GETTING STARTED:

A PRIMER FOR STATES ENTERING THE INTERSTATE COMPACT

Congratulations! Your state has joined the Interstate Medical Licensure Compact.

That, by itself, is an accomplishment. As you might expect, though, there is more work ahead as your state prepares to participate fully in the operations of the Compact.

The Interstate Medical Licensure Compact Commission (IMLCC) wants to assist you in those preparations. The IMLCC's Communications Committee has developed the following primer for that purpose.

The primer addresses eleven subject areas related to Compact implementation. Each of these areas has key questions that your state will need to answer based on the applicable laws, rules, policies and procedures in place in your state. The IMLCC recognizes the diversity among its states and so has chosen not to presume what your answers will be.

Each area also has narratives of "One State's Experience," i.e. how two of the original Compact states addressed each of these areas. In many areas, this state's decisions had to be made prior to IMLCC decisions in order for the state to be ready once IMLCC processes were put in place. These narratives are intended only to provide one approach to addressing these nine subjects, but not a "one size fits all." Your state will arrive at your own individual answers, processes and procedures. If this primer helps you reach that goal, even in small ways, it will have served its purpose.

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TABLE OF CONTENTS

1) Our state has joined the Compact. Now what?

- **IDENTIFYING COMMISSIONERS:** Who appoints the Commissioner(s) from your board? (Governor, Department, Board, other?) Is there an appointment process? If the Board doesn't appoint, can it recommend appointees?

  STATE EXPERIENCE #1: The legislation that entered this state into the Compact also specified that the Governor would appoint the state's two Commissioners to the IMLCC. The state has only one medical board (overseeing both M.D. and D.O. licensees) so both Commissioners would have to come from that board.

  Shortly after the Governor signed the Compact legislation, the board took the initiative and recommended two people to the Governor—a physician board member and the board's executive. This occurred before the effective date of the new Compact law, giving the Governor time to consider the recommendations.

  As the law took effect, the Governor made his appointments, naming the two individuals recommended by the board.

- **IDENTIFYING THE COORDINATOR(S) TO IMPLEMENT THE COMPACT:** Who will be responsible for getting the Compact up and running in your state? The Board's executive director/administrator? Department managers? A task force?

  STATE EXPERIENCE #1: This Board's executive is also a Commissioner with the IMLCC and made personal involvement in implementation a priority. As a result, the executive assumed the role of coordinator for implementation. Because the board is part of an agency, with functions spread among several units, the executive began making contacts with the units responsible for licensing, fiscal matters, database management and complaint processing. The board's legal team also was briefed in anticipation of rulemaking.

  STATE EXPERIENCE #2: This Board's licensing manager is also a commissioner. This allowed the use of current licensing processes to complement the implementation of the compact. The manager was able to work with other departments, such as IT, to change systems where necessary. In addition, the manager kept the Board informed of process changes and how implementation was progressing.

2) Rulemaking.

- **IS RULEMAKING NECESSARY?** Early conversations with licensing, compliance, IT and fiscal probably will identify whether rules are needed to specify procedures or state-specific aspects of Compact participation.

- **BRING LEGAL INTO THE CONVERSATION (if they're not there already.**) Rulemaking by the Board probably will not be able to proceed without direct involvement by legal counsel.

  STATE EXPERIENCE #1: As one of the first states to join the Compact, this state's medical board began contemplating rules even before the IMLCC was ready to institute its online application process. The board created a rule addressing in-state physicians who would identify the state as their State of Principal License and seek a Letter of Qualification. The rule was brief and anticipated physicians applying directly to the board.

  The rule went into effect shortly before the IMLCC opened its online application portal but was written in such a way that the board could defer to IMLCC processes once they were established.

  It was determined that the board did not need a rule to govern "incoming" Physicians who selected the state for expedited licensure based on a Letter of Qualification from elsewhere.

3) Fees.

- **ARE DIFFERENT FEES NEEDED FOR LICENSES ISSUED VIA THE COMPACT?** Since the license issued is the same as a license issued through traditional methods, should the fee be the same? Or should it be different because the cost of issuing a license is expected to be less? Does your state pro-rate the cost of a license based on the proximity of the renewal deadline? Are there any other considerations specific to your state?

