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Connie Clarkston
Executive Director

To: Members of the Board of Registration for the Healing Arts

From: Sarah Schappe, General Counsel

Date: January 13, 2015

RE: Interstate Compact

Over the last few months, staff has been studying the Interstate Medical Licensure Compact ("Compact"). A copy of the current version of the Compact with specific comments is attached to this memo. However, this memo will highlight some major areas of concern.

To my knowledge, there are no estimates of the number of physicians who will qualify for compact licensure. However, in 2012, the last year data is available, there were 878,194 actively licensed physicians in the US. 51,139 of those had 3 or more state licenses. 138,274 of them had two active licenses.[1]

I. Administration

A. How it works

The Compact would be governed by the Interstate Medical Licensure Compact Commission ("Commission"). This Commission would consist of representatives of each state's Board. If there is a combined board, like ours, the Board would send two representatives. If the state has separate medical and osteopathic boards, each board would send one representative. Each representative would have one vote. A quorum would consist of a majority of the representatives. Most decisions would be made by a majority of the representatives present.

The Commission would appoint an executive committee, which can act when the Commission is not in session, except that it cannot make rules.

The Commission has the authority to promulgate rules, maintain offices, hire personnel, purchase property, and levy and collect an annual assessment from member states.

[1] A Young, A Census of Actively Practicing Physicians in the United States, 2012, Journal of Medical Regulation, available at https://www.fsmb.org/Media/Default/PDF/Census/census.pdf.

B. Potential Implications

Many things about the governance and day-to-day working of the Compact are left to the rulemaking process. Therefore, it is unknown how it will work on a day to day basis. Additionally, because of the quorum rules and voting rules, decisions could be made by a minority of stakeholders. For example, if seven states belong to the Compact, there will be fourteen members of the Commission. Eight of those are necessary to constitute a quorum. Five of those would be a majority vote. So, in essence, the representatives of three states can decide policy, including finances, for the entire Compact.

Additionally, because all powers except rulemaking may be delegated to the executive committee, that body will be able to make a lot of decisions, including financial decisions. Exactly who will serve on this committee and how they will be chosen is left to the bylaws.

This Commission also would have the power to issue opinions interpreting the Compact. This could be very helpful in making sure it states administer the compact and the same way. However, these opinions are not binding on courts so courts in different states could issue conflicting opinions or orders.

It is also possible Commission could make rules regarding auditing procedures, which would help ensure uniformity among states. There currently are no auditing or quality assurance provisions in the Compact.

II. Licensure

A. How it works

If a physician wants to participate in the compact, he or she would first get a traditional state license in a Compact state. Then physician would apply for a "letter of qualification." To qualify for this letter the physician would have to demonstrate that he:

- Graduated from an approved medical school;
- Passed each step of the USMLE, COMLEX, or predecessor examination within three attempts;
- Completed a residency program;
- Be board certified by ABMS or AOA;
- Have a full and unrestricted license in a Compact member State of Missouri;
- Have never been convicted or received a deferred disposition for a felony or "gross misdemeanor";
- Have never had his license to practice medicine disciplined, except for non-payment of fees related to the license;
- Have never had the DEA or BNDD suspended or revoked; and
- Not be under active investigating by a licensing agency or law enforcement.

If the physician qualifies under the above criteria, the original state will issue a "letter of qualification." Each subsequent state that physician would like a license in is required to issue a license based solely on that letter of qualification and payment of the appropriate fee.

B. Potential Implications

There are many who will not qualify for compact licensure, including those who are not board certified, those with a past criminal history (even a relatively minor history) and those with past disciplinary history (including things like a reprimand for failure to obtain required CME or a HB 600 suspension for failure to pay taxes). The Compact will not assist these individuals with portability of licensure.

The Compact also takes away the state's autonomy and authority to grant licenses. If the applicant is deemed "compact eligible" by any other compact state, all member states must grant licensure based on that eligibility. There is no discretion to look at moral character, malpractice history, training irregularities, or other requirements. There is also no opportunity for a state to disagree with another

state's interpretation of the compact requirements or their determination that a particular applicant meets those requirements.

There is also a concern that this system is setting up a two tiered licensure system, which could be used inappropriately as a proxy for quality or competence. Compact qualification could become an advertising tool, a requirement for credentialing at hospitals, or for placement on insurance panels. While this does not directly affect the Board, it could have a great effect on licensees and could lead to pressure to allow more physicians to become compact eligible by loosening the requirements.

