] Campus counseling centers struggled to implement the technology, administrative processes, and other infrastructure required for telehealth treatment. More than 40% of colleges had no information about mental health treatment on their websites during the spring of 2020.[44] During the first few months of the pandemic, 55% of college students reported that they didn't have access to mental health treatment.[45]

Workforce Shortage in Mental Health

The pandemic generated confusion, stress, and uncertainty that affected services across occupations and was acutely felt within healthcare. Personal stressors and lack of childcare exacerbated staffing shortages of mental health treatment providers; 75% of mental health providers are women, who were disproportionately affected by childcare burdens. Additionally, early COVID-19 exposure protocols required staff members to take off prolonged periods after possible exposure, and social distancing and safety requirements created barriers to in-person care as facilities were retrofitted to comply.

The demand for mental health support far exceeds the supply: over half of Americans live in geographic regions with designated shortages of mental health providers.[46] The current shortage of psychiatrists lies between 15,000 and 30,000; more than 60% of practicing psychiatrists are over age 55, and it is anticipated that many will be headed toward reducing their clinical work or retirement in the next decade.[47,48] The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that the United States needs to quadruple its current number of mental health providers to meet patients' needs.[49] Given the fractured systems, vicarious trauma, and emotional exhaustion, burnout has become rampant among mental health providers.[50] Some research has found that more mental health providers are leaving the field than entering it.[51]

Primary Care Restrictions

Primary care requirements are a hurdle to psychiatric treatment, as guidelines recommend—and some health-care systems require—that

those suffering from mental health symptoms first seek treatment from their primary care doctor. Yet fewer than 20% of college students visit a primary care doctor while at college because most college students are physically healthy, and intermittent contact with their pediatrician is often sufficient for their medical needs.[52] Primary care providers may provide a referral to psychotherapy, prescribe a medication, or both. Patients whose symptoms are severe or don't improve, however, should be treated by a psychiatrist.[40,53,54] The use of medication for mental health symptoms is rapidly rising. More than 20% of young adults ages 18 to 29 are prescribed psychiatric medications.[4]

Insurance Plans and Ghost Networks

Insurance plans create excessive burdens for both providers and patients. Health plan participation is declining among psychiatrists and other mental health professionals due to administrative challenges, inadequate reimbursement rates, and delays in reimbursement.[55–57] Although health plans are required to have enough clinicians within every specialty to ensure that appropriate care is available for their members, inaccuracies in health plan provider directories abound and conceal deficient provider networks. Known as "ghost networks," these inaccurate listings include providers who are out of network, not accepting patients, unavailable, retired, or even dead.[58]

While inaccurate health plan directories are pervasive across specialties and negatively affect patients seeking different types of medical care, they are uniquely problematic within mental health: more than half of the mental health providers listed in health insurance directories are "ghosts," and 20%–30% of the phone numbers for mental health providers are incorrect or non-working numbers.[41,42,59] One study found that 60% of mental health providers in a Medicaid directory do not see Medicaid patients.[60] Recent studies found that only one in five phone calls to mental health providers in the Medicare directory and one in 10 phone calls to child psychiatrists in the Blue Cross Blue Shield provider directory resulted in scheduling appointments.[41,42] Only one in 20 phone calls to child psychiatrists result in scheduling an appointment if the patient has Medicaid.[41] These inadequate provider networks and directories create significant delays in mental health treatment and fuel a sense of hopelessness among patients seeking care.[40,42,61]

Telehealth Past and Present

Prior to COVID-19, most hospital systems offered limited telehealth services, and these services were growing slowly.[66,67] Radiology, cardiology, and psychiatry specialties were the most likely fields to integrate some form of telehealth, although radiology and cardiology were primarily using telehealth for interpretation of diagnostic testing rather than direct patient encounters.[67] Reimbursement was variable and often inadequate.[68–71]

Telehealth is often promoted to increase access, particularly for patients in rural, impoverished, and other underserved areas, and patients in these areas do use telehealth at a higher rate than patients elsewhere.[11,72] However, some data suggest that the most underserved patients may not substantially benefit from telehealth due to problems with internet access, hardware access, technology, and other limited resources related to poverty and housing instability.[73]

Currently, telehealth is used more than twice as frequently in mental health treatment as compared to any other type of health care.[74] Most psychiatrists have a positive attitude toward telehealth.[75,76]

Treatment Expense

Because of under-resourced college counseling centers, referral barriers, and pervasive problems with health plan provider networks, many patients seek treatment from out-of-network mental health providers and psychiatrists.[55,56] This requires that patients pay for the care directly and submit documentation to their health insurance plan with hopes of receiving reimbursement.[40,62] Reimbursement is unpredictable, and the cost of out-of-network care is significantly higher.[63–65] This shifts considerable financial risk onto patients and families seeking care and often becomes a deterrent to care—costly in more ways than one.[40]