- **ARE FEES ESTABLISHED BY RULE OR BY MORE INFORMAL POLICY DECISIONS?** If fees are set in rule, then make sure they are covered in your Board's rulemaking.

  STATE EXPERIENCE #1: In this state, fees are set in administrative rule, so rulemaking was necessary. Fee changes were placed into the same rulemaking proposal as the "process" rule.

  The state's medical board wanted to make sure there was no perception that a license issued via the Compact was somehow "different" than a physician license issued via the traditional application process.

  The board decided every physician license issued should cost the same amount of money, regardless of the method used to issue it or when it is issued. To make that clear, the board amended its rules on physician license fees to include a fee for "Physician license issued via interstate compact." The amount was the same as a "License application fee": $500.

  Renewal fees did not need to be addressed, as every physician license has the same renewal fee, regardless of the process through which the license is issued.

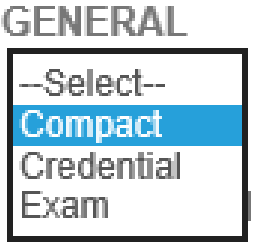
  While this state contemplated a state-specific Compact application fee, this became unnecessary once the IMLCC set its fee of $700, with $300 earmarked for the physician's State of Principal License.

Interstate Medical Licensure Compact
A faster pathway to medical licensure

4) Licensure database / info technology.

- **IDENTIFYING NEW PHYSICIANS WHO ENTER VIA THE COMPACT.** Your state will need to identify the physicians who acquire licenses from your board via the Compact. This information will be useful when it's time for those physicians to renew their licenses via the IMLCC. Presumably, you'll also want to be able to report how many physicians entered your state via the Compact and, perhaps, where they are located.

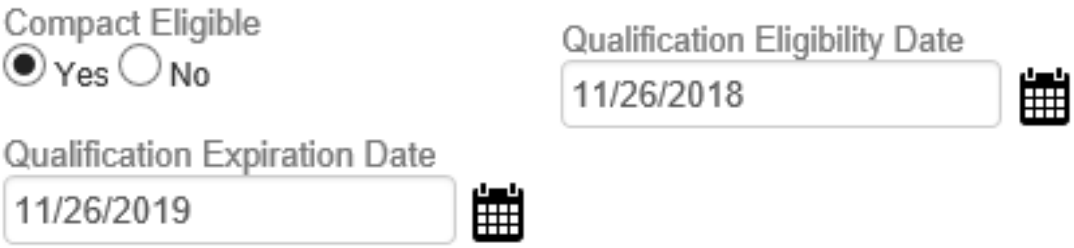
  STATE EXPERIENCE #1: This state's database already had fields to note whether a license was given as the result of the applicant passing an examination (identified as "exam") or on the basis of existing licensure in another jurisdiction or certification from a non-government organization (identified as "credential.") At the request of the board executive and the agency's licensing unit, the database managers added a third field for "compact" to note physicians who came into the state via that route.



  STATE EXPERIENCE #2: This state's database prefixes to denote differences in licenses. However, the board wanted to ensure that compact licenses were the same as those issued the traditional way. This led to the creation of a "flag" to internally denote compact licenses. The flag allows staff to run reports and gather data.

- **IDENTIFYING LICENSEES WHO RECEIVE LETTERS OF QUALIFICATION.** Similarly, your state will want to know which of your physician licensees received a Letter of Qualification for the Compact and when that occurred. You'll also want to know how many of your licensees received a Letter of Qualification.

  STATE EXPERIENCE #1: This state had its database managers add new fields to physician licensee records to identify whether a physician is "Compact Eligible" or not. If a physician has received a Compact LOQ, the database shows when it was issued and when it expires.



STATE EXPERIENCE #2: In this state, a new marker was created to denote licensees who have requested an LOQ. The marker is the same for those who qualify and those who don't. In addition, because this state does not use criminal background checks, a new section had to be added to the database to handle this information.

- **IDENTIFYING LICENSEES WHO ARE FOUND TO BE INELIGIBLE FOR THE COMPACT.** Conversely, your state also will want to know which physicians were found to be ineligible for the Compact. You'll also want to know how many physicians were turned down.

- **INFORMATION YOUR DATABASE REQUIRES BEFORE A LICENSE CAN BE ISSUED.** For instance, does your database require an "application" record before a "license" record can be created? Is there specific information that every record must have in order to be created?

