

The Interstate Telemedicine Compact and the Agenda of the Federation of State Medical Boards

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ABSTRACT

The Interstate Telemedicine Compact (ITC) proposed by the Federation of State Medical Boards (FSMB) is neither necessary nor desirable for expanding access to medical care. Its main effect will be to increase influence and revenues of a private corporation, the Federation of State Medical Boards (FSMB), through regulatory capture. It is likely intended to bypass physician resistance to proprietary Maintenance of Certification/Maintenance of Licensure (MOC/MOL). Conflicts of interest and lack of transparency are serious issues.

Current Telemedicine Laws and Practice

Most states have not addressed the issue of telemedicine even intrastate. They have not introduced legislation that would enable licensed physicians to bill for services by phone, I-phone or e-mail. In rural states the market is limited. In states with urban areas, telemedicine is unnecessary because of the overwhelming presence of extensive university systems such as California's.

Many concierge physicians offer telemedicine services as "included components" of enrollment plans, but specific reimbursement for such services is typically not allowed under federal or proprietary insurance coverage.

Patients greatly desire to have physician contacts, and to have questions answered in person when receiving care. With modern I-phones and computer programs, actual "face time" can occur electronically to facilitate contacts, while still allowing personal local visits to the physician. Indeed, many state medical boards forbid prescribing to patients without contemporaneous, physical presence and specific documentation of history and physical examination in the patient's chart.¹

Interstate Telemedicine

Intrastate telemedicine insures that state regulations prevail, patients and physicians are generally not too distant from each other, and in-state medical offerings are bolstered. Interstate telemedicine specifically exports funds and expertise, especially from rural states, further limiting local care. While intrastate telemedicine facilitates expanding regional expertise and in-state referral, interstate telemedicine will often draw the patient out of state and

"out of network," creating increased billing and travel costs because there are no "in-network" insurance agreements.

Interstate or long-distance telemedicine should always be a consultation, with a physician at the bedside to access history and physical findings, render physical care, and treat complications. It is possible that with interstate telemedicine, large corporate entities will provide single physicians overseeing dozens or even hundreds of nurses, practicing medicine on patients never seen by a physician. Or essentially a computer will become the physician.

Because telemedicine should be viewed as a consultant procedure, it is reasonable to define the consultation to occur at the location of the telemedicine consultant, governed by the rules of his state, with the practice of medicine occurring in the state of the patient, who is under the care of the local physician. In this way, patient-physician interaction is maintained along with higher levels of medical care. Telemedicine physicians would need to have only one license to provide consultation in all states. Telemedicine would be limited to true experts providing rare consultation, not just replacing standard care from afar.

A model for consultative practice, which does not require multiple state licenses, is found in other professions. For example, Chicago lawyers can provide advice (and bill for it) to their colleagues in New York or Texas without being licensed there.

While interstate telemedicine can provide scarce or unusual expert consultations for patients, it is now most commonly used for evaluation of radiology studies, which are read by consultants often as far removed as India or Australia. This provides no increase in expertise, but only "relief" from night call coverage by local radiologists. There is no improvement in consultation depth or quality. There is, however, an export of financial gain from the region, along with a decrease in the total number of working physicians, just as happens with the technical support services of many computer companies.

The Role of the Federation of State Medical Boards (FSMB)

What is the problem with the current system? Why do we need an interstate telemedicine compact (ITC)? No corporate interests are served by intrastate telemedicine, and there is no role for the Federation of State Medical Boards (FSMB). Defining telemedicine as consultation, which occurs in the state of the consultant, would

expedite truly expert telemedicine care and reduce costs of such practice, but would eliminate the need for FSMB involvement or for multiple state licenses, which bring revenue to every individual state board while imposing extensive costs and multiple legal liabilities upon every physician. FSMB wants to define telemedicine as occurring at the site where the patient is located.² This creates the need for physicians to purchase multiple licenses at great cost, between \$300 and \$2,000 in each state, wherever their consultations are provided.³

The FSMB is a private, tax-exempt corporation, with \$45 million in gross revenues in 2013. FSMB has historically been successful in coercing state medical boards to require many of their “products,” including the ECFMG, FLEX, USMLE, and SPEX tests, as well as their Federation Credential Verification Service (FCVS) and physician licensure verification. FSMB “products” all financially profit FSMB, without any evidence that they improve patient care. These products can be found listed on the FSMB homepage, www.fsmb.org, along with the costs.

The FSMB has further enticed the state boards to require use of their “universal application form,” for “nominal fees” of course, as a means to collect data on physicians and to promote corporate profit from sales of this information. While hospitals strictly control pharmaceutical and medical device representatives from entering hospital grounds in order to reduce undue sales influence, FSMB has free rein of all state medical boards to peddle influence and its products.

