MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 29, 2015
ATTENTION: Members, Medical Board of California
SUBJECT: Interstate Licensure Compact
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

This item is in follow up to action requested by the Medical Board of California (Board) Members at the January 2015 Board Meeting.

BACKGROUND:

A presentation was provided at the January 2015 Board Meeting on the Interstate Licensure Compact (Compact). The presentation was provided by Board staff and the Federation of State Medical Boards' (FSMB) President and Chief Executive Officer, Humayun J. Chaudhry, DO, MACP. After the presentation and discussion on the Compact, public comment was heard. Several issues and concerns were raised by the public on the Compact. The Board Members voted to support the compact in concept. They directed Board staff to work with the Legislature and also to look at the issues raised by the public to determine if the Compact would be approved in California. After the January 2015 Board Meeting, staff compiled all of the concerns from the public and requested a response from the FSMB legal counsel and staff. A response was received. In addition, Board and DCA legal counsel have reviewed the responses and agree with the responses provided based upon the Compact language.

CONCERNS/QUESTIONS AND RESPONSES PROVIDED:

1) The Board is in a large state but it only gets one vote on the Commission.

   Response: In accordance with the structure and composition of other Compact Commissions, each state is granted equal representation, regardless of its population. The Compact does provide more representation than other compacts that California has previously entered into, as each member state will appoint two representatives to the Compact Commission. The decision to appoint two individuals, rather than one per state, was made so that 14 states, including California, that have a separate allopathic and osteopathic board, are fully represented. The increased number of representatives also provides more oversight to the Commission's activities, ensuring that all states are in compliance with the terms of the Compact.

2) What will the Compact cost the Board?

   Response: California will continue to set and assess its own licensure fees. Therefore, there is no anticipation of a loss in revenue for the Board.

   Under Section 13(a), the Compact Commission has a permissive power to levy and collect an annual assessment from each member state to cover the cost of the operations and activities of the Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources.

   Under the funding model used to facilitate operations of the Nurse Licensure Compact, for example, each member state contributes $3,000 per year to fund the Commission. Although the funding models are different, some states have used this estimate as part of their fiscal note.

However, it is anticipated that user fees as well as appropriations from outside funding sources, such as federal and private grants and contributions from the FSMB, for instance, would be sufficient to cover operations.

In other states considering the Compact, fiscal notes indicate that the state would be able to implement the Compact within their current licensure fee revenues and absorb related workload within existing staff while others reported possible staff increases to facilitate licensure and information sharing. For example, Texas anticipates that the Compact would produce a two-year net impact to General Revenue Related Funds that would be a positive impact of $31,180 based in part on the number of additional licenses issued through the Compact.

3) If the Board wants to make any change, it has to have other states make the change too. That is a concern.

   Response: Substantive changes to the Compact via amendment must be enacted into law by unanimous consent of the member states. The contractual nature of a Compact agreement requires all states (thus parties to the agreement) to agree to the same terms and conditions of participation.

4) Unlike the Board, there is no requirement for a mix of both physicians and public members on the Commission.

   Response: While there is no requirement for a public member from a state to be appointed to the Compact Commission, there is no restriction either. Under Section 11(d), the Compact specifically cites that a “Member of the public appointed to a member board” may serve as a Compact Commissioner.

   The California Legislature, when considering the Compact, may offer an amendment that would instruct the Governor/Legislature on selecting appointees (including appointing a public member), as long as the requirements are in accordance with the Compact.

5) It is the public’s view that the FSMB finalized the compact without any public consumer input.

   Response: Per the FSMB, the claim of exclusion of consumer patient input is not accurate. Multiple drafts of the Compact were distributed to a wide array of consumer and patient advocacy organizations, including AARP, Parkinson's Action Network (PAN), the National MS Society, and the American Heart Association. Several of these groups, including AARP and PAN, provided comments that helped refine the Compact during the drafting stage. Drafts of the Compact were also posted to the FSMB website prior to the release of the September 2014 final model legislation and shared through various media outlets in an attempt to solicit additional comment.

   The FSMB is proud of the support they have received from consumer organizations, including several state chapters of AARP, the Helmsley Charitable Trust, and the Guinn Center for Policy Priorities.

6) Any amendments to the Compact itself must be, "Enacted into law by unanimous consent of the member states." In addition, the compact empowers the Commission to promulgate rules, which "Shall have standing as statutory law." This section goes on to say, "But shall not overwrite existing state authority to regulate the practice of medicine." This seems to be contradicted by another Compact provision, "All laws in a member state in conflict with the Compact are superseded to the extent of the conflict." Thus, to the extent that California has already enacted patient protections that exceed Compact standards, they may become null and void if California were to sign on to the Compact. If California wishes to enact higher patient safety standards in the future, the state may be precluded from doing so.