  STATE EXPERIENCE #1: This state's database required an "application record" to be in place prior to the issuance of a license, after which a "license record" is created automatically. As a result, licensing staff must create an "application record" and enter key information into it, as well as all documentation sent by the IMLCC through the DocuSign process. In practice, this takes less time than creating an "application record" through traditional application processes. But it still requires manual input of information by someone skilled in using the database, i.e. a trained licensing specialist.

- **UPDATING YOUR LICENSURE DATABASE TO ACCOMMODATE THE IMLCC PROCESS.** For instance, are licenses usually issued only upon payment of fees? In the case of the IMLC, all fees are paid to the Commission, which then passes them onto the states. Reimbursement to the states takes time, however. At present, states must send invoices to the IMLCC for the fees they are owed.

  STATE EXPERIENCE #1: This state's database was programmed so that no license could be issued until the proper fee was received. For physician licenses issued via the Compact, that feature had to be turned off, but only for those licenses. As a result, "incoming" physicians receive their licenses even though the state has not yet received its required fees. Once the fee is received from the IMLCC for a given individual, the payment is noted in the database.

STATE EXPERIENCE #2: In this state, applications are not acted upon until the fee is received. This process was changed for compact applications and the fees are received after the license has been issued. However, this state also has a jurisprudence exam that must be taken and passed prior to licensure. Compact applicants are notified of the requirement and are not issued the compact license until the exam has been successfully taken.

5) The DocuSign workflow, IStARS and “envelopes.”

The IMLCC has adopted DocuSign as the workflow product for LOQ and license requests by physicians. Once a physician makes an application through the IMLCC portal, that person’s information becomes a DocuSign “envelope” containing all the relevant documentation. The “envelope” then is forwarded to the appropriate state, either for LOQ review or for issuance of a license.

“IStARS” is the acronym for the IMLCC’s workflow program, which uses DocuSign. Applications requiring attention from your state will arrive from the IMLCC via “DocuSign NA3 System” with a heading that looks like this:

- **DECIDING WHO RECEIVES THE “ENVELOPES” FROM DocuSign and IStARS.** Who is going to receive and handle information from DocuSign? The board executive? Licensing staff? Someone else?

  STATE EXPERIENCE #1: In this state, the DocuSign envelopes come to the board executive, who then forwards the information to licensing specialists.

  In the case of applications for a Letter of Qualification, the executive also sends an e-mail to the physician with additional information about what the physician needs to know about fingerprinting and criminal background checks in this state. (Background checks are not required for licensure in this state via the traditional application method.)

Licensing staff inform the board executive when licenses are issued or LOQ's are approved. The executive then completes the DocuSign workflow and submits it to the IMLCC.

By personally handling the DocuSign envelopes, the executive has been able to create and manage a record of names and numbers of LOQ applicants and "incoming" licensees during implementation. That information has proven helpful in keeping track of how quickly LOQ's or licenses are issued and in identifying physicians who haven't submitted all of their information for LOQ review.

Eventually, the entire IMLCC/IStARS/DocuSign workflow process is expected to be transferred to the licensing unit. The executive can then use reporting features in the database to identify individuals and numbers of LOQ's and licenses issued.

6) Training licensure staff.

- **SELECTING THE WORKERS.** Will "front line" licensing staff do this work? If so, how many? What level of experience should those people have? Are enough applications anticipated that they'll require dedicated staff who will review only those applications?

  ONE STATE'S EXPERIENCE: In this state, the decision was made to assign IMLCC applications to only those licensing specialists who already had experience with traditional physician license applications. They would work directly with the board executive.

- **THE "HOW" AND "WHO" OF TRAINING.** Is it the board executive's responsibility to conduct training re: Compact processes? A unit manager? A dedicated training specialist or agency unit? Who will develop the training? What's the best way to deliver training--in-person, by webinar, in print form?

  STATE EXPERIENCE #1: In this state, the board executive first met with licensing specialists who already were experienced with processing physician applications through traditional means. Their supervisors also were included. Together, they reviewed the requirements of the Compact for both license issuance and Letter of Qualification reviews. Based on those conversations and the suggestions of the licensing specialists, the board executive created draft checklists and outlines of the tasks that the specialists would be expected to perform.