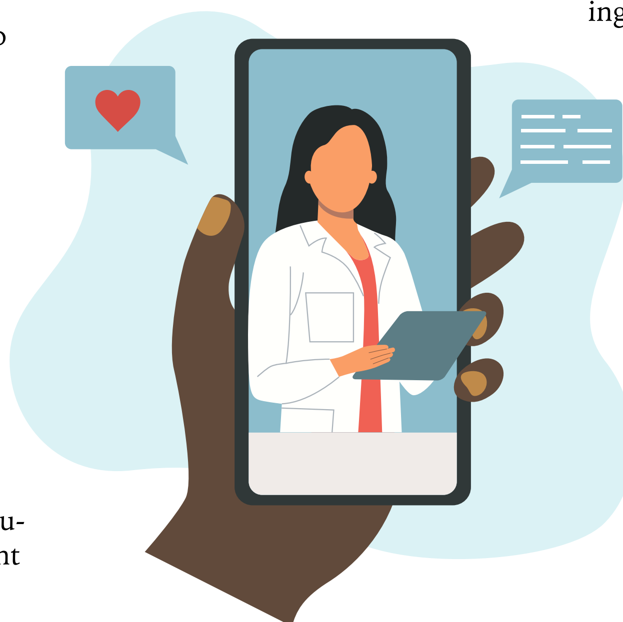
PART
THREE

A Path Forward: Telehealth Opportunities and Obstacles

Telehealth is a method to increase access to mental health and psychiatric treatment, and more than one-third of all telehealth encounters are for mental health.[71,74,77] Research demonstrates the safety, efficacy, and cost-effectiveness of psychiatric treatment via both video and phone.[77,78] At the beginning of the pandemic, insurance plans offered limited or no insurance coverage for telehealth. Questions about the legality of providing telehealth across state lines for students who relocated after campus evacuation further compounded the confusion.[79]

Expansion of telehealth was immediately prioritized at the start of the pandemic. In addition to improving access, telehealth minimized the need for in-person encounters that presented logistical barriers and exposure risks to both patients and clinicians. Medicare, Medicaid, and private insurers soon expanded coverage for telehealth encounters.[80] The federal requirements for in-person appointments for the prescription of controlled substances, which include medications that are commonly used to treat ADHD, anxiety, and substance use disorders, were waived. Eventually, parity laws required health plans to provide the same reimbursement rates for telehealth encounters as in-person visits. By 2022, telehealth services increased to 15 times their pre-pandemic level.[81]

While relocation necessitated by dormitory evacuations is no longer driving the need for telehealth for college students, students' frequent moves between their childhood homes, college campuses, study abroad programs, and summer internships make telehealth a desirable if not necessary option for young adults. Restrictions on practicing medicine across state lines, however, still interfere with continuity of mental health care, and the resulting loss of access to treatment for this increasingly vulnerable population creates a significant risk of harm.



The Limitations of State Medical Licensing

Seventy-one distinct medical boards oversee medical licensing in the US states, territories, and Washington, DC.[13] These medical boards are responsible for medical licensing, investigating complaints, and disciplining physicians. Each state has a medical licensing application process and requirements for maintaining a license, including annual fees and continuing medical education. Obtaining each medical license may be onerous, lengthy, and expensive. The fee for one state medical license can be more than $1,000, and the process can take more than six months.

Medical care and provider licensing are overseen by state agencies and medical boards in the state where the patient, not the provider, is geographically located at the time of the encounter. Doctors treating college students may be required to have a medical license in any state where the student travels. Additionally, a controlled-substance license may be required to prescribe

certain medications used to treat anxiety and ADHD, both common among the college student age group.

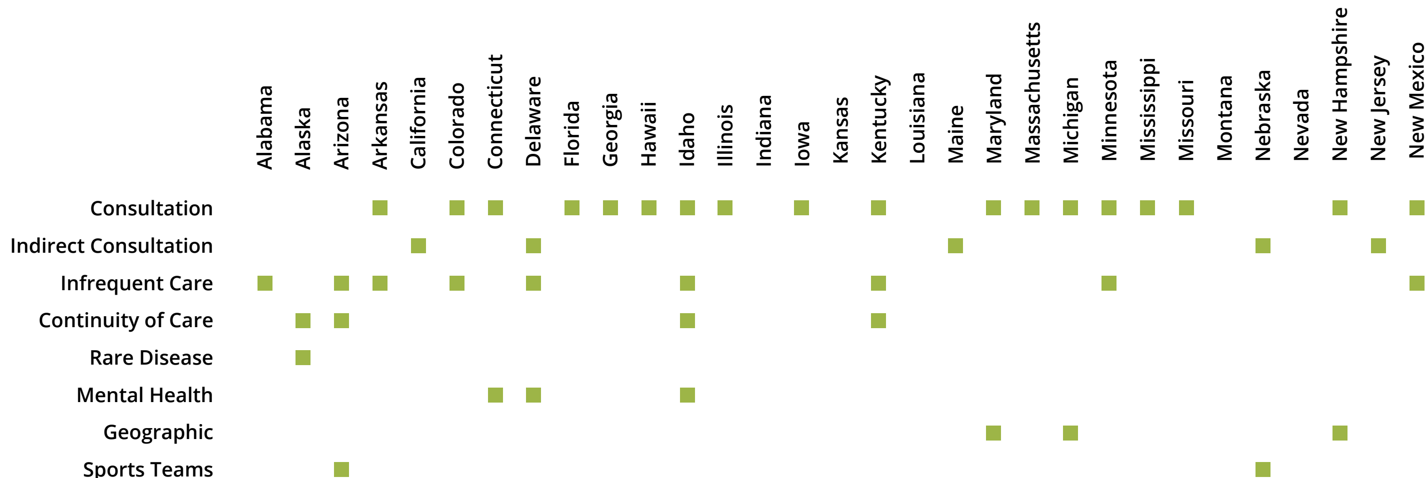
More than 40 states have a medical licensing exemption that could allow access to care across state lines for college students.