However, for those that qualify Compact licensure could be a much quicker route to obtaining licenses. Depending on fees set by the Commission and the states for this type of licensure, it could be less expensive, especially for those obtaining numerous licenses.

III. State of Principal Licensure

A. How it works

State of principle licensure was called the "home state" in previous drafts of the Compact. The state of principal licensure is designated by the physician. The state of principal licensure can be any state where the physician:

- Primarily resides;
- At least 25% of the practice of medicine occurs; or
- The location of the physician's employer.

If no state qualifies as one of the above, then the physician may use the state of residence for federal income tax purposes. A state of principal licensure can be designated at any time. The Commission is supposed to develop rules governing this procedure.

B. Potential Implications

The state of principle licensure is important because it can affect discipline. If the state of principle licensure revokes the license, than all the other licenses based on that are automatically revoked. This leads to manipulation in a couple of ways. If a licensee knows that a state is investigating them and that it is likely that they will revoke his license, then that licensee will have a great incentive to change their state of principal licensure.

If the license in the state of principal licensure expires, then all Compact licenses expire. Licensees would have to reapply for license(s). This could lead to a period of time that the physician is unlicensed and unable to practice.

Because much of the process of designating and changing the state of principal licensure is to be set forth in rules, it is really unclear how this would work in practicality, including if there are fees associated with it. However, it does seem that the states have no say in the process. If the physician wants to change his designation and qualifies, then it will be changed.

Some of the people staff discussed the Compact with believed that rules could be written requiring cause to change the state of principal licensure or allowing changes only under certain circumstances. They also interpreted the Compact to require that the physician obtain a "regular" license in the new state of principal licensure prior to making the change.

IV. Renewal

A. How it works

A licensee is eligible to renew through the Interstate Compact Commission if he/she:

- Maintains a full and unrestricted license in the state of principal licensure;

- Has not been convicted or had a deferred disposition for a felony or "gross misdemeanor";
- Has not had any license disciplined, except for non payment of fees related to the license; and
- Has not had a DEA or BNDD certificate suspended or revoked.

The Commission will collect the fees to renew the license and collect and distribute information to the member boards. Licensees will still have to comply with the CME requirements of each state. The renewal schedule will continue to be set by individual states.

B. Potential Implications
As I understand it, part of the impetus for the Compact was to make having multiple state licenses easier for physicians. This provision does not do that, and arguable complicates it having multiple licenses even further.

The renewal provisions require the licensees to still comply with each state's renewal process, but insert the Commission in as a middleman in the renewal process. It will add another layer of bureaucracy and another potential fee to the process. Each state will set their own schedule for renewals and will set their own continuing education requirements.

A licensee cannot renew the compact license if he has a criminal conviction during the year, has a disciplinary action against his license or has a suspension or revocation by DEA or a state BNDD agency. This would mean that the licensee would have to reapply for a regular license in each state he holds a license.

One area that will affect the Board directly is that it does not appear that the attestation questions we currently ask will be asked as part of the renewal process.

Again, some of this may be clarified by rules. However, the rules cannot change the fundamental requirements of the Compact.

V. Investigations

A. How it works
The Compact allows joint investigation, but also allows any member state to investigate a violation in any other member state. So, if Missouri and Kansas are both member states, Kansas can send investigators to Missouri to investigate. Kansas doesn't have to tell us they are investigating here.

This section also says that a subpoena issued in one state is effective in any other member state.

B. Potential Implications
Because states can investigate in any other Compact state, complainants could make a complaint to every state in which the physician has a license and could subject the physician to multiple, simultaneous investigations. There are also concerns about state sovereignty with these investigations across state lines. While some might argue that this can occur now, as a practical matter, investigations rarely cross state lines (at least here). Because of the authority given in the Compact, investigations across state lines may increase.

Reciting that subpoenas are effective across state lines in the Compact doesn't make it so. While there are legal mechanisms to enforce subpoenas for witnesses in criminal cases and for depositions in civil cases (though Missouri has not adopted this), I have not been able to find any provision which applies to administrative investigative subpoenas.