  Further conversations led to refinements of the checklists and task outlines, followed by testing. For LOQs, licensing specialists tested the checklists and task lists by reviewing the license records of physician members of the medical board, as if those physicians were seeking LOQs. For license issuance to "incoming" physicians, the database's "test" environment provided a means to create application and license records for fictitious applicants without affecting the actual database.

  Communication with licensing specialists continues, especially as the specialists work with the process and suggest improvements. As a result, the time spent by licensing specialists on IMLCC applications has been reduced, with no reduction in quality.

  STATE EXPERIENCE #2: In this state, the licensing manager handles compact applications. Much of this states licensure process is done online and the compact was

found to be a much more manual process. Due to the small staff size and number of applications normally handled, it was felt, at the time, that this would represent an increased burden to staff working at full capacity. Staff has been trained and provide cover when the manager is away.

7) Issuing licenses / License renewals

- **A LICENSE ACQUIRED VIA THE COMPACT IS NO DIFFERENT THAN ANY OTHER LICENSE.** The Compact makes clear that a Physician license issued by a state through the mechanism of the Compact is no different than a Physician license issued through existing state-specific application processes. Participating states are discouraged from adding special designations to licenses—or printed license certificates—that convey that they are somehow different from other Physician licenses.

- **EXPIRATION DATES.** The expiration date should be no different for a license issued via the Compact than for a license issued at the same time through your state's application process. If your state has an annual expiration date, then licenses issued via the Compact process would expire on that date, as would all other Physician licenses. If you have "rolling" dates based on when a license was issued, follow that protocol for licenses issued via the Compact.

  STATE EXPERIENCE #1: This state's Physician licenses are valid for two years and and have a common expiration date of March 31. (The only difference is whether that date is in an odd-numbered or even-numbered year. Roughly half of this state's Physician licenses expire each year.) For new licensees, the expiration date is set automatically by the licensure database. This is true for licenses issued via Compact as well as those issued via standard application processes.

- **PREPARING FOR LICENSE RENEWALS.** The Compact's statutory language requires that Physicians who receive licenses via the Compact's expedited process renew those licenses through the Compact Commission. The process essentially works like this:

  1) 90 days before a "via Compact" Physician's license expires, your state contacts that individual and directs him/her to begin the renewal at the IMLCC website. If your state has additional requirements for renewal, you can also inform the Physician of those at the same time. You might provide renewal forms or, if your renewal process is online, the link to the URL where the Physician can fulfill your requirements.

  2) The Physician goes to the IMLCC website, initiates the renewal and pays your state's renewal fee.

3) Your state is informed of the renewal by the IMLCC via DocuSign “envelope.”

4) If your state has additional requirements for renewal, you can follow up with the Physician and make sure those requirements are fulfilled.

STATE EXPERIENCE #1: As of the creation of this primer, this state has not gone through a renewal process for Physicians licensed via the Compact. But preparations have been made. 90 days prior to the March 31 expiration date, reminder e-mails will be sent to Physicians whose licenses are “about to expire” directing them to do two things:

1) Go to the IMLCC website to initiate renewal and pay the renewal fee.
2) Submit a printed renewal form and attestation to the state. At present, the online renewal process requires payment of a fee, so that poses an obstacle.

All expiring Physician licensees will get a reminder notice from this state about 60 days prior to the expiration date. So Physicians licensed via the Compact will get two reminders, plus any automatic “last reminders” the licensing database generates closer to the renewal deadline.

STATE EXPERIENCE #2: In this state, automatic notices are sent 60 days prior to renewal and drive licensees to the state’s online system. The state had to create a work around in the database so that compact licenses are not automatically noticed of renewal. Manual notices are created for compact licensees directing them to complete the renewal process through the compact website.

- **CONTINUING MEDICAL EDUCATION & AUDITS.** Does your state require Physicians to attest to the completion of required continuing medical education when they renew? Does your state have any other requirements that must be noted? Think about these things when you prepare to notify your “via Compact” Physicians about renewals. And make sure you inform them that they are subject to all laws and rules of your state, including those on CE or other renewal requirements.

8) Forms / Templates.

- **DEVELOPING STATE-SPECIFIC FORMS, EITHER FOR STAFF OR FOR APPLICANTS.** What specific forms might be needed for your state to implement the Compact? Forms for your licensing staff? Forms for applicants following licensure or license renewal through the IMLCC?

