

To: Thomas Ryan, Executive Director of the Wisconsin Medical Examining Board

From: Eric Fish, Sr. Director of Legal Services for the FSMB

Date: March 16, 2015

Re: Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact has been enacted in Wyoming and South Dakota, and awaiting signature by the Governors of Utah and West Virginia. Legislatures in 14 other states are currently considering the Interstate Medical Licensure Compact. With the predicted upcoming shortage of physicians, especially in rural and medically underserved areas, expanding access to medical services through innovative measures that preserve the rights of states to regulate professions is paramount. The expedience with which state legislatures are considering this initiative is a testament that under a looming threat of federal preemption, the Interstate Medical Licensure Compact is a viable policy under which qualified physicians seeking to practice in multiple states would be eligible for expedited state licensure, in a process which ultimately preserves state authority.

Prior to Wednesday's meeting of the Wisconsin Medical Examining Board, I wish to provide the following comments in response to concerns raised about the Interstate Medical Licensure Compact. For ease, I addressed the concerns by section but will provide additional commentary during the discussion.

Section 2

The term disciplinary action was not defined in the compact because the term 'disciplinary action' has several meanings to various state medical boards. During the drafting process, the workgroup attempted to balance what each state would consider a disciplinary action. Some felt that all actions by the board, including letters of concern that did not directly restrict the license, were to be considered disciplinary actions. Other states considered disciplinary actions as only those actions of public record the license to practice may be directly affected. Noting the variance, the term was left undefined, to be clarified by rules promulgated by the Interstate Commission. A benefit of leaving this definition to rulemaking is that as disciplinary approaches change across

the country, the member boards can more easily modify the definition to ensure the necessary information flows to member boards through the compact.

Section 5

The compact does not create a new class of license. Physicians who are licensed through the compact mechanism receive the same, full and unrestricted license to practice, as those holding only one license in the state, or those who choose to be licensed through the current process.

What the compact does create is an expedited system of licensure that can be used by physicians that meet the standards of eligibility.

In order to be licensed through the compact process, an eligible physician must first hold a full and unrestricted license to practice in the state selected to serve as the state of principal licensure. In issuing this first license, that state would have primary source verified a physician's information. The physician would apply for eligibility through this state, which at the time of application, would perform the criminal background check.

The licensure process facilitated by the compact is not based on a model of pure reciprocity. Instead, the process sets forth a procedure for expedited licensure. A physician would apply and have their eligibility verified by a member state, which will then communicate the necessary information to the Interstate Commission. The Interstate Commission would then facilitate the sharing of all information with those member states the physician selects for additional licensure. As a result of the acceptance of the principal state's attestation, there will be a substantial reduction in the time it takes for a physician to be issued a license in an additional state. If the member states see fit, a process of review may be incorporated by rule. However, during the drafting, it was believed that the verification process, as well as the improved data sharing, would mitigate the need for such a process.

Section 6

The ability of each state to levy fees on licenses it issues through the compact process is not compromised. Section 6(b) permits the Interstate Commission, if it so chooses, to assess a processing fee that will largely offset, if not totally eliminate, the burden on the member states as well as support the technical infrastructure for the data sharing.

Section 7

The Interstate Commission is a clearinghouse for the renewal process. Each state will charge its chosen renewal fee. The Interstate Commission will not take a percentage of the renewal fees. Renewal with the Interstate Commission facilitates an expedited renewal process for those physicians licensed through the compact process. For example, if a physician has 3 licenses that must be renewed in one year, the Interstate Commission will work with the state boards to provide the physician the necessary renewal questions and create a portal where a physician can enter in renewal information to be used across all three states as well as any information that is state specific.

Section 8

The database to support the coordinated information system is not a new product. Much, if not all, of the information necessary is part of the FSMB's Board Action Database and various other databases used by medical boards. Creation of the system would entail repackaging existing information on participating physicians and delivering it to all states.

Under Section 8(c) member boards would report disciplinary or investigatory information as determined necessary and proper by rule of the Interstate Commission. The intent of this section was to empower the Interstate Commission to facilitate the sharing of certain types of reports universally related to the disciplining process, and to do so by adoption of a rule. Again, related to the lack of definition of disciplinary action, the member boards will determine what information would be shared.

Participating states are allowed to comment on any rules through their appointed commissioners. All rulemaking is subject to the Administrative Procedures Act and public notice and opportunity to comment will be given. Moreover, interested parties may serve as non-voting observers to the commission and provide input on rules.

Section 9

If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. Member boards could then take individual action on that license to either reinstate it, or proceed with their own disciplinary process.

Treating action on the license from the state of principal license different than action on licenses received from a member state was a compromise for those state boards who wanted to ensure patient safety in light of the expedited licensure. The 90 day requirement was selected since most, if not all, boards meet at least quarterly.

