The Interstate Medical Licensure Compact Commission: Growth, Success, and the Future

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The Interstate Medical Licensure Compact Commission (IMLCC) was born from an idea proposed at the April 2013 Federation of State Medical Boards House of Delegates meeting, when a resolution was adopted to formally explore the creation of a new physician licensure system. It was based on a simple question, with a complex answer: "What are the common standards of licensure that could be verified by one and accepted by many?"

The House of Delegates resolution resulted in the adoption and publication in October 2013 of "Eight Consensus Principles" for a physician licensure system that could utilize an interstate compact:

1. Participation in an interstate compact for medical licensure will be strictly voluntary for both physicians and state boards of medicine.
2. Generally, participation in an interstate compact creates another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act.
3. The practice of medicine occurs where the patient is located at the time of the physician-patient encounter and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.
4. An interstate compact for medical licensure will establish a mechanism whereby any physician practicing in the state will be known by, and under the jurisdiction of, the state medical board where the practice of medicine occurs.
5. Regulatory authority will remain with the participating state medical boards, and will not be delegated to any entity that administers the compact.
6. A physician practicing under an interstate compact is bound to comply with the statutes, rules, and regulations of each compact state wherein he/she chooses to practice.
7. State boards participating in an interstate compact are required to share complaint/investigative information with each other.
8. The license to practice medicine may be revoked by any or all the compact states.

The purpose of this article is to review how the IMLCC has fared against these foundational principles during the execution of the licensure-compact idea and where the Interstate Medical Licensure Compact is now heading.

Background

The IMLCC became a legal organization when, on April 15, 2015, the Governor of Alabama signed legislation authorizing establishment of the Compact in that state. The IMLCC statute, as written, requires that Compact legislation be enacted in at least seven states before a legal Compact can be formed; with this action, Alabama became the seventh authorizing state, creating the legal threshold that made it possible for the Compact to proceed.

Development of the Compact moved forward, and on April 7, 2017, the Alabama Board of Medical Examiners and Medical Licensure Commission of Alabama received the first IMLCC application. On April 20, 2017, the first license using the IMLCC process was issued by the Colorado Medical Board.

Commissioners — two selected from each IMLCC member-state — met several times to finalize a set of bylaws governing IMLCC operations and rules that would provide the framework for how a physician would apply for and receive licensure. Once the organizational framework was in place, it was time to design and implement the system by which applications would be received and processed — and how to pay for the system.

A grant from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) accomplished two major goals by providing: (1) financial stability to ensure a

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robust, functional and secure system infrastructure; and (2) start-up financial resources, rather than gathering donations and financial support from member boards over time. The FSMB Foundation provided a one-time grant, making it possible to open a checking account and pay incidental bills.

Licensing Begins

The IMLCC process begins when a physician opens an online application from the IMLCC webpage, starting with the establishment of basic eligibility by answering pre-qualification questions. The physician then provides more detailed information, which is reviewed to determine final eligibility. After review and verification of the information provided on the application, and if eligibility is established as a result of that review, the physician's declared State of Principal License (SPL) issues a Letter of Qualification (LOQ). The SPL must be a Compact-participating state, in which the physician already holds a full, unrestricted license. With the completed application and the LOQ, the physician is then able to select the Compact member states from which he or she would like to receive additional full, unrestricted licenses.