FSMB recently tried and failed to impose its objectionable Maintenance of Licensure (MOL) program on physicians.⁴ It is now attempting to use its ITC to facilitate its own interests and usurp the legislative power of state medical boards.⁵ Ultimately, the ITC could be used to circumvent resistance to MOL.^{4,6} The ITC re-defines “physician” as one who is certified by a member of the American Board of Medical Specialties—even though board certification is increasingly recognized as a false promise by the 24 ABMS member boards themselves.⁷

FSMB claims that its concern is to expedite telemedicine and licensure in multiple states. Dr. Humayun J. Chaudhry, FSMB president and CEO, told *Medscape Medical News* that FSMB is well on its way to developing an “interstate medical licensure compact” that would address the issue of reciprocity, but would still require multiple licenses and all of the costs.⁸ FSMB Advocacy Director Lisa Robin said, “In essence, the compact streamlines the process of applying for medical licenses in multiple states while keeping the responsibility for licensing and disciplining physicians within state boards.” Of course this ITC licensing must occur through FSMB as the oversight organization, including full payments, under the new compact streamlining FSMB profits above all.³ In reality nothing is streamlined. Multiple licensing is continued. The FCVS can already be accessed for this purpose for a \$350 fee. The ITC will demand use of this “federation service.” (Note that a required service is really a tax.)

Conflicts of Interest

FSMB lures state board members with expense-paid travel as “scholarships” to FSMB meetings, thus giving the appearance of representing the boards while asserting influence over them.⁹ This became very evident in recent years in Ohio, where FSMB supported one-third of all board members’ travel to their national meeting in 2014. At the meeting, FSMB executives were seated in leadership positions on the Ohio State Medical Board (OSMB).⁹ This is regulatory capture: FSMB uses state medical boards to introduce legislation, thus making a market for its “products,” which are then imposed on physicians.

When Ohio physicians and representative organizations identified these conflicts of interest, Richard Whitehouse, the OSMB’s executive director and FSMB board member suddenly departed. A state ethics board investigated Whitehouse, and also FSMB’s chairman, Lance Talmage, who was at the same time the state board member leading the push for MOL program implementation.^{10,11}

Resistance

Not every state has accepted FSMB and ITC propaganda. The Missouri State Medical Board recently evaluated and rejected the ITC for multiple legal and medical reasons after receiving a Jan 13, 2015, letter from Missouri General Counsel Sarah Schappe. Citing many facts from the FSMB’s own journal, she argued against the need for such a compact. For example, “there were 878,194 actively licensed physicians in the US. Only 51,139 of those had 3 or more state licenses. 138,274 of them had two active licenses.”¹² As a physician practicing in the panhandle of West Virginia, which is only 11 miles wide, my need for three state licenses is geographic and not linked to telemedicine. This is true for the vast majority of physicians with multiple state licenses.

Alternatives

The telemedicine industry supports federal plans to allow physicians to practice in any state by being licensed in only one state, much like driver’s licenses or automobile registrations. The Veterans Administration, the military, and federal hospital systems have used this “one license” modality successfully for decades and outside of state oversight. Most state medical boards strongly oppose this, as individual board funding would decline, or at least not be augmented.

FSMB also opposes this. It would prevent FSMB from having control over the process and from imposing requirements that their “products” become intrinsic mechanisms for licensure recognition.

The nursing profession implemented an interstate licensing compact under the National Council of State Boards of Nursing as far back as 1999.¹³ This compact now

includes 24 states. Only one license in the home state of residence is required, facilitating licensing and reducing costs in the nursing profession. All executives are installed directly from the many state medical boards, creating an entity commanding more than \$100 million yearly in gross receipts.

Reciprocity in licensing, with state boards interacting directly with each other, is a logical method that does not involve corporate intrusion or the formation of additional non-governmental agencies, excessive "products," and the considerable costs associated with these.

We should attempt to expand regional interactions of community physicians with the regional medical centers of excellence formed as leaders within each state's boundaries. If very specific and specialized experts (i.e. pediatric cardiophysicians) are needed, adjacent state tertiary centers can be selectively contracted and licensed as determined by individual interstate cooperative efforts. This will best serve patients and their families, be cost-effective, and improve physicians' abilities to see patients in person and access known experts.

Conclusions

Expanding and promoting telemedicine, and expediting multi-state licensure can be better accomplished without the involvement of FSMB. Its corporate interests conflict with the interests of physicians and patients in reducing costs and preserving the patient-physician relationship essential to good medicine.

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