If there is a physician who saw a patient in Missouri and Kansas (and both are members of the compact) then Missouri would issue a subpoena to KU Med Center where some of the care took place. KU can simply refuse to comply (and probably would since their authority to release records to us is questionable). Once they refused, we have to sue to enforce the subpoena. Not only is that travel and litigation costs, but attorney licensure is a state by state issue. We have to find an attorney in Kansas to represent the Board. The Kansas Board's attorneys likely won't because Missouri doesn't pay their salaries. Likewise, the Missouri Board probably won't authorize me to sue to enforce subpoenas from other states. This also leads to problems with attorney ethics and conflicts of interest if they are representing multiple boards. So, as a practical matter, I am skeptical whether we can really enforce these subpoenas.

If this would lead to increased sharing of information and coordination (not duplication) of investigations, it could lead to better and faster investigations. It could also lead to some resource sharing in complex investigations that cross state lines.

VI. Discipline

A. How it works

1. If the license in the state of principal licensure is revoked, surrendered, or relinquished in lieu of discipline, then all Compact licenses are automatically placed on the same status (without a hearing). However, a member state can reinstate the license, if the license in the principal state is reinstated..

2. If any disciplinary action is taken by a state other than the state of principal licensure, then the other states can impose the same or lesser action or take separate disciplinary action.

3. If a license is revoked, surrendered in lieu of discipline, or suspended, then all other compact licenses will be immediately suspended (without a hearing) for ninety days. The other states may terminate the suspension early.

B. Potential Implications

Other than number 2 above, there is not any discussion of probation, restrictions, or limitations. Because of the provisions in the renewal section, if a physician's license was probated by the state of principal licensure, he/she couldn't renew it, but it is not clear that there is direct authority for the Board to discipline the license.

The greater concern is that the provisions of 1 and 3 require action on the part of the state without due process. There is no procedure in these provisions for a hearing. Besides the legal implications, which would include the courts invalidating the law, the practical side is that when that state of principal licensure revokes the license, the licenses in all other states are revoked that same day. The physician has to quit practicing immediately (no wind down period and little to no notice depending on the procedures in the other states).

Currently, Missouri does not have either a process to reinstate these licenses or to terminate suspensions. If the Compact were proposed here, I would suggest additional legislation to define and streamline this process.

One significant difference between current law in Missouri and law in many other states is suspensions. In general, courts in Missouri are reluctant to uphold a deprivation of property rights, like the right to a professional license, without a pre-deprivation hearing. In some states, the board can suspend a license without a hearing being held prior to the suspension. It is unclear if the hearing in the other state (assuming there was one) would meet this requirement to discipline the Missouri license. It is unlikely, in my opinion, that a suspension in another state, which occurred without a hearing, would meet this requirement.

Lastly, the ninety day suspension provided by section 3 above may not give the Board in Missouri time to dispose of the case. For example, if the Board were notified of a case on January 15, it is too close to the January Board meeting to hear the case then. The next Board Meeting on May 14 and 15, more than ninety days. As currently written, the license would be suspended on January 15 and reinstated on April 15.

Again, some have suggested that rulemaking can solve some of these issues. I am skeptical that rules could change this underlying framework, but rules clarifying the process and timelines could help.

VII. Costs to States

A. How it works

The Interstate Compact Commission has the power to charge an annual assessment to the state boards. This assessment will likely be voted on by a majority of the members present. They will also set how the fees are apportioned. So it is possible that all participating states could pay a flat fee (the Nursing Compact works this way) or that fees are apportioned in some manner (based on state population, the number of licensees participating in each state, the number of licensees that have designated your state the state of principal licensure, etc.). Once the majority sets the fee, the state boards will have to pay it.

B. Potential Implications

The startup costs, which could be passed on to the state boards, will be significant. The Commission will have to hire staff, buy and develop a computer system, rent or buy office space, etc. No one has been able to provide information on what any of the anticipated costs would be.

However, the Nursing Compact charges states $6,000 per year. The Nursing Compact provides far fewer services than the Commission would in this Compact, so it is likely that the cost would be greater.

Some have suggested that these initial costs can be covered by grants. After the startup costs, the Commission could fund itself through licensure fees.

If fees were assessed directly to the Board, it is unlikely the Board's current appropriation would support the assessment.