While physicians overwhelmingly prefer that national licensing replace state medical board licensing, such a change is unlikely in the foreseeable future due to opposition by state medical boards and state medical associations given the reliance on the revenue from medical licensing fees.[82,83] The primary exception to state medical licensing requirements is physicians who work at Veterans Affairs (VA) hospitals, as these physicians are able to practice at any VA hospital as long as they have one valid unrestricted medical license from one of the 71 medical licensing boards.[84] Additionally, a 2018 federal law created an exemption for physicians who are traveling with a sports team.[85]

Barriers related to state medical licensure were rapidly removed at the start of the pandemic to facilitate access to medical care.[7,71] Loosening medical licensing requirements was critical in order to allow physicians to move across state lines to ameliorate physician shortages or practice telehealth across state lines to improve access and continuity of care.[7,86] Many medical boards offered emergency medical licenses, and governors issued executive orders that allowed physicians with active medical licenses in other states to practice within their state.[79,87]

Recently, public health emergency policies that expanded patients' access to telemedicine, allowed doctors to practice across state lines, and waived the requirements for in-person encounters began expiring.[88] While there is a long precedent of physicians providing routine continuity of care to patients who crossed state lines for a short period of time, such as refilling a prescription for a patient who forgot to pack their medication for vacation, the legality of this practice is called into question amid the expiring exemptions.[6]

These policies have resulted in widespread confusion about caring for patients across state lines and led to pursuing unreasonable loopholes. Many large health-care systems require that patients enter the state for the duration of their telehealth visit, and it has become



STATE EXEMPTIONS TO MEDICAL LICENSING REQUIREMENTS

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa
Consultation				■		■	■		■	■	■	■	■		■
Indirect Consultation					■			■							
Infrequent Care	■		■	■		■		■				■			
Continuity of Care		■	■									■			
Rare Disease		■													
Mental Health							■	■				■			
Geographic															
Sports Teams			■												

	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico
Consultation		■			■	■	■	■	■	■				■		■
Indirect Consultation				■								■			■	
Infrequent Care		■						■								■
Continuity of Care		■														
Rare Disease																
Mental Health																
Geographic					■		■							■		
Sports Teams												■				

commonplace for patients to drive across state lines to sit in a parking lot during a telehealth visit.[6,86] Two states have gone as far as criminalizing the provision of patient care via telehealth without an active medical license in the state. However, most states do have a state telehealth registry or a state medical licensing exemption that might permit a physician in another state to treat a college student, although they appear poorly understood and underutilized.[6,7,11,71]

State Exemptions

The Federation of State Medical Boards (FSMB), the American Medical Association (AMA), and the Association of American Medical Colleges (AAMC), among many other influential professional organizations, support commonsense exemptions for circumstances such as continuity of care for patients who are traveling for short periods of time. However, the FSMB and the AMA emphasize that the commonsense exemptions should be implemented at the state level by existing medical boards rather than at the federal level.[12,13]

Most states have exemptions that permit physicians to practice telehealth across state lines in specific circumstances, although these exemptions have wide variability and often contain confusing language. Certain exemptions apply only to physicians who hold a DO and exclude those who hold an MD.

New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	Washington, DC	West Virginia	Wisconsin	Wyoming
	■		■		■									■		■		■	■
■			■	■						■	■	■	■		■		■		
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STATES WITH A TELEHEALTH REGISTRY

Arizona	Kansas	Oregon
Delaware	Louisiana	Vermont
Florida	Minnesota	West Virginia
Georgia	New Mexico	