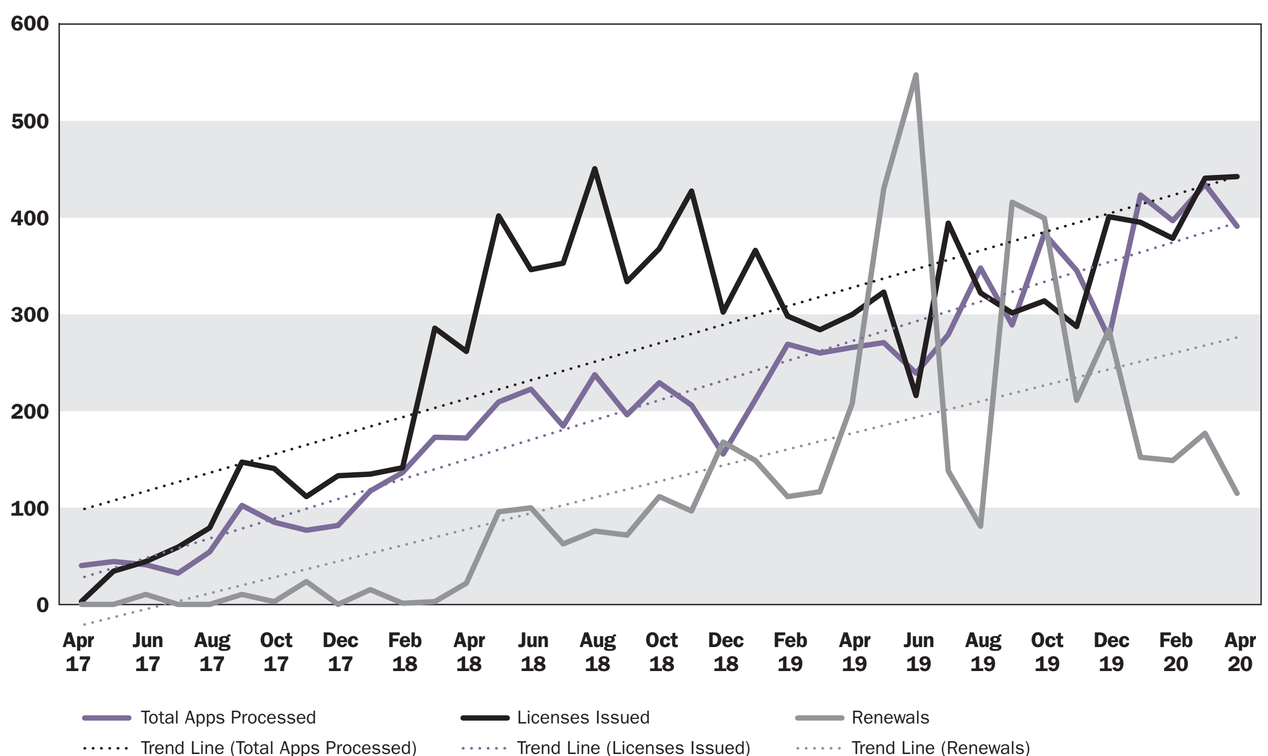
These licenses are issued by the individual states—just as they would be using the standard licensing process. But because the application for licensure in these states is routed through the Compact, the overall process of gaining multiple licenses is significantly streamlined through the use of a single application.

With a legal structure in place, funding secure and an information technology (IT) system established, the IMLCC began processing applications.

Early estimates were modest. It was expected that an average of 40 to 50 applications per month would result in 1.5 licenses per application. This prediction held true until the fall of 2017, when a pattern of major expansion every four to six months began to develop. From January through April 2020, the monthly average grew to 407.25 applications, resulting in 1.01 licenses per application. Figure 1 shows the rapid and steady increase of applications, licenses issued and licenses renewed.

Early expectations were that a low number of applications using the Compact would be received and then volume would steadily increase as word about

Figure 1
IMLCC Applications, Licensing and Renewals
2017–2020 (IMLCC Processing Data)



Source: Interstate Medical Licensure Compact Commission

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the Compact spread. However, the number of applications received quickly grew beyond original predictions when the value of the streamlined, single-application process to obtain multiple licenses was recognized by a broad spectrum of health care organizations and physicians. The number of Compact member-states expanded, from the original seven required to create the Compact to today's 29 states, the territory of Guam and the District of Columbia — 31 in total — with active legislation now pending in four states. To date, more than 10,000 licenses have been issued utilizing the Compact process.

Progress on Consensus Principles

In 2020 the IMLCC celebrated three major milestones: the five-year anniversary of its creation, the three-year anniversary of issuing its first license, and the issuance of its 10,000th license — which makes this a good time to take stock of how the process has gone and what issues, if any, should be addressed in the future.

In assessing its progress, the Commission begins by asking: "How does the 2020 version of the IMLCC hold up to the Eight Consensus Principles that guided its development?"

Principles 1 and 2 ensure that the process is voluntary and augments and enhances a state's licensure process. The IMLCC accomplishes these principles by leaving the member state's Medical Practice Act intact. This idea was at the heart of the planning process behind the IMLCC's growth. Most member boards report that IMLCC applications represent between a 5% and 15% annual increase in new license applications above the application volume prior to implementing the IMLCC.