  STATE EXPERIENCE #1: For internal uses (such as by licensing specialists) the board executive has created forms and templates in draft form. They can be refined relatively quickly as experience with IMLCC processes uncovers potential new elements and/or efficiencies.

  This board does not require any additional information from "incoming" physicians granted a license via the Compact. However, other states might require newly-licensed physicians to submit additional information or attestations, such as completion of a certain number of CME hours re: opioid prescribing.

9) The money.

As noted earlier, the IMLCC collects fees on behalf of the member states and/or boards. All fees paid to the IMLCC are by credit card. At present, states or boards are expected to send invoices to the IMLCC for the fees owed to them.

NOTE: Eventually, the IMLCC may be able to electronically transfer fees to states immediately upon collection. For now, payments are made by check to each state or board that submits an invoice.

- **KEEPING TRACK OF FEES COLLECTED BY THE IMLCC.** How often should invoices be prepared and sent to the IMLCC? Who should prepare and send them—the board executive? The fiscal office? Another entity or individual within the agency? How will the state or board know the amount to be invoiced? How will the resulting payment be allocated and accounted for?

  STATE EXPERIENCE #1: With each new notification from the IMLCC via IStARS and DocuSign, the board executive notes the physician involved and the amount collected by the IMLCC on the state's behalf (either the $300 state share of the IMLCC's LOQ application fee or the amount of the state license fee collected.)

  This state invoices the IMLCC at the start of each new month and provides a list of physicians and fees collected for each, with a total amount owed to the state. The list is shared with licensing and fiscal employees.

  Once payment is received, licensing and/or fiscal employees who normally handle application fees apply the appropriate fee to each physician's application record.

10) Keeping your board (and perhaps others) informed.

- **WHAT THE BOARD EXPECTS.** What kind of regular reports does your board already receive about applications and licensing? What does the board expect in those reports? How involved is your board in the IMLCC? Are your state's Commissioners active? Do they report on their involvement either at IMLCC meetings or committee work in between meetings? What might be helpful in keeping the board informed about IMLCC work?

- **USE YOUR WEBSITE.** Who controls the content of board or agency websites? Must content be approved before it can be posted? Can a special area be created on medical/osteopathic board websites for IMLCC information? Can the website offer links to the IMLCC website or certain areas within it?

  STATE EXPERIENCE #1: In the months before the IMLCC had its own website, Compact states were required to post information about upcoming meetings, rules hearings and rule/policy development on their medical/osteopathic board websites. This was the only way to provide information to interested parties. This state's medical board executive arranged for a new area to be created on the board's website with a tab identifying it. Meeting notices, minutes, hearing information were posted there, along with information about the state's two Commissioners.

  State board websites remain an important entry point into the IMLCC and can provide links to important information for physicians, state board members and others interested in the Compact.

- **INFORMING OTHERS WITHIN STATE GOVERNMENT.** Would the Governor's office or legislative services agency be interested in how your state's implementation of the Compact? Other health-related agencies? Other licensing or regulatory boards?

- **KEEPING OTHER INTERESTED PARTIES IN THE LOOP.** Who else might care about your state's role in the Compact? The state's AMA or AOA affiliates? The state hospital association? Health care policy groups? Locum tenens recruiting firms active in your state? Media organizations that focus on health care topics?

11) Staying in touch with the IMLCC.

- **IDENTIFYING YOUR CONTACT PEOPLE.** Who will be the main contact in your office or agency when the IMLCC leadership or staff needs to get in touch? Who will be authorized to contact the IMLCC for assistance or to share information on applicants, licensees or newly appointed Commissioners? Who will coordinate attendance, travel or other logistics for Commissioners doing IMLCC business?

  STATE EXPERIENCE #1: Because this state has only one unified medical board and the board executive is a Commissioner, it made sense to locate all of the responsibilities for interaction with the IMLCC in that person's office. When necessary, the board executive can coordinate the other Commissioner's travel and attendance at IMLCC functions. And the board executive can coordinate IMLCC-related business with other units of the agency.

  For a state which decides not to have the board executive as a Commissioner, it may still be best to have the board executive as the "hub" of IMLCC activities. But other people may be appropriate, too. Each state makes its own decision on this point.