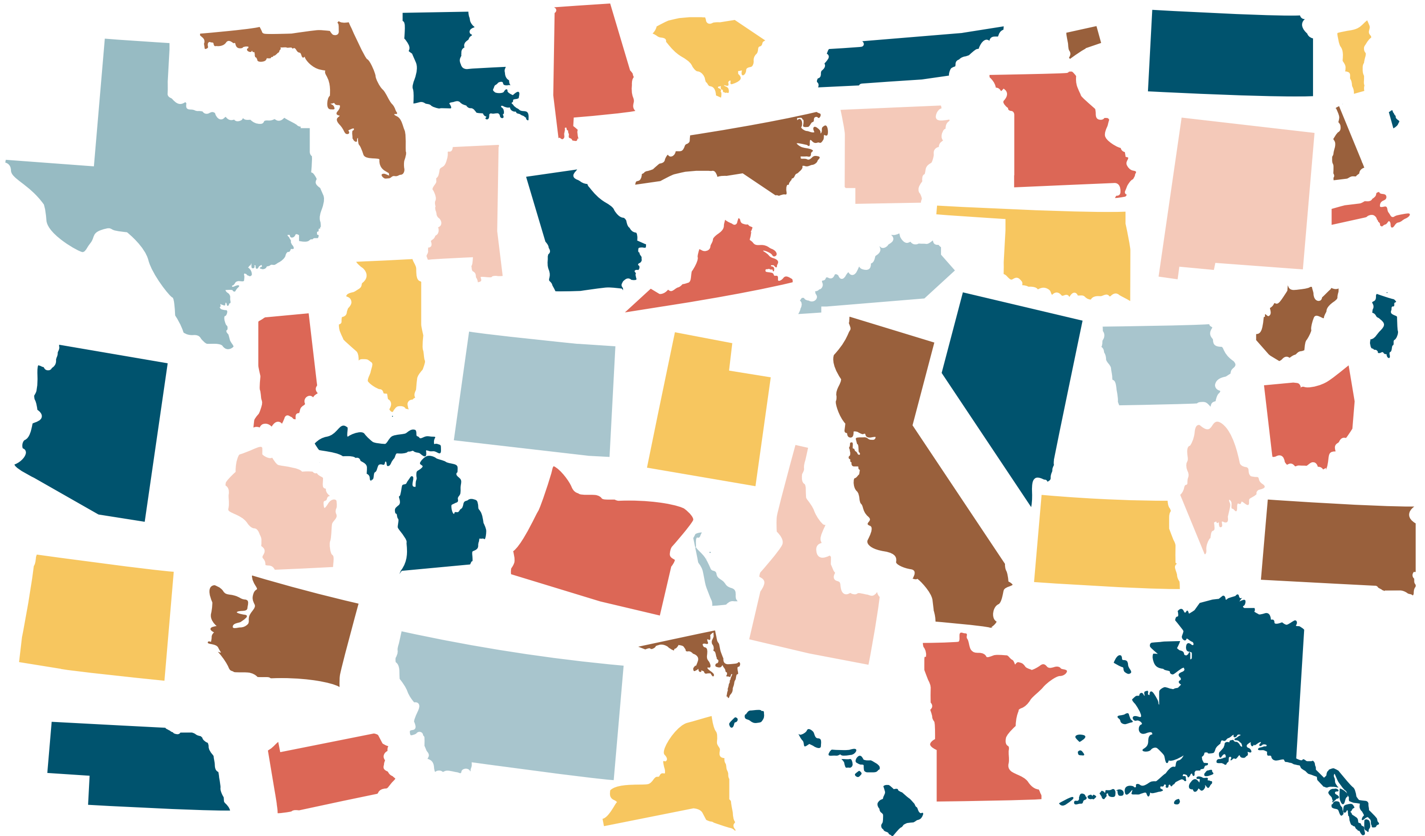
In addition, exemptions for mental health professionals do not always specify whether the exemptions apply to physicians treating mental health conditions. Given the complexity of these exemptions, it is unclear if they are increasing physicians' willingness to see patients across state lines and thus increasing patients' access to care.

State Telehealth Registries

States are increasingly creating pathways for physicians with an active medical license in another state to care for patients via telehealth only without obtaining a full medical license. These are variously referred to as a telehealth registration, certificate, or license. The number of registries is rapidly expanding. The laws overseeing registries specify that the physician can only provide care via telehealth in that state, not provide in-person treatment. Some state telehealth registries are managed by a government agency rather than the state's medical board. A few states have telehealth registries that are available to physicians with a DO but not to physicians with an MD. While physicians are required to pay an initial application fee and annual fees, state-specific continuing medical education is not required. The telehealth registration fees are lower than the full medical licensing fees, ranging from $150 in Florida to $500 in Arizona, whereas the full medical licensing fees are $955 and $1,000, respectively.

Regional Licensing Reciprocity

Regional licensing reciprocity agreements could allow a physician licensed in one state to practice medicine in a small group of adjacent states. Regional reciprocity agreements have been attempted in multiple regions of the United States, but they have all failed. Most



recently, there was an effort in 2022 to create a reciprocity agreement between the District of Columbia, Maryland, and Virginia, designated the DMV Medical Excellence Zone.[7,89,90] Such an agreement would have allowed physicians with a full active medical license in any one of these regions/states to practice in the others without obtaining additional medical licenses. Unfortunately, this effort failed in the state legislatures, likely due to opposition from state medical licensing boards.

Uniform Telehealth Act

The Uniform Law Commission proposed the Uniform Telehealth Act in 2022 as model legislation for states with the goal of decreasing barriers for physicians providing telehealth to patients across state lines. The Uniform Telehealth Act proposes that individual states pass laws creating a state telehealth registry for out-of-state physicians who hold an active full medical license in another state. This legislation differs from a federal or multi-state licensing program because state medical boards would retain control over reviewing applications from each physician and taking disciplinary action. The Uniform Telehealth Act proposes that each state create a telehealth registry where physicians licensed in other states can apply for a certification to treat patients in that state via telehealth only. This model was based on telehealth registries in Florida and Arizona. Eleven states currently have telehealth registries, but none passed the specific law proposed by the Uniform Law Commission. The awareness and utilization of existing state telehealth registries is unclear.

Federation of State Medical Boards and the Interstate Medical Licensure Compact

In 2017, the FSMB developed the Interstate Medical Licensure Compact (IMLC) to increase the efficiency of obtaining medical licenses and decrease obstacles for physicians who want to practice medicine in multiple states, while respecting the autonomy of the state medical boards.[91,92] States that participate in the IMLC share information about actively licensed physicians to expedite the pathway to obtaining additional licenses in other states. However, physicians who are seeking medical licenses through the IMLC still face significant administrative and financial burdens. Physi-

cians may spend thousands of dollars for both initial licensure and maintenance fees and have spent as much as $90,000 to be licensed in all 50 states.[93,94] While 80% of US physicians are eligible to use the IMLC to obtain licenses in additional states, fewer than 7% have used it. Many other healthcare professions, including psychologists and social workers, have more effective interstate licensing compacts, which lower administrative burdens and fees. A more effective model is a multistate licensing system that issues one license that allows practice in multiple states, as is available to psychologists and social workers.[95,96]

At the Federal Level

Although physicians overwhelmingly support one federal licensing system, even modest attempts at the federal level have been unsuccessful.[97–99] As a result of the political infeasibility of a federal licensing system due to the opposition of state medical licensing boards, most federal legislative proposals supplement, rather than dismantle, state medical licensing boards. However, none of these proposals—despite the facts that they have been introduced in multiple committees by members of both parties, and both mental health and telehealth receive bipartisan support—have made it out of their respective committees for a vote.