Principles 3, 4, 5, and 6 ensure that the Compact process addresses the licensure process but leaves the authority over the practice of medicine with the state. The IMLCC continues to reinforce the principle that the Compact process is one option for licensure, but once the license is obtained, the physician must comply with the practice of medicine requirements of each state. These include registering for the state's physician profile data bank, obtaining authorization for prescription authority and treating patients only in the states where the physician is licensed.

The license issued to physicians using the Compact process is a full, unrestricted license — the same as if obtained through the traditional application process. To ensure a relationship with a key touchpoint in the process, physicians are required to maintain a State of Principal License (SPL) as long as they have active licenses issued through the Compact. The IMLCC staff acts to support the Compact's licensure processes and answer questions regarding these processes, but decisions about eligibility and the practice of medicine are always considered the purview of the medical board that issued the license.

Principles 7 and 8 focus on protecting the public. The IMLCC has developed a process for member boards to share disciplinary actions and to participate, on a voluntary basis, in joint investigations. Fortunately, fewer than five physicians who have used the IMLCC process have had disciplinary action taken against their licenses. The IMLCC's process of notifying other boards of disciplinary action worked quickly and effectively. The process is being enhanced with a new system, which will provide member boards an online tool for compiling investigative information that can be shared with other member boards in a controlled, secured environment.

Every year, the IMLCC conducts a data study of completed applications from April through March. Statistically, the information from the study relates directly to the entire application population. These data studies provide important benchmarks about the changing needs identified in the application process. For example, as more states join the Compact, there has been a corresponding increase in the number of additional application requests. This occurs when a physician completes an original application, obtains licenses using the original application and subsequently wants to obtain additional licenses, generally from the newly joined member states. This increase in additional license requests has resulted in a corresponding decline in the number of licenses obtained per application, since most additional license applications are a request for one or two new licenses. It is important to note that the average amount of time to complete the full process has remained fairly constant, even in the face of the increased number of applications.

It is hoped that system improvements implemented during June 2020 will reduce the process time through the use of system-generated reminders and notices about pending applications. And we do not yet know what the impact of the COVID-19 pandemic will have on the IMLCC's processing time. Data from various aspects of the Compact licensure process are provided in Figure 2.

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Lessons Learned

After five years, a number of key observations have emerged, which are now helping guide us as we shape the Compact's path to the future. We have learned that:

- **There continues to be a degree of confusion about the IMLCC**. We are frequently asked: "Is the IMLCC a not-for-profit organization?" The IMLCC is neither a for-profit nor a not-for-profit organization; legally, the IMLCC is classified under IRS code Section 115, as a "governmental instrumentality." This means that the IMLCC becomes a regulating authority that is part of each state's government, with the authority to collect fees and issue rules. To function and exercise its authority, the IMLCC is governed by commissioners, with two appointed by each member state. All the functions and actions of the IMLCC are governed by the commissioners through an executive committee. The executive committee hires an executive director to oversee management of day-to-day operations.
- **There continues to be occasional confusion about the licenses issued using the compact process**. There is no such thing as a "Compact" license. Each member board is responsible for the issuance of full, unrestricted licenses. The resulting license is the same, whether it is obtained using a traditional application process or the IMLCC process.
- **We have learned that States of Principal License (SPL) continue to have problems, in some instances, gaining access to the FBI Criminal History Report Information (CHRI).** This has caused implementation delays. A fingerprint-based background check must be completed in order for the CHRI information to be supplied to the SPL. Additionally, the SPL must obtain the CHRI information from an FBI authorized source, such as a State Police Department or State Criminal Bureau of Investigation. Occasionally, an SPL's requests for the CHRI have been delayed or denied. The IMLCC and the impacted member boards continue to work with the FBI to resolve the misunderstandings about the IMLCC processes, how the information will be used, and the legal authority held by the SPL to access the CHRI.
- **We have learned that no matter how good the instructions, self-help information and effective online process, there will always be a demand for someone to answer a phone call or email to help applicants through the process**. The IMLCC receives more than 350 phone calls and more than 450 emails every month.
- **We have learned that there is a processing phenomenon that takes place when several bordering states are part of the Compact**.

