State of Vermont
Department of Health
Board of Medical Practice
108 Cherry Street–PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-657-4220
[fax] 802-657-4227

Agency of Human Services

February 20, 2018

Senate Health & Welfare Committee
Vermont General Assembly
115 State Street
Montpelier, VT 05633-5301

Re: Response to Committee Request for Additional Input on S.253, An Act Relating to Vermont's Adoption of The Interstate Medical Licensure Compact

To the Committee:

Thank you for inviting the Board of Medical Practice (BMP) to comment on certain testimony submitted to the Committee regarding S.253, the bill that proposes to have Vermont adopt the Interstate Medical Licensure Compact (IMLC). The testimony the Board was asked to comment on is full of misstatements and misunderstandings about the IMLC, the Board of Medical Practice, and regulation of physicians in the United States. This submission will address the points raised in the written testimony, beginning first with one labeled as an addendum.

1. It Does Not Take Four Months or Longer for the Board of Medical Practice to Issue a License

The average time for the BMP to issue a license is less than a month, once the applicant presents a complete application. The Board issues licenses twice per month, once on the first Wednesday of the month and once on the third Wednesday (excepting only months with holidays or the shutdown of state government because of weather). If an applicant has some form of adverse history (e.g., criminal conviction, disciplinary action by another state, malpractice history), the application must be reviewed by the Licensing Committee, which meets only on the first Wednesday of the month, but applicants who have no history that requires review by the Licensing Committee are granted a license within about two weeks of when the application is complete. It may take as long as four months for applicants to get a license from when they begin the process if the documentation they must provide BMP is delayed. One of the most common causes of delay is the failure of an individual who the applicant has asked to submit a reference to forward the reference to BMP in a timely manner. Other common contributors to delay are failure to provide documentation about past adverse history such as malpractice and criminal convictions. In the end, I can say with confidence that 99% or more of licenses are granted in a month or less from the time that the application becomes complete. The time it takes for the applicant to gather the required materials is outside the control of the Board. In a very small minority of cases, the Licensing Committee requests additional information or the negotiation of conditions on a license, which results in the process taking longer than one month from the date on which the application becomes complete, but that is rare.

2. Use of the IMLC Will Reduce the Time and the Effort It Takes to Obtain a License

The ILMC will provide a streamlined process that will reduce the time and effort needed to obtain a medical license. Physicians licensed in a participating state, and who can claim at least one IMLC-participating state as a "state of principal license," will be able to be licensed by having the state of principal licensure verify that they meet the IMLC criteria. They will not have to arrange for direct-source verification of medical education, residency, examination scores, all state licenses, etc., which is what is required now. All the time and expense involved with obtaining that documentation will be replaced by the single verification from the state of principal licensure, which will verify that the applicant meets all the Compact criteria. In the initial months of operation of the IMLC it may have taken several weeks for the process to be completed, but it is only fair to expect that with experience, and with each of the participating states ironing out its own procedures, that the time will be substantially reduced. Once member states' IT systems are updated to incorporate the IMLC pathway, processing times should be even faster.

3. IMCL Fees

An accurate statement of the fees is available on the IMLC website at http://www.imlcc.org. The base fee is $700, each additional participating state requested by the applicant at the time of application is an additional $100. Those fees are in addition to the underlying fees for the state license in each state to cover the cost of running the medical boards, which provide licensing and regulation of the practice of medicine in the states. The reasonableness of the fee structure will be judged in the long run by the physicians who chose to use the IMLC, or not.

4. The IMLC Does Not Create a Requirement for Specialty Board Certification, or Maintenance of Specialty Board Certification

The IMLC does not create any requirements for any physician who does not choose to use the IMLC procedure to obtain a license. Even for those who do choose to use the IMLC, while it is true that they must possess a current specialty certification or a time-unlimited specialty certificate to qualify to use the Compact process, it is not necessary for them to maintain specialty board certification once licensed through the IMLC. The assertion that any physician must maintain certification is simply wrong. The requirements for renewal of licenses through the IMLC are found at page 10, line 10 through page 11, line 13. Ongoing maintenance of specialty board certification is not one of those requirements.