VIII. Costs to Licensees

A. How it works

In addition to the fees paid by the participating states, the licensees will also pay fees to the Interstate Compact Commission. It is likely that there will be fees for initial qualification under the compact, for changing the state of principal licensure, and for renewal. Additional fees might include mandated use of the Federation Credentialing Verification Service (FCVS) which currently costs at least $350. They could also mandate use of the FSMB Uniform Application, which currently costs $50. In addition to any fees set by the Interstate Compact Commission, states will continue to charge licensure fees.

B. Potential Implications

It appears that licensees could be paying significantly more than they currently are for participation in the Compact as neither the FCVS or the uniform application are required in Missouri.

IX. Records/Information Sharing

A. How it works

The Compact requires a "coordinated information system" which will include a database of all physicians licensed pursuant to the Compact or who have applied for Compact qualification or licensure. There are not a lot of details about how this would work. However, there is certain to be costs to develop it, which would have to passed on to the initial members of the Compact. Secondly, the Compact says that the system should be established, but doesn't discuss maintenance.

There are also provisions addressing information sharing. The Compact stays that all "public actions or complaints" against a physician who has applied or received a compact license shall be reported. It also allows rules to be promulgated to govern the reporting of disciplinary and investigative information. Member Boards are also required to share complaint and disciplinary records.

All information distributed to member boards is required to be filed "under seal and used only for investigatory or disciplinary matters."

B. Potential Implications
It is unknown how the coordinated information system will interface with our computer system. Because our system contains information about other licensees who are not participating in the Compact, there are significant concerns about allowing direct access into our database. There is a possibility we could do a daily "data dump" into the Compact System. However, these details will have to worked out once the Compact system is created.

The provisions about filing under seal are also concerning. Right now, all information about investigations and licensure is filed together. It seems that the Compact would require the information received from the Commission or other member boards to be filed separately and it may be subject to different rules for disclosure. The language also seems to say that the licensee could not have access to his file unless it was part of an investigation or disciplinary matter. That is in conflict with our current law. This could increase the resources needed for records maintenance and for answering records requests.

Scenario

This is based on our reading and interpretation of the Compact as currently written. It is possible that rules or advisory opinions issued by the Commission could modify some of the below.

Dr. Smith is a board certified ER physician. She would like to have licenses in Missouri, Kansas and Oklahoma – all of which are participating the in the Compact. She is moving to Joplin from New York, where she had a medical license. New York does not participate in the Compact. She is planning on working mainly in Missouri, but may do locums work in Kansas and Oklahoma for a company headquartered in Oklahoma.

Dr. Smith applies for and is granted a Missouri license. She then applies for a "letter of qualification" for a compact license. This is also granted. Dr. Smith then applies for and is granted licenses via the Compact in Oklahoma and Kansas. Dr. Smith then designates Oklahoma as her principal state of licensure. Because the locums company is headquartered in Oklahoma, and that state qualifies for the state of principal licensure.

Two years later, Dr. Smith's privileges are revoked by the hospital in Oklahoma because she was diverting controlled substances. The Oklahoma board issues an order placing her license on probation.

Because probation is not mentioned in the Compact, Missouri and Kansas cannot take reciprocal action. At this point, Dr. Smith is not eligible to renew through the Compact. So she can't renew her Kansas license when it is due in June. (Oklahoma renews in January, so that isn't an issue yet).

Missouri sends a settlement agreement to Dr. Smith. She does not accept it and we schedule a HB265 hearing scheduled for July.

In June, it has become apparent that Dr. Smith is not complying with her probation and Oklahoma intends to have a hearing. Dr. Smith changes her state of principal licensure to Missouri, which qualifies because she resides here. Oklahoma suspends her license in late July for failure to comply with her probation. Missouri issues an order placing her on probation after the HB265 hearing in late July.

Because her state of principal licensure is now Missouri, the Oklahoma revocation suspends her Missouri license for 90 days (it doesn't automatically revoke it). Missouri does not have a legal mechanism to terminate the suspension, so it stays in place. Missouri is content to not take further disciplinary action based on the suspension in Oklahoma (since the license is on probation here and she is now complying).

However, when Dr. Smith's Missouri license is up for renewal in January, she cannot renew through the compact, because she has disciplinary action. Dr. Smith must reapply for a "traditional license." There is a delay in receiving her transcripts and the license is not granted (on probation) until March.

Dr. Smith sues Missouri for suspending her license without due process and failure to renew her license without due process and appeals the issuance of her license on probation. She also sues Kansas for failure to renew without due process.

SDS