   Response: The Compact was drafted so that the highest standards acceptable to all states were incorporated into the terms of the document. In fact, the inclusion of fingerprinting was at the insistence of the Board.

   The legal standing of Compacts as contracts between states nullifies any action that is in conflict with the terms of the Compact. This contractual nature controls over unilateral action of a state to impair the obligations of the contract. As cited in Section 1 of the Compact, "the Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act." The Compact is simply a mechanism to offer a voluntary, expedited pathway for licensure for eligible physicians. Those laws or state decisions which are in conflict with the expedited process agreed to in the Compact would be superseded. The other area where California laws would be superseded is with regard to accepting out-of-state subpoenas from member states regarding member physicians, document sharing, and automatic discipline pursuant to Section 10 of the Compact.

   Once a physician is licensed in a state via the Compact process, he/she must abide by the rules, regulations, and laws of the state where he/she is practicing and treating patients. Hence, a licensed physician treating a patient in California must abide by all of the regulations and standards currently in place in California. Physicians practicing in California will still be bound by the future requirements and regulations imposed for patient safety, including continuing medical education or completion of other patient safety programs or procedures.

7) While the Compact states it will make its information and official records public, it is not explicit how those will be made public or how the information will be made available. There is no assurance that the Commission will be transparent and make public the data it collects in a manner already provided by the California law and Board policy.

   Response: Under Section 11, the Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Commission shall keep minutes that shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes. The Commission shall make its information and official records, to the extent not otherwise designated in the Compact or by its rules, available to the public for inspection.

   The Commission, by law, has a duty and responsibility to be public and transparent. All rulemaking will be done in a manner consistent with state administrative procedure law, which requires a notice and a period of comment.

In addition, the public disclosure laws for California licensees will remain as stated in the Business and Professions Code whether the licensee goes through the normal licensing process or through the Compact.

8) There may be additional costs and workload that may be associated with the Compact for the Board. This may result in additional license fees due to the potential increase in volume of work for the Board's staff.

   Response: While the Compact will require the Board staff time to facilitate the gathering and sharing of information with the Commission, it should dramatically reduce the time staff currently spends in verifying the credentials of its applicants seeking licensure via the Compact. If a physician seeks to be licensed in California, and applies via the Compact process from another Compact member state, the State of Principal Licensure, the Commission will disseminate an attestation letter of eligibility and all applicable fees to the Board. The Board will not be required to re-validate and verify the physician's credentials, which would be required if the physician applied via the traditional licensing process. Therefore, with a reduced workload, and more staff time available for investigations and other duties of the Board, the FSMB anticipates boards will function more efficiently by participating in the Compact.

   A medical license issued via the Compact will be the same full and unrestricted license as the one California currently issues via the traditional pathway. Once California receives an application from a Compact applicant, it will issue the license in the same manner.

9) What is the problem that is trying to be solved by creating an expedited license? Is there a problem with California's existing licensing process?

   Response: While there may not be an issue specific to California's existing licensing process, there is an issue with multi-state licensing nationwide. The states are in a historic era that is putting significant demand and strain on the health care system: an anticipated physician shortage; lack of access to care in rural and underserved communities; expansion of ACOs and multi-state health systems; millions of new patients entering into the health care system due to the *Affordable Care Act*; and the rise of telemedicine technologies to treat patients across state lines. With nearly a quarter of the U.S. physician population holding more than one state medical license, and many more expected to do so in the years ahead, the Compact will offer a mechanism to facilitate multi-state practice, support license portability, expand access to care, and enable telemedicine, while ensuring each state's medical regulatory authority in the protection of the public.

   There is growing concern in the U.S. Congress and Executive Branch (pushed by powerful corporate interest groups) about the state-based medical licensure system, and how it is a barrier to the delivery of care, especially across state lines. Prominent Members of Congress have introduced legislation that would effectively create a one-state license model (i.e. Driver's License model), expand state licensure exceptions, or implement a national medical license system that would eradicate state medical boards' ability to fulfill their duties and sacrifices patient protection. Under these proposed models, the practice of medicine could be construed to occur where the physician is located at the time of the encounter, subjecting California patients to the rules and courts of other states. Given the Compact's growing

support among states, stakeholders, and national policymakers, the calls for a nationalized licensure system have quieted down dramatically in the past two years. If the Compact does not succeed, it is anticipated another strong push for national licensure in Congress will occur.