5. Section 1420x and the Meaning of Supersede

Dr. King's statement on behalf of FSMB was and is accurate. The IMLC does not undermine the autonomy or control of the practice of medicine of any participating state. By its own terms, the IMLC "creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act." S.253, page 2, lines 9-10. If one studies the terms of the Compact, it is clear that the terms of the Compact that might be in conflict with state law, and thus supersede state law, are matters such as the requirements for licensure. It is a given that by

participating in the IMLC and accepting this alternate pathway to licensure that the pathway found in existing state law will be superseded, but only with regard to those physicians who choose to obtain a license via the Compact. I could go on about this point at length, but it seems a matter easily settled by asking the attorney assigned by the Legislative Council.

6. The IMLC Commission Will Not Regulate Physicians and the IMLC Does Not Create a New Requirement for Suspension or Revocation of Licenses in All Member States

The allegations about "a new requirement" are unfounded. For states that participate in the IMLC, "[a]ny disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct that may be subject to discipline by other member boards, [...]." S.253, page 13, lines 8-10 (emphasis added). For unprofessional conduct serious enough to result in revocation, surrender, or suspension, the status is automatically extended to other IMLC-obtained licenses, but subject to the right of the member boards to reverse the automatic action. S.253, page 14, lines 17-19. This is a commonsense provision for public protection that echoes existing Vermont law. 26 V.S.A. § 1366 provides that upon obtaining a certified copy of another state's revocation or suspension the Board should follow the process for immediate interim suspension.

7. Misstatements About FSMB and the IMLCC

The addendum closes with a misstatement about the IMLCC being a subsidiary of the FSMB. The IMLCC, as all bodies created as entities operating multistate compacts, is a joint venture operated by its member states. The Commission is directed by the voting commissioners, who represent their states. The FSMB does not have a vote. Legally, the IMLCC is no different from the hundreds of compact bodies that allow the states to cooperate to find solutions together. Other examples are regional transportation authorities, regional pollution control efforts, and interstate school compacts. FSMB worked with the states and the United States Health Resources and Services Administration to hold meetings attended by a large majority of states. The idea for a compact grew out of those meetings and moved forward only because a compact for medical licensing became the shared vision of many states.

8. Commenter's Concerns About Due Process

The commenter expressed concerns about loss of due process. As already explained above at 6, Vermont law already provides for immediate, emergency suspension when a licensee is the subject of another state's revocation or suspension. Also, the provisions of the IMLC pertaining to discipline in another member state apply only to physicians who choose to use the IMLC. The commenter did not divulge his reasoning of how the language applies to physicians who do not participate in the Compact, but he is plain wrong. By its terms, the IMLC applies only to physicians who make use of it. This is another point that might be easily resolved with input from Legislative Council.

9. The Commenter's Alternatives

The Commenter suggested two alternatives to the IMLC. One is to just let providers practice in other states via telemedicine without being licensed in that other state. There are so many problems with that proposal, I will present them in bullet points for brevity's sake.

- End of state's rights to regulate who practices in their state. End of ability to set standards for education, training, examination performance, etc. Overnight, for telemedicine, the standard would become the most lax standards in the nation, and telemedicine providers would have an incentive to be licensed in the states that provide the least oversight.

- Jurisdiction over those out-of-state providers? Without the ability to order cooperation with an investigation, would the Board be required to work through the courts in other states to investigate unprofessional conduct, and what would be the basis for action? Just how would that work? Would Alabama, for instance, expend resources to investigate harm to a Vermont patient caused by a physician located in Alabama? What legal authority would the Alabama board have to subpoena documents and witnesses in Vermont, even if they were willing to investigate unprofessional conduct in this state? Does the General Assembly want to forego the ability to regulate the conduct of out-of-state providers who are affecting Vermont patients and Vermont communities? An obvious example is the rules regarding the prescribing of opioids for pain created by Act 173 of 2016. The ability to require practice according to Vermont Rules is tied to the ability to require Vermont licensure – does Vermont want to allow practice in accordance with rules and oversight that is lax enough to have given rise to pill mills?

- If Vermont providers could practice telemedicine in distant states where they are not licensed, would BMP be expected to oversee and investigate their conduct in those remote locations? How would travel for investigators be funded? Subpoena power over documents located in those distant locations? Payment for travel of the patients to come to Vermont to testify? If the commenter is concerned about due process, the proposal for this "solution" should include thoughts on how due process would be achieved and paid for if Boards had to regulate practice on the other side of the nation.

