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September 19, 2016

Comments on Interstate Medical Licensure Commission Proposed Administrative Rule Chapter 5, "Expedited Licensure."

To: Commissioner Mark Bowden, Interstate Medical Licensure Compact Commission, Bylaws and Rules Committee Chair and Committee Members

Dear Commissioner Bowden,

Thank you for the opportunity to provide comments on the Proposed Administrative Rule on Expedited Licensure.

We would like to raise a number of concerns about the proposed rule for the committee to address.

1) The model proposed for expedited licensure is unnecessarily complex and bureaucratic. Consider that the nursing licensure compact allows for licensing of nurses in all member states with ONLY one license while the Interstate Medical Licensure Compact requires a physician to license in each and every state at substantial cost. The Interstate Medical Licensure Compact along with the proposed rule does not meaningfully reduce the costs for multi-state physician licensure.

In addition, nurses are now increasingly practicing medicine and the structure and rules of the Interstate Medical Licensure Compact creates selective disadvantages to physicians in competition with NPs.

Congress has also introduced legislation, H.R.3081 - TELE-MED Act of 2015, to allow Medicare patients to receive care from a Medicare-enrolled physician licensed in any state. Similar reciprocity is granted to U.S. military and VA physicians, thus demonstrating the cost-effectiveness and safety of allowing cross-state medical

practice, without the need for the complexities added by the Commission under development. Legislation granting reciprocity to physicians serving athletic organizations has been passed or is under consideration in numerous states and the U.S. Senate just this month introduced HR 921, the Sports Medicine Licensure Clarity Act of 2016, to institute such reciprocity on a federal level.

2) The requirement in section 5.4(1)d of the rule, mandating certification exclusively by ABMS- or AOA-approved boards, should be removed and the related provision in the Compact should also be stricken as:

a) No single medical board in the United States requires such certification as a licensing requirement.

b) This creates a discriminatory process for physicians with time-limited certification.

b) The American Board of Medical Specialties (ABMS) & AOA (American Osteopathic Association) have been subjected to significant criticism regarding anti-competitive practices, financial impropriety, and misrepresentations about quality improvement due to certification and maintenance of certification. By the ABIM's own admission "they got it wrong" and have repeatedly changed their recertification requirements. The Commission must ask if they will ever "get it right"?

c) Two other certification boards, NBPAS and ABPSUS, exist in the USA and multiple exist internationally. It is notable that the Compact and Commission fail to allow physicians certified by these entities access to Compact licensure, especially given the fact that there is no indication the certificates matter at all in any way to quality or improvements in care. We believe that the omission of these alternatives, in light of the close ties of the FSMB and ABMS, calls for an investigation into the occurrence of any inappropriate and potentially illegal collusion of the various entities involved in writing the Compact and its rules and those benefiting financially from the implementation of the Compact.

3) "Primary Source Verification" is defined in item "dd" of the proposed rule's definitions and the definition includes reference to the FSMB's FCVS. However the term "Primary Source Verification" is not otherwise mentioned in in the proposed rule text. Our concern is that the definition signals the possibility that the additional purchase FSMB-controlled services, like the FCVS, might be required for Compact participation.

A need to register with the FSMB's FCVS would represent an additional overcharge as the rule already proposes a current "letter of qualification" from the medical board in the state of primary licensure. This letter should satisfy any and all need for primary verification of any and all documents. Presumably all have been already primary verified by the home state licensing board. This possibility suggests the inefficiency and blatant and primary attempt of FSMB to increase revenues unnecessarily to their organization.

4). Section 5.6(1)b of the proposed rule states that a "letter of qualification is valid for 365 days from its date of issuance to request expedited licensure in a member state. There shall be no waiver of this time limit."

It is unclear what demands are to be set to allow issuance of such "letter of qualification" after the first 365 days have passed. If a physician seeks Compact licensure in an additional state after the expiration of the letter presumably the physician will be required to apply again with his principal state of license to obtain another letter of qualification. Would this mean that the physician's ABMS- or AOA-approved certification would have to be current when seeking a new letter? Despite the provision in 5.4(1)d that current certification is only required on the initial determination of eligibility, the 365-day rule creates ambiguity that begs clarification.

And most if not all states have licensing requirements lasting periods of 2 years-much longer than 365 days. How does this 365-day rule impact physicians with existing multi-state licenses at the time of their initial Compact eligibility? If such physicians plan to seek future "expedited" licensure via the Compact in these states, and the relevant renewal dates are more than 365 days in the future, will they again need to obtain a letter of qualification?

We have additional concerns, beyond the scope of this particular proposed rule, that raise questions about the solvency of the Compact. We will name just two of many: 1) the FBI questioning the authority of the investigatory powers delegated to the non-government regulatory entity, the Interstate Medical Licensure Commission. 2) concerns about the appearance of pay-for-play created by FSMB-lobbying of Congress and federal agencies and subsequent federal taxpayer-funded grants received by FSMB for Compact operational funding.

In conclusion, as the Compact preserves the existing requirement to purchase multiple licenses in every state of practice, with the addition of additional service fees, and the enormous costs associated with the board certification mandate, not to mention the

possibility of requiring the purchase of other services like FCVS, the entire Compact as structured is not a meaningful solution to the problem it seeks to solve.

Without a significant reworking of the Compact concept, perhaps using the more efficient nursing compact as a guide, physicians may very well find it more cost effective, and even faster, to bypass the Compact and continue to license directly with each state of practice.

Thank you for taking our comments into consideration. We look forward to the Committee's response to our concerns.

Sincerely,

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AAPS Board Member

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AAPS Executive Director