Most state laws offer an exemption for consultation, although the criteria may be confusing. Typically, consultation exemptions specify that they allow an out-of-state specialist to practice in collaboration with a physician licensed in the patient's state. Consultation, infrequent care, and continuity of care exemptions have significant overlap. The language in these exemptions is often ambiguous and inconsistent across states. A few states specify that out-of-state physicians can only provide consultation without payment or that treatment must be prescribed by the physician licensed in the state. Although multiple states define the limit for the infrequent exemption as 10 encounters per year, Rhode Island has an out-of-state telehealth consultation that permits only one encounter.

Eight states have exemptions for geographic proximity that permit physicians licensed in adjacent states to practice medicine in areas close to the state's borders. The state of Washington allows patients in certain parts of the state to be seen by physicians in Canada.

Five states recently created exemptions for mental health treatment. These exemptions may or may not specify which of the 20+ types of mental health providers are covered under their exemption. For example, Connecticut's exemption specifically includes physicians, while South Carolina's exemption specifically excludes physicians. Idaho does not define "mental or behavioral health provider." The language about providers in Delaware's exemption is indiscernible to this author.

Although physicians overwhelmingly support one federal licensing system, even modest attempts at the federal level have been unsuccessful.

Most states currently have at least one medical licensing exemption that may be relevant to college students and could facilitate continuity of care for students who spend short periods of time in that state. However, the state laws are often confusing, and the exemptions are inconsistent from state to state, requiring significant investment of physicians to research each state's specific exemptions.

PART
FOUR

Pioneering Research to Inform Change ("Secret Shopper" Study)

This paper focuses on US college students' access to psychiatric treatment. Our "secret shopper" study simulated a scenario in which a college student wanted to schedule an appointment with a psychiatrist in their hometown and subsequently expressed the desire for continuity of care when they returned to college in another state in the fall.

The supposed student attends school in one of seven states with a telehealth registry or licensing exemptions that could allow continuity of care while the student is away at college. The scope of our study was restricted to psychiatrists, as each of the 20+ types of mental health clinicians have separate licensing requirements, laws, and regulatory boards. We examined psychiatrists' responsiveness to emails and calls from potential new patients, health insurance plan participation, availability, and attitudes toward treating a student attending college in another state. We also gathered data regarding response rates, acceptance of new patients, time interval from initial outreach to first available appointment, out-of-network fees, mode of service delivery (virtual, in-person, or both), accuracy of the advertised information, and overall patient experience.

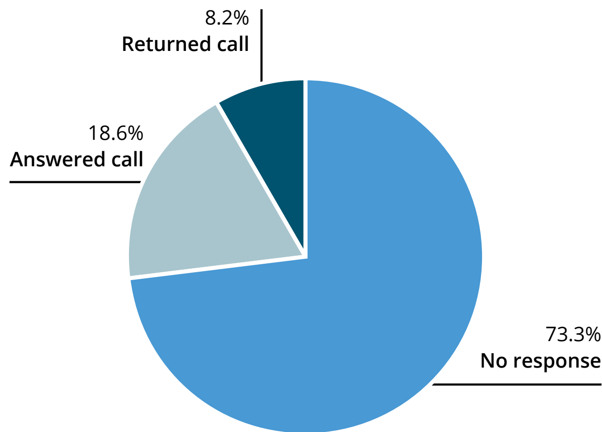
COLLEGE STATE	RELEVANT EXEMPTIONS
Alabama	Infrequent care exemption
Delaware	Telehealth registration; infrequent and mental health exemptions
Florida	Telehealth registration
Idaho	Consultation, infrequent, continuity of care, and mental health exemptions
New Hampshire	Consultation and geographic exemption
Oregon	Telehealth registration; infrequent and continuity of care exemptions
Virginia	Consultation, continuity of care, and mental health exemptions

Additionally, we investigated the effectiveness of current state telehealth registries and state licensing exemptions in increasing access to continuity of psychiatric care for college students. We assessed psychiatrists' knowledge of existing state licensing exemptions, their willingness to learn about state licensing exemptions, and their willingness to care for a patient across state lines if permitted by state licensing exemptions.

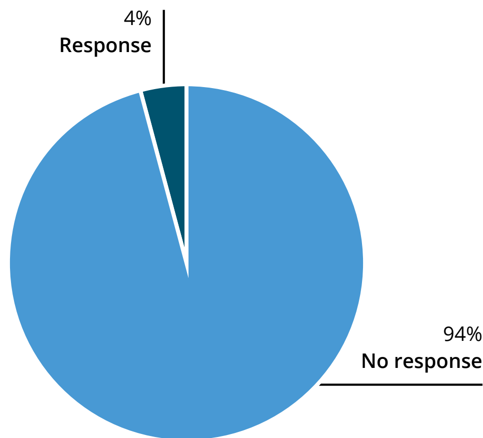
Ninety-five percent of psychiatrists were unaware that most states have licensing exemptions.

