

# Interstate Medical Licensure Compact

imlcc.org

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NEWSLETTER

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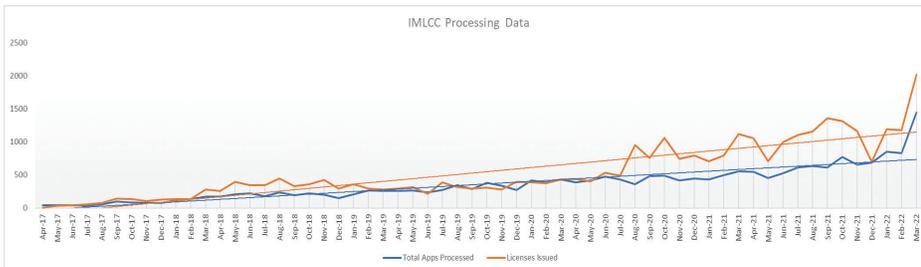


## Overview Information

By Executive Director Marschall Smith

The utilization of the Compact process by physicians over the past 5 years has been phenomenal and demonstrated a need in the licensing process. The Compact works closely with our member boards to bring a value-added process to the essential work that they perform in the evaluation of physician qualifications and enforcement of their medical practice act. The use of a high-bar standard enables Compact eligible physicians to quickly and efficiently obtain licenses – a process that proved critical during the height of the COVID-19 pandemic, as demonstrated in the chart below.

The Compact staff are committed to making the next 5 years as productive and exciting as these initial 5 years.



CALENDAR YEAR	APPLICATIONS PROCESSED	LICENSES ISSUED
2017	553	745
2018	2,216	3,767
2019	3,402	3,768
2020	5,166	7,385
2021	6,995	12,195
2022 - Q1	3,3132	4,392

## The IMLCC: The First Year

By Commissioner Ian Marquand (Montana)

So, you have an active interstate compact for medical licensing. What do you do now?

In the summer of 2015, that question hovered over the states that had accepted the IMLC. The language of Compact outlined the role of the governing commission but said nothing about how that body should begin its work.

After some preliminary e-mail discussions, Illinois agreed to host an organizational meeting and invited Compact member states to send representatives. We met in Chicago on September 1, 2015 and, by day's end, had a date, location, agenda and task list for an initial meeting of the IMLCC.

On October 27, 2015, commissioners assembled in Chicago for the IMLCC's first official meeting. That first day included two important items of business – the adoption of organizational bylaws and selection of officers. I was surprised and honored to be elected the IMLCC's first chair and felt energized as the commission spent the following day creating a committee and leadership structure. We set meeting calendars and outlined our next steps. The IMLCC had begun its journey.

Watchers of our work anxiously awaited the details of how – and how soon – physicians could receive licenses via the Compact. During the early months, my response often was “We don't know yet.” We also encountered new challenges >>

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# Going Live – 2017 Chair

By Commissioner Jon Thomas, MD (Minnesota)

The Federation of State Medical Boards (FSMB) convened a meeting of its member boards on January 17, 2013 to address the criticism levied against state-based licensure. We took seriously the need for a licensing system that was more responsive and efficient without sacrificing patient protection.

The meeting was optimistically called “Innovative Approaches to Facilitate Multi-State Medical Practice.” The idea of a Compact was introduced. I was fortunate to be at that initial meeting and every consequential meeting during the development and implementation of the Compact. This included the inaugural meeting of the IMLCC on October 26, 2015 in Chicago. As a surgeon, those 4 years felt like an eternity, but in government time, it was a remarkable achievement.

During that initial year, the phone calls were daily and sometimes several times a day. We were talking to each other, Congressional leaders in DC, lawyers, the FBI, media outlets and member boards. Unlike my involvement in fully funded organizations with staff to do the work, we started the Commission with no money or staff. All of the work was done by the newly appointed Commissioners and the Executive Leadership

who spent an inordinate amount of time getting the Commission off of the ground. It was a labor of love, and we were able to germinate the seed and grow what was then a fragile plant that has now taken root. It has been a joy to witness. The added bonus for me is that in my new role I needed multiple licenses in several states that were part of the IMLCC. I was able to use the compact, and it was seamless and quick, with the exception of the FBI

**The journey and experience were exciting, frustrating, rewarding, nerve-racking and incredibly fulfilling. The camaraderie amongst those of us who believed in the idea was deep.**

background check. It was quite an honor to have been a part of this innovation in licensure.