- The Telemedicine for Medicare Act of 2015 was introduced. It did not pass. I submit that was because proponents of that bill did not have answers for many questions, including those listed above.

The second proposal is to mimic Ohio, which offers a $1,000 service to collect documents for physicians who are applying for licensure, in addition to the regular licensing fee. The concerns about the IMLC fees stated on the second page seem to have abated by page 3. The Ohio "solution" is only for a single state. If it became widespread it would cost many thousands of

dollars for physicians who seek licensure in many states. It would do nothing for Vermont physicians who would like access to a streamlined process to obtain licensure in multiple other jurisdictions. Also, because so much of the process of obtaining documentation is outside of a board's control, it is difficult to understand how anyone could claim to have the application complete in 21 days, when any one of the many sources of documentation could be the source of a delay. Finally, it would be risky, at best, to guess at how many physicians would use a "concierge" service to become licensed in Vermont, so as to determine how many additional state employees to hire to take on this new role. Twenty-two states have elected to make the IMLC state law, while only Ohio has chosen the "concierge" solution.

10. Loss of State Sovereignty

It is a bit ironic that the commenter is a proponent for allowing unlicensed practice in Vermont by out-of-state physicians and does not see that as an injury to sovereignty, yet expresses concern about sovereignty if Vermont joins another compact. The ability to regulate professional practice within a state is a fundamental state right. Vermont has joined dozens of state compacts. They all involve giving up to some degree the individual state's right of self determination on an issue, but in exchange the state gains entry into a multi-state solution to a problem, or a means to advance state interests. As with any compact, the member states share liability for the obligations of the body. These are false concerns; members of the Compact have the right and ability to control the body's spending and actions, and as with any compact participation must be taken seriously. It does not mean that the IMLC is a bad idea. The states benefitted from the assistance of the Council of State Governments in drafting the IMLC language and the provisions of the bill comport with the practices for operation of a compact as seen in hundreds and hundreds of compacts across the nation.

11. Investigations of Physicians in or by Other States

The closing paragraph on page 4 of the longer set of comments reveals a lack of understanding of how professional licensing works in the United States. The IMLC does not give authority to member states to investigate physicians in other states. Rather, the IMLC reflects the reality that when licensed professionals obtain a license in a state, they become subject to the state's oversight. That oversight extends to conduct that occurs outside Vermont for physicians who are licensed here. The easiest way to explain why this must be so is with an example. If a physician is licensed in both New Hampshire and Vermont commits acts of unprofessional conduct in New Hampshire, Vermont has the right, and I submit the BMP has the obligation, to examine the conduct and make a determination if there has been unprofessional conduct. By obtaining the license, the physician accepts the jurisdiction of Vermont. If this were not the case, a physician who harmed patients in New Hampshire could simply come across the border and begin practicing in Vermont, potentially presenting an identifiable risk of harm to Vermont patients. Right now, without the IMLC, if New Hampshire investigates and responds to the unprofessional conduct with a sanction that triggers the immediate suspension provision of 26 V.S.A. § 1366, there may be an immediate interim suspension. Or, if New Hampshire fails to take action, Vermont may still investigate and take action based on the conduct.

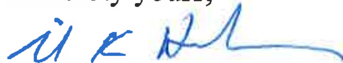
Conclusion

The Board of Medical Practice asks that you assess the IMLC based on informed and rational analysis of its terms, not on uniformed speculation and false assertions about the Compact, the Board, the FSMB, and regulation of the practice of medicine in general. If you have any doubt about how seriously you should take the two documents in question, please consider the commenter's suggestion on page 3. He writes:

> *Rather than ease in obtaining a license, I suspect that a much greater motivation for out-of-state doctors3 to serve Vermonters would be the opportunity to make more money in Vermont relative to somewhere else. I have scoured the text of S.253 and I find no provision to raise fees for physicians.* [sic]

Regardless of whether that is a facetious remark intended to be humorous, or based on a detachment from reality, it's a good indicator of how helpful these comments are to furthering an informed discussion of the IMLC.

Sincerely yours,



David K. Herlihy
Executive Director