Consistent with recent research, more than nine phone calls were required to find one psychiatrist who was currently accepting patients and covered by any health insurance plan.[41] Ninety-five percent of psychiatrists were unaware that most states have licensing exemptions. Only 5% of psychiatrists were already aware of exemptions, and 30% of psychiatrists were willing to care for the student regardless of whether it was permitted by licensure laws or exemptions. Thirty-five percent were unaware of exemptions and unwilling to learn about exemptions. Another 30% expressed a willingness to learn about licensing exemptions, but 30% of those initially expressed willingness to learn about exemptions eventually decided that they would not treat this college student even if permitted by licensing exemptions.

PSYCHIATRIST PHONE CALL RESPONSE



PSYCHIATRIST EMAIL RESPONSE



Outreach to Psychiatrists

During May and June 2023, we emailed 901 psychiatrists who advertised in *Psychology Today* and practiced in one of 10 states: Alabama, Arizona, California, Georgia, Idaho, Louisiana, Massachusetts, Mississippi, New York, and Texas. Among the psychiatrists we initially messaged, 55% identified as female, 21% indicated proficiency in more than one language, and the average years of experience was 19.

Only 36 (4%) of the 901 psychiatrists responded to our first email, and 100 (19%) of 539 psychiatrists answered our first phone call. We ultimately established contact with 282 (31%) psychiatrists after multiple emails and calls.

We encountered several barriers to contacting psychiatrists, including spam blockers, incorrect phone numbers, and nonfunctional numbers. We were often unable to discern exactly which of these problems caused specific calls to fail. In order to circumvent the challenges of spam blockers, we employed a multifaceted approach involving the utilization of multiple phone lines and phone services. Further, we used provider databases from state medical boards, health insurance plans, and CMS to find additional contact information for providers. As recent research has demonstrated, health plan provider directories and other databases are riddled with inconsistencies and errors regarding provider contact information.[100]

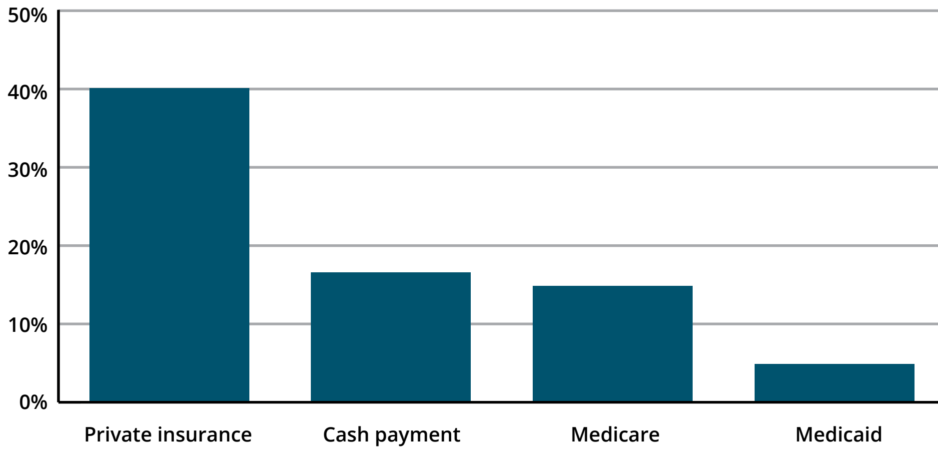
Response: Availability, Payment, Willingness to Provide Care

We ultimately identified 143 psychiatrists who were accepting new patients. Of those, 61 (43%) were treating patients only via telehealth and 4 (3%) were treating patients only in person, while the remaining 78 (55%) were treating patients both via telehealth and in person.

