

# Update: The Interstate Medical Licensure Compact of the Federation of State Medical Boards

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The Federation of State Medical Boards (FSMB) has to date been awarded more than \$1.4 million in federal grant money to implement the Interstate Medical Licensing Compact (IMLC). FSMB has used the straw-man argument, emphasizing telemedicine as the singular need for the development of this quasi-governmental entity, which claims to facilitate physician licensing in multiple states. Many telemedicine organizations and most states have not supported or accepted FSMB's "multiple license method" as useful or necessary.

The IMLC program requires physicians to purchase a license in each and every state, which would cost more than \$25,000 per physician per cycle if all 50 states were members and all licenses acquired. One is free to purchase any member state's license, but must first purchase a "home state" registration at additional cost over and above the secondary state's "usual and customary" fees. The purchase of additional certifications and the use of FSMB "services" are additional costs, not included in this discussion, which are likely to increase as the IMLC takes hold. The IMLC, after the requisite initial seven states signed on, "inaugurated" in October 2015, with 11 states forming this organization.<sup>1</sup> The IMLC then approved an annual budget of \$225,446, based on availability of grant money, allocating 63 percent for travel and dinner expenses for commissioners to attend meetings.

IMLC legislation was produced and pushed in all 50 states by FSMB as a means to develop a market and increase FSMB legislative control of physicians in all states. The IMLC does not expedite or improve licensing. Their licensing program began only in early April of this year in Iowa. Currently, only eight of the 18 member states are actually taking applications online.

IMLC is an organization of state boards under Section 115 of the Internal Revenue Code, and to date has no physical headquarters or office. The website is run under FSMB's authority, and as the Commission is without headquarters or executive director, the mailing address since the inception of the Commission has been that of the office of the current serving chairperson.

IMLC requires physicians to register in their "home state" at a significant cost (\$700) mandated by each individual state and as a prerequisite to apply for IMLC licenses in other member states. This "letter of qualification by a state of principal license attesting the physician is qualified for expedited licensure through the Compact" is only valid for 365 days, during which time the physician must repeatedly attest to meeting all requirements, including current Maintenance of Certification (MOC).<sup>2</sup> After one year this letter becomes outdated, and the physician must go through the process again. If a physician relocates to a different state, a new "home state registration" is immediately mandated. The IMLC charges for "home" registration even when a license already has been issued, and adds a fee for acting as an intermediary on top of the licensure fee for each state. Note that individual state fees range from \$75 in Wisconsin and

Alabama to \$700 in Illinois for the state license, plus the cost of the one-year duration "home state license" at \$700.<sup>3</sup> These fees are subject to change.

The IMLC imposes additional physician costs, obligations, and legislative and regulatory hurdles. Although no state requires MOC to obtain a license, the IMLC still requires current certification and thus MOC when initially registering. Once a physician is registered with the IMLC, renewals will also be through the IMLC, with recurrent fees. While MOC compliance is not yet required for subsequent registrations, the IMLC has the power to grow and unilaterally change requirements. FSMB could later introduce obligatory Maintenance of Licensure (MOL) and other proprietary, expensive measures.

FSMB and other private licensing organizations already provide services to "expedite" single and multiple license applications under the Federation Credential Verification Service (FCVS).<sup>4,5</sup> FCVS, while expensive, has consistently poor service reviews from users.<sup>6</sup> Thus, the FCVS has limited political usefulness to FSMB nationwide, while providing significant income to fund the FSMB agenda in states (e.g. Ohio and West Virginia) where physicians are required to use FSMB products in applying for licensure. FCVS has been specifically incorporated in the IMLC rules as an official required "primary source verification" entity, another way to increase its revenue.