Figure 2
IMLCC Key Metrics Year by Year

Item	April 2017 to March 2018	April 2018 to March 2019	April 2019 to March 2020
Number of completed applications included in the data study	654	2,845	2,995
Average number of licenses obtained per application	3	3	1.6
Percentage obtaining 1 or 2 licenses per application	68%	64%	80%
Percentage obtaining 3 or more licenses per application	32% *With 13% obtaining 7 or more licenses*	36% *With 13% obtaining 7 or more licenses*	20% *With 6% obtaining 7 or more licenses*
Percentage of applications determined to be ineligible	11%	10%	16%
Percentage of applications which were additional license requests — using the original Letter of Qualification but a separate application	11%	20%	26%
Average number of days between application submission and Letter of Qualification being issued	34 *With 33% obtained in 15 days or less*	36 *With 32% obtained in 15 days or less*	37 *With 34% obtained in 15 days or less*
Average number of days between Letter of Qualification being issued and all requested licenses being issued	15 *With 46% obtained in 7 days or less*	19 *With 51% obtained in 7 days or less*	20 *With 51% obtained in 7 days or less*

Source: Interstate Medical Licensure Compact Commission

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The Compact provides a process by which the physical state boundaries can be eased so that a patient can seek the best available care from a broader pool of available physicians. For example, a physician located in Minneapolis may be closer to patients in rural northern Wisconsin than those in Madison — so a patient could decide to see a Wisconsin-licensed physician at either the physician's Minneapolis office or Madison office. The IMLCC has received anecdotal information that suggests that rural and underserved hospitals can extend hours and services through the use of telemedicine and remote care from physicians who are able to obtain licenses quickly and easily. This is an area that the IMLCC will be researching to determine if data supports the reports.

Compact Accomplishments

In a relatively short period of time, the IMLCC has achieved a great deal. Among the key highlights:

- **The Compact has expanded to encompass more than half the states**. Compact legislation has passed in 29 states, the territory of Guam and the District of Columbia. In 2020, Compact legislation was on track for introduction in seven states, until the COVID-19 pandemic interrupted the legislative sessions in most states. We have learned that most of those seven states will re-introduce Compact authorization bills in the 2021 legislative session.
- **Physicians use the Compact**. Between April 2017 and May 2020, more than 7,800 applications have been received and more than 10,000 licenses have been issued using the Compact process — a strong indicator that the process works and fills a need in the physician community.
- **The Compact is fiscally sound**. The IMLCC's operational functions are paid through a budget based on revenues generated from the application fees paid by physicians. The IMLCC has always operated on a balanced budget and has been steadily building a reserve fund in anticipation of a future in which financial support from grants is either reduced or no longer existent. The original HRSA grant, for example, which was provided in 2015, enabled the IMLCC to create and implement a processing system and IT infrastructure with increased capacity and reporting options. Starting in July 2018, the IMLCC has been able to commit its own financial resources to matching the amount previously available from grant funds for IT improvements. This ensures that we are invested in making the right decisions about IT projects, such as creating an improved, more user-friendly system interaction that includes enhanced dashboards and summary information for physicians and member boards when logging into their accounts.
- **The Compact's greatest achievement is the creation of a streamlined approach to physician licensure**. The IMLCC creates multiple pathways to obtain a license using a single application. Instead of providing the same information to multiple states to be reviewed and vetted, the information already held is verified by a state where the physician currently practices, and can then be used to obtain licenses in up to 30 additional jurisdictions within 45 days. The IMLCC process, when used to augment a state's traditional licensing process, increases the number of providers in a state and increases care options for patients.

Conclusion

The Interstate Medical Licensure Compact Commission was created as an answer to the challenge of finding common standards verified by one and accepted by many. Through the hard work and dedication of IMLCC commissioners, member-board staff and IMLCC staff, the Compact stayed true to its original Eight Consensus Principles, answered the challenge and created the framework that will allow it to continue into the future.

The Compact's answer was also made possible with input, recommendations and support from the broader health care community; including the FSMB, health care systems, locum tenens companies, professional organizations, HRSA and especially the physicians who use the system. By working together, we have created an answer that has forever changed the way that physicians are licensed and ultimately how they are able solve the health care needs of their patients. ■

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