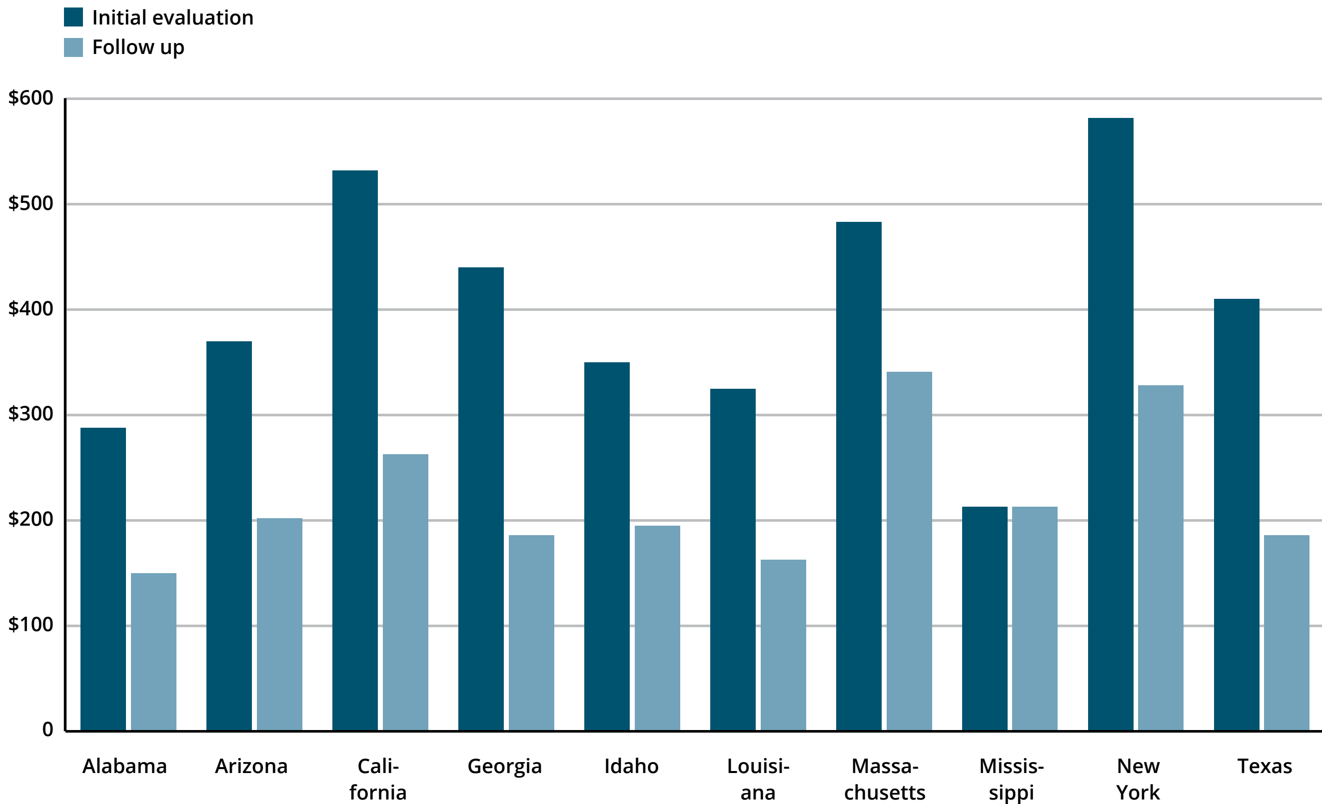
On average, it took nine phone calls to reach one psychiatrist who was accepting new patients and covered by any health insurance plan; 77 phone calls to reach one psychiatrist who was accepting new patients and covered by Medicaid; and 108 phone calls to reach one psychiatrist who was accepting new patients, was covered by Medicaid, and offered appointments in person. These findings underscore the daunting challenges associated with just making initial contact with a psychiatrist and are consistent with recent research.[41,101]

Among the 901 psychiatrists advertising in Psychology Today, 435 (48%) were in-network with any health insurance plan, 121 (13%) were in-network with Medicare, and 40 (4%) were in-network with Medicaid. The average out-of-pocket cost for an initial appointment

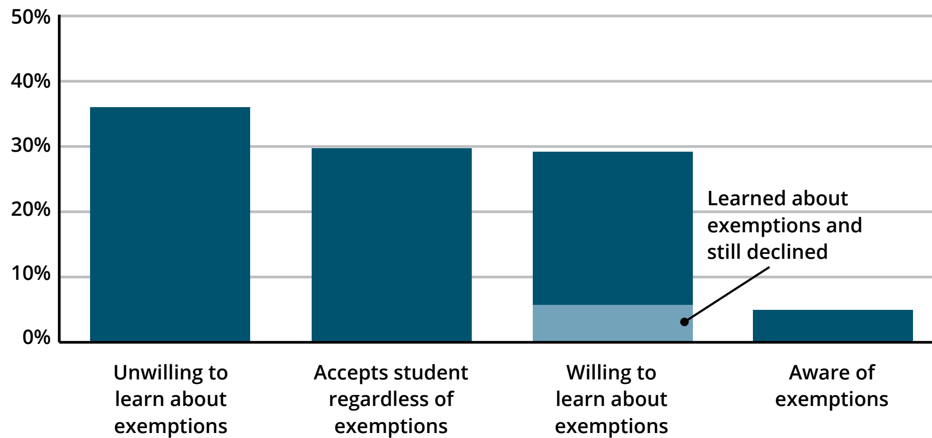
PSYCHIATRISTS' PAYMENT OPTIONS



RATES FOR OUT-OF-NETWORK PSYCHIATRISTS



PSYCHIATRISTS' ATTITUDES TO SEEING COLLEGE STUDENTS ACROSS STATE LINES



was $487, and the cost of a follow-up appointment was $254. The out-of-pocket cost for an initial appointment ranged from $150 to $2,000, and the out-of-pocket cost for a follow-up appointment ranged from $100 to $750.

Of the 143 psychiatrists who responded to our outreach and were accepting new patients, 43 (30%) expressed a willingness to provide care for college students who attend college in another state regardless of that state's laws and exemptions. Only 7 (5%) demonstrated knowledge that state-based licensing exemptions allow telehealth across state lines under certain circumstances. Forty-two (29%) of the psychiatrists initially expressed a willingness to learn about these exemptions following some persuasion, while 51 (36%) expressed an unwillingness to learn about state licensing exemptions or care for patients across state lines under any circumstances. Of the 42 who initially expressed a willingness to learn about state licensing exemptions, 9 (21%) were subsequently unwilling to treat a patient across state lines even if it was permitted by state licensing exemptions.

After 901 emails and 539 phone calls to psychiatrists advertising in Psychology Today, we identified 50 psychiatrists willing to see a college student who was home for the summer and attended college in another state. However, only 12 of these psychiatrists were covered by any health insurance plan. This represents an enormous burden on a college student to find one psychiatrist willing to see them during college and could easily interfere with urgently needed care.