10) There is a potential that the Compact will increase potential violations of the corporate bar. How will the corporate bar be enforced, particularly when there are other states that do not have a corporate bar, and whose law applies? Is it where the employer is located? Is it where the physician is located?

Response: Under Section 4, an eligible physician may declare the State of Principal Licensure to be: (1) the state of primary residence for the physician, or (2) the state where at least 25% of the practice of medicine occurs, or (3) the location of the physician's employer, or (4) if no state qualifies under subsection (1), subsection (2), or subsection (3), the state designated as state of residence for purpose of federal income tax. A physician may re-designate a member state as state of principal license at any time, as long as the state meets the requirements in subsection (a).

The eligibility requirements for entry into the Compact process (e.g. specialty certification) are higher than any state has for initial or renewal of medical licensure. Therefore, regardless of which state the physician selects as his/her State of Principal Licensure (assuming the aforementioned criteria is met), he/she must still meet the eligibility requirements of the Compact.

In addition, the physician must abide by the laws where the patient is receiving the treatment and therefore, a physician seeing a patient in California must abide by the laws of California, including the bar on the corporate practice of medicine.

11) There are concerns regarding the schools that are approved to meet the requirements for licensure under the Compact. California has its own list of approved schools, but there is a difference between that and what the Compact requires.

Response: A physician applying for licensure via the Compact must be a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent. If the physician does not meet these criteria, he/she is still eligible to apply for licensure in California via the traditional path. The Compact is completely voluntary for physicians.

12) There are concerns about sharing information. Currently, complaints under California law are confidential. It is unclear if other states have this provision as well. In addition, if that information is shared in other states, will that also continue to be confidential?

Response: Many states consider complaint information confidential. The Compact allows for the sharing of complaint information only between Compact member states, and only for physicians participating in the Compact process. Under Section 8, all information provided to the Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters. The Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

13) The Compact requires the Board to provide an expedited license to a physician from another state, so long as that other state investigates the physician's credentials and background and finds that the physician meets the eligibility criteria in the Compact. The Board has no control over this decision. The Board is required to accept the word of that other state, when, in fact that other state medical board may not be as well-resourced and it may not have public protection as its highest priority.

    Response: Every state medical board, and the FSMB, considers public protection as the highest priority. The documentation and credentials verification that will be shared from the State of Principal Licensure to the Commission to other selected Compact member states will ensure that all physicians who are issued a license via the Compact process have met the eligibility requirements of the Compact.

14) The Compact says, "The provisions of the Compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine." The Compact also says in Section 24, "All laws in a member state in conflict with the compact are superseded to the extent of the conflict." There may be several consumer protection laws in California, many of them enacted through the Board, which will not be able to be enforced for physicians who are licensed under the Compact.

    Response: Consumer protections in place in California will continue to be upheld via the Compact. The Compact is solely a means for an eligible physician to be issued a license in an expedited manner. Once the physician is licensed and treating a patient in the state, he/she must adhere to that state's consumer protection laws. The same scenario applies if a physician from another state is granted a license by California via the traditional pathway.

15) The Compact says a physician who has a criminal conviction, cannot get an expedited license. However, the Compact does not address very weak expungement of criminal conviction laws that exist in many other states, including California, which allow a physician to get a conviction expunged and to then answer no to the question: Have you ever been convicted of a crime.

    Response: A court's authority to expunge criminal records is principally derived from statute, but some courts view this power as inherent to the court. The expungement of an order is subject to the Full Faith and Credit Clause, but there are some where it does not automatically apply to issues where a state can show a rational interest. In *Hughes v. Fetter (1951) 141 U.S. 609*, the U.S. Supreme Court stated that "every state has the constitutional right to enact laws and the corollary right to enforce those laws within its borders"; the full faith and credit clause does not compel the displacement of local law without a showing that "upon some rational basis . . . [the foreign state's interests] are superior to those of the forum."

    If this issue is seen by the Commission as an area of concern, the rulemaking authority provides a mechanism to address the issue and balance member state interests.

16) The Board intends to disclose the same information about physicians licensed under the Compact as it does about physicians with a regular California license. However, Section 8 of the Compact says what information shall be reported to the Commission and it concludes

by stating that all information provided to the Commission or distributed by member boards is confidential.

Response: The information shared between the member states through the Commission will include data such as licenses held, disciplinary actions taken, and contact information. The facilitation of data sharing will allow states to coordinate disciplinary actions and ensure a high level of patient safety.

In California complaint information will continue to be confidential, however, information required to be public under the laws of California will continue to be public.