The IMLC has reportedly been founded as an independent, quasi-governmental organization, although no documentation has been provided by the IMLC Secretary to date in response to a Freedom of Information Act request. This status has become a significant problem for the IMLC, as it may not be able to obtain information needed for criminal background checks from the FBI. According to FBI attorney Christopher B. Chaney, there is no federal statutory authority for the FBI to share criminal files with a private entity.<sup>7</sup>

The IMLC is almost exclusively composed of and run by non-physicians, specifically, the hired executives of the member state medical boards, who enjoy expense-paid travel to meetings of the IMLC at various member state locations, such as Salt Lake City, Utah. Like-minded non-physician regulators are thereby enabled to directly influence medical practice under FSMB oversight, while minimizing direct state physician and legislative oversights imposed in the home states. FSMB has been repeatedly criticized as a physician-adverse organization. FSMB, which pre-dates most licensing and educational regulation, uses state medical boards to impose use of FSMB products on physicians. FSMB initially targeted foreign medical graduates (FMGs) and then medical students to purchase their increasingly expensive and time-consuming testing products: ECFMG, FLEX, USMLE, FCVS, and SPEX. Specific examples include Arizona and Mississippi, where either active certification/MOC, or alternately SPEX, is required on every initial application if 10 years have passed since first licensing elsewhere. FSMB previously attempted, unsuccessfully, to impose Maintenance

of Licensure on practicing physicians by state law mandate in Ohio in 2010, while colluding with the American Board of Medical Specialties (ABMS) to impose universal MOC on all physicians.<sup>8</sup> The IMLC is FSMB's "next generation" corporate attempt to force FSMB's private corporate programs onto the practice of medicine nationwide and at great cost, through regulatory capture. It is very likely that the overt and excessive costs and controls will doom the IMLC to failure, as informed physicians will choose not to use this program and to advocate for more rational reciprocity in licensing.

### Alternatives to IMLC

There is no need for federal licensing or private corporate/interstate organizational control of licensing for any profession. Reciprocity and legal subjugation of practice performed under the laws of each state where practice occurs is a preferred, economical, viable, and rational method for interstate practice. This format exists today for many licenses, including driving, nursing, and physician medical licenses, albeit only under specific conditions:

- 1) Insurance company physicians and nurses directly impact patient medical care daily using peer-to-peer consultations and "case management" decisions across state lines, specifically to deny care recommended by primary care attending physicians.
- 2) The Veterans Administration, the largest single health care network in the U.S., currently allows any physician to practice at any VA facility throughout the U.S. by virtue of any valid single state license.
- 3) Traditionally such VA practice was restricted to care within VA institutions, but recently VA programs reached into the homes of patients to deliver care by telemedicine, including that by advanced practice registered nurses (APRNs).<sup>9</sup>

Additionally, federal bills are being introduced to allow all Medicare patients to be treated across all state lines by any Medicare participating physician from any state.<sup>10</sup>

Interstate agreements could easily establish such reciprocity and without corporate intermediaries, federal licensing, or additional costs. Legislating reciprocity for the whole practice of medicine means securing one license from one state for practice throughout all states. This could also be mandated at a federal level for all practicing professionals without introduction of new licensing, while leaving the authority to regulate and license to each home state, and ensuring adherence to legalities in each state under local laws. State laws continue to ensure oversight over the level and scope of care. Medical boards have sufficient interstate influence to ensure the ability to revoke a license or impose the full extent of the laws in any state by virtue of reciprocity. These interstate mechanisms have long been imposed as bootstrap sanctions. Medical board oversight, however, is now being circumvented by nurse practitioners, who are increasingly being authorized to practice medicine without state medical board oversight, being overseen only by nursing boards. This raises questions about the importance of medical board oversight, as supervision of the practice of medicine is turned over to a nongovernmental agency like the IMLC or FSMB.

There is already an interstate compact, covering at least 25 states, for nursing. Nurses obtain a home license in the state of

residence, but can practice in any compact state while abiding by the law of that state.<sup>11</sup> In this, nurses have a clear market advantage over physicians.

All state drivers' licenses function based on such reciprocity and without loss of state control or ability to enforce both state and international laws where the driving occurs.<sup>12</sup> Penalty points are referred back to the home state and can lead to driving license revocation and increased insurance premiums.

### Conclusions

It is time to take control of interstate licensing from the FSMB and change the paradigm from requiring multiple licenses and fees for physicians across state lines to create straightforward reciprocity for the whole of medicine. Physician licensing should not be used as a political vehicle for exercising FSMB corporate power. The restraint of trade imposed under multiple wasteful and senseless obligations excludes the highest trained professionals (doctors) from interstate practice. Removing it would facilitate securing patient rights and practitioner availability.

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