*Dr. Thomas is the ENT Medical Director at Optum and served as the IMLCC Chair from November 2016 to November 2017.*

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## The IMLCC: The First Year Continued from page 1

along the way, namely the FBI’s refusal to share confidential criminal background information with certain medical boards (including mine) until their states amended their physician licensing statutes. (My state wouldn’t complete that process until 2017.)

Nonetheless, thanks to dedicated and diligent work by the volunteer commissioners, the IMLCC made tremendous strides during its first year. We had help – the National Center for Interstate Compacts provided administrative support, while the Federation of State Medical Board obtained a federal grant that financed the Commission’s initial activities and helped provide a stable fiscal environment in which the IMLCC could build and grow on its own terms.

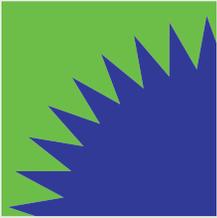
I remain proud of my time on the IMLCC and consider it one of the most satisfying experiences of my working life. To all my fellow commissioners and everyone who made that first year successful: Thank you.

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*Ian Marquand served as Executive Officer for the Montana Board of Medical Examiners from 2011 to 2019. He was appointed to the IMLCC in 2015 by Montana Governor Steve Bullock and was elected the Commission’s first chairperson that fall. He now lives in Los Angeles with his family.*

**INTERESTED IN HAVING YOUR STATE  
BECOME PART OF THE COMPACT?**

**Contact Marschall Smith at [imlccexecutivedirector@imlcc.org](mailto:imlccexecutivedirector@imlcc.org).**



# Creating the Interstate Medical Licensure Compact (IMLC)

By Rick Masters, Legal Counsel, Interstate Medical Licensure Compact Commission

**A**s we celebrate the 5-year anniversary of the IMLC it is instructive to see how far we have come to revisit the history of this creative process.

The genesis of the Compact occurred in 2013, when the Federation of State Medical Boards ('FSMB') worked with its member state boards and special experts to study the feasibility of an interstate compact to support medical license portability nationwide, while simultaneously ensuring state regulatory authority in the protection of the public. Among the issues driving the need for the Compact were, and still are, physician shortages, the influx of millions of new patients into the health care system as a result of the Affordable Care Act, and the growing need to increase access to health care for individuals in underserved or rural areas through the use of telemedicine as well as in person care as permitted by state or territorial law. The advent of COVID-19 has underscored the need for cross border practice by physicians using both telehealth and in person.

The Compact was drafted by state medical board representatives, with the assistance of the FSMB and the Council of State Governments. Throughout the two-year drafting process, input and feedback was received and incorporated from a multitude of stakeholders, including state medical boards, provider organizations, patient advocacy organizations, hospitals and health systems, and the telehealth industry. Since the final model legislative language was released in September 2014, thirty-seven (37) states and territories have enacted the Compact. The Compact is supported nationally by the American Medical Association and the American Osteopathic Association.

The success of the IMLC has rested upon the legal principles to promote both the uniformity and collective state control and oversight which is ensured by the manner in which the compact is structured.

These include the following:

**1** The Compact does not supersede the State's autonomy and control over the practice of medicine. On the contrary, it is the ultimate expression of state authority. States continue to maintain control of the practice of medicine through a coordinated legislative and administrative process. In the Compact, the practice of medicine is defined as where the patient is located, not where the physician is located. As such, all initial disciplinary actions will be handled by the Board of the state or territory where the patient is located, just as it is conducted today.

**2** The Compact is entirely voluntary for physicians to utilize. The Compact's definition of a physician does not change the existing definition of a physician in a state or

territory's existing Medical Practice Act, nor does it change the basic requirements for state medical licensure of a physician seeking only one license within a state or territory, or who chooses to become licensed in additional states through existing processes.