Summary

Based on this experience, a college student might need to make 11 phone calls to find a psychiatrist if the student is able to pay cash for an out-of-network provider and 45 phone calls to find a psychiatrist who is covered by a private health insurance plan.

Ninety-five percent of psychiatrists in this study were unaware that state telehealth registries or state licensing exemptions might allow them to treat patients across state lines. Even when informed about state telehealth registries and state licensing exemptions in the state where the student attends college, 65% were still unwilling to provide treatment across state lines when the patient returned to college. Thus, state telehealth registries and state licensing exemptions appear ineffective in increasing access to care for college students who are traveling across state lines for educational and professional opportunities.

PART
FIVE

Recommendation: National Continuity of Care

Informed by quantitative and qualitative research, as well as by trends in mental health status and care for college-age students, the following recommendations are potential paths forward.

Instituting a national continuity of care exemption for young adults until age 26. Commonsense exemptions are supported by most organizations, including the Federation of State Medical Boards, the American Medical Association, the American Psychiatric Association, the American Telehealth Association, and most physician organizations, although some emphasize that commonsense exemptions should be enacted by each state. However, federal action, rather than disjointed state legislation, is essential to cut through the ineffective maze of state exemptions and to effectively address the mental health needs of adults.

Of note: Numerous states have specific exemptions for physicians traveling with a sports team. Sports exemptions were first passed in the state legislatures, but in 2018, Congress passed the Sports Medicine Licensure Clarity Act, which allows physicians and other health-care providers traveling with a team to practice in other states.[85,88] The Sports Medicine Licensure Clarity Act also requires a physician's medical liability insurance provider to cover any out-of-state medical services the physician provides to the team's athletes.

Challenging state medical board interference with an established doctor-patient relationship as an anticompetitive practice that causes injury to consumers. In the context of a national youth mental health crisis and the demonstrated barriers to finding a new psychiatrist, the practice of state medical boards barring licensed providers in other states from seeing long-term patients while those patients are attending college in another state constitutes an unfair practice.

The authority of the FTC to regulate state medical boards was made clear in a 2015 Supreme Court case regarding dentistry, determining that state medical boards are subject to antitrust regulation, and restrictions by a professional board can be deemed an anticompetitive practice.[102] Per the Federal Trade Commission Act, the FTC is tasked with preventing an unfair method of competition that "causes or is likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition."[103,104] A 2016 report by the FTC stated that "for occupations that depend on interstate mobility [...] the need for interstate mobility likely outweighs local concerns, such as minor variations in the qualifications of licensees from different states," and that there is accordingly "little justification for the burdensome, costly, and redundant licensing processes that many states impose on qualified, licensed, out-of-state applicants."[105] In 2018, the FTC weighed in on telehealth and licensure, stating that "the necessity of multi-state licensure for physicians who practice across state lines is often considered a barrier to the deployment of telehealth services, and that less restrictive alternatives could reduce the burdens of practicing across state lines yet maintain appropriate standards of safety, quality, and effectiveness."[106]

Requiring health plans to reimburse patient encounters across state lines to protect continuity of care for young adults until age 26. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for private-sector, employer-sponsored health plans. ERISA regulates health plan coverage for nearly 140 million Americans. Recent amendments to ERISA expanded protections afforded by private insurance, including a right to temporary continued health coverage after such events as a loss of a job, and expanded access to mental health services under the Mental Health Parity Act.[107]

Issuing a mandate to recognize commonsense exemptions and protect the continuity of care until age 26.
While this policy would only directly mandate providers accepting Medicaid and Medicare, CMS mandates often influence norms in the provision of care broadly and would accordingly be a positive step toward securing widespread continuity of care exemptions.

A working group can determine which federal agencies have the authority to enforce commonsense exemptions for other circumstances, such as rare diseases, on a national level. If the working group concludes that no federal agency currently possesses the authority to enforce commonsense exemptions, a committee could draft federal legislation that affords the best-suited agency the authority and responsibility to enact national commonsense exemptions.

Expanding health-plan provider networks and combating ghost networks.
The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted in 2008 and requires health plans to cover mental health care at the same level as other medical care. Despite this, millions of people pay for out-of-network mental health care, which is significantly more expensive than in-network mental health care, and the proportion of out-of-network mental health care has increased. A "secret shopper" study conducted by the Senate Committee on Finance's majority staff identified systemic barriers to scheduling appointments with mental health providers.[108]

The Biden Administration recently announced a proposal to increase access to in-network mental health care and decrease the cost of out-of-network mental health care. President Biden's Unity Agenda creates more stringent oversight of private health plans and requires health plans to report specific outcomes measures to prove that they provide adequate access to in-network mental health care.[109] This proposal also reduces red tape like prior authorizations, closes loopholes for non-federal government health plans, and delineates other violations of MHPAEA.

In Conclusion

Our research—including both an extensive investigation of physician attitudes of existing exemptions and dozens of meetings with key stakeholders—points toward one feasible solution to protecting access to psychiatric care for college-age students: federally mandated commonsense exemptions for continuity of care. Uniform, unambiguous, and reasonable exemptions—such as for college students who are out of state for limited periods of time for academic or professional opportunities—are needed at the federal level to address pressing issues of access to treatment during the nation's persistent, pervasive youth mental health crisis.

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