**3** In order to obtain a license through the Compact, a physician must meet nine eligibility requirements, including holding specialty certification at the time of application and having no disciplinary actions. The requirements are of the highest criteria to ensure all states and territories have the ability to join the Compact and to ensure physicians have the highest standards to protect patient safety.

**4** The Compact Commission serves as an administrative clearinghouse of licensing and disciplinary information among participating member states and territories. The Commission does not have regulatory control over physicians or the practice of medicine. It neither issues nor revokes licenses. Its only purpose is to facilitate interstate cooperation and the transfer of information between member states and territories. Regulatory control, including scope of practice, remains with the respective medical boards.

**5** The Commission is not a new layer of bureaucracy, but rather an innovative modality that enhances information sharing between state medical boards, thereby expediting the licensing process and better protecting patients.

**6** State participation in the Compact is, and will remain, voluntary. States are free to withdraw from the Compact at any time and may do so by repealing the enacted statute. The withdrawal provisions of the Interstate Compact are consistent with other interstate compacts currently in place for a variety of purposes throughout the country.

The Interstate Medical Licensure Compact is a tribute to the work of medical regulatory boards, physicians, and other key stakeholders to reach consensus in support of a state-based solution that simultaneously expedites state medical license portability while ensuring the protection of the public. The IMLC is a legacy about which all of those involved in its establishment can be justifiably proud.

*Rick Masters is the Legal Counsel to the Interstate Medical Licensure Compact and has also served as Special Counsel to the National Center for Interstate Compacts.*



## Federation of State Medical Boards – Celebrating Five Years of Improving Access and Portability

By Humayun J. Chaudhry, DO, MACP & Lisa Robin, MA

The Interstate Medical Licensure Compact (IMLC) began as a novel concept and has since grown into a powerful tool that has revolutionized cross-state medical licensure and improved access to care for countless patients across the U.S. In response to a resolution (submitted by the Wyoming Board of Medicine) adopted by the FSMB House of Delegates in 2013, the FSMB convened a group of leaders from state medical boards and experts in interstate compacts to begin drafting model legislation that would streamline the process for licensing physicians across state lines. Model legislation was completed in late 2014 and, in May 2015, the seventh state enacted the legislation, triggering the formation of the IMLC.

The success of the IMLC is a testament to the ability of the nation's state and territorial medical boards to evolve and come together to make license portability a reality. This historic achievement would not have been made possible had it not been for the strong and steadfast leadership of the Interstate Medical Licensure Compact Commission (IMLCC) and IMLCC's staff. The FSMB enthusiastically congratulates the IMLCC on its success and its role in strengthening state-based licensure and improving patient care.

We also acknowledge the U.S. Department of Health and Human Services, HRSA License Portability Grant Program and the Council of State Governments National Center for Interstate Compacts for their contributions to the development and implementation of the IMLC.

*Dr. Chaudry is the FSMB President and CEO and Ms. Robin is the FSMB Chief Advocacy Officer.*

## 2022 Chair

By Commissioner Mark Spangler  
(West Virginia)

The Interstate Medical Licensure Compact is growing and developing at a consistent pace. With 37 states and territories now participating, the goal of streamlining the licensure process for physicians who want to work in multiple states is coming to fruition. The IMLC has proven to be integral in meeting the needs of patients by increasing access to care. Throughout the Covid-19 Pandemic the IMLC pathway to state licensure was utilized by a record number of physicians seeking to practice throughout the nation in some of the most underserved regions. Never has licensure portability been so relevant and necessary to addressing our nation's healthcare needs.

While the IMLC adds new participating states, the Interstate Licensure Compact Commission is committed to the continued development of resources to assist

***I am convinced that our goals will continue to be accomplished, expanding access to care in a safe and accountable framework.***

physicians, state medical boards, state legislators and other partners. The success of the IMLC hinges on the integrity that each participating medical board brings to the table as we collectively work together to provide this expedited pathway to licensure while protecting the public by ensuring the sovereignty of each participating board. Throughout the last five years there has been much growth and expansion as the compact has evolved. The next five years we will be challenged to meet our goal with new and unknown variables. But, thanks to the foresight and hard work of all who have been involved and committed to this national compact, from its inception to its current composition, I am convinced that our goals will continue to be accomplished, expanding access to care in a safe and accountable framework.