Regarding the subpoena, the process in the compact mirrors an analog process for civil litigation, the Uniform Interstate Depositions and Discovery Act, in which the state where discovery is to take place simply reissues the subpoena of the issuing state, and the new subpoena is then served on the deponent in accordance with the laws of the discovery state. The UIDDA has been enacted by 34 jurisdictions and is currently pending adoption in Wisconsin via rule of the Supreme Court.

Sections 11-24 (Generally)

Sections 11 through 24 set forth the basic operations of the Interstate Commission, the administrative body charged with the administration of the compact. The powers provided to the Interstate Commission to fulfill its charge were included at the suggestion of the Council of State Governments, which helps compact commissions operate and succeed in fostering interstate cooperation. Terms related to rule making, withdrawal, and process have been tested and refined through experiences with other compacts and previous court decisions. The establishment of this entity and its powers is legally recognized in both state and federal law and these boilerplate terms are already in compacts enacted by the Wisconsin legislature.

Section 12/13

Throughout the drafting and enactment process, it has been clear that in order to succeed, the compact must be as close to budget neutral as possible, and thus, self-sustaining. Under the terms of the compact, the Interstate Commission may assess processing fees for expedited licensure, ultimately off-setting any burden on the member states. Additionally, the Interstate Commission is enabled to seek grants and secure outside funds to support initial and future funding. The FSMB is working with states that have already enacted the compact to secure grant funding to support compact operations pursuant to the recently announced License Portability Grant Program.

States that have enacted and are considering the fiscal implications of participation in the compact and determined that any increased costs to the agency, which is statutorily required to generate sufficient revenue to cover its costs of operation, would be offset by an increase in fee generated revenue by participation. I have attached examples of these fiscal notes for information.

Section 13(a) sets for a permissive levy, if necessary, of the member states. This section is necessary in order to maintain the state as the 'funder of last resort', and therefore secure the state action immunity protections for any commissioners appointed by that state to serve on the Commission. This language is boiler plate language that is part of several other compacts enacted in Wisconsin, most recently the Interstate Compact for Adult Offender Supervision and the Military Interstate Children's Compact.



Fiscal Note

H.B. 121 2015 General Session
 Interstate Medical Licensure Compact
 by Ward, R.



General, Education, and Uniform School Funds

JR4-5-101

	Ongoing	One-time	Total
Net GF/EF/USF (rev.-exp.)	\$22,000	\$(9,400)	\$12,600

State Government

UCA 36-12-13(2)(b)

Enacting this bill could generate \$500,000 in dedicated credits revenue, \$96,000 in ongoing Commerce Service Fund revenue beginning in FY 2016 and \$9,000 in one-time Commerce Service Fund revenue in FY 2016 through increased licenses. After associated costs, the bill could increase year end transfers to the General Fund by \$12,600 in FY 2016 and by \$22,000 in FY 2017.

Revenues	FY 2015	FY 2016	FY 2017
Commerce Service Fund	\$0	\$74,000	\$74,000
General Fund	\$0	\$22,000	\$22,000
Dedicated Credits	\$0	\$500,000	\$500,000
Commerce Service, One-time	\$0	\$18,400	\$0
General Fund, One-Time	\$0	\$(9,400)	\$0
Total Revenues	\$0	\$605,000	\$596,000

Enacting this bill could cost Commerce \$18,400 one-time from the Commerce Service Fund to develop rules and support one-time technology costs. The bill could cost the Department of Commerce \$74,000 from the Commerce Service Fund each year beginning in FY 2016 for staff support related to licensure, investigation, accounting support and for ongoing database maintenance. Spending from the Commerce Service Fund impacts year end transfers to the General Fund. The \$500,000 in dedicated credit revenue could be transferred to other states for licensing fees as part of the compact.

Expenditures	FY 2015	FY 2016	FY 2017
Commerce Service Fund	\$0	\$74,000	\$74,000
Dedicated Credits	\$0	\$500,000	\$500,000
Commerce Service, One-time	\$0	\$18,400	\$0
Total Expenditures	\$0	\$592,400	\$574,000

Net All Funds	\$0	\$12,600	\$22,000
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Local Government

UCA 36-12-13(2)(c)

Enactment of this legislation likely will not result in direct, measurable costs for local governments.

Enacting this bill could cost an estimated 500 individuals a \$1,000 licensing fee to obtain licensure in multiple states. Additionally, an estimated 575 applicants may apply for the interstate compact license fee of \$160.

Performance Note

JR4-2-404

No performance note required for this bill

Notes on Notes

Fiscal notes estimate the direct costs or revenues of enacting a bill. The Legislature uses them to balance the budget. They do not measure a bill's benefits or non-fiscal impacts like opportunity costs, wait times, or inconvenience. A fiscal note is not an appropriation. The Legislature decides appropriations separately.

FISCAL NOTE

	FY 2016	FY 2017	FY 2018
NON-ADMINISTRATIVE IMPACT			
Anticipated Revenue increase			
SPECIAL REVENUE FUND	\$24,000	\$48,000	\$48,000
Source of revenue increase: Increased number of applications for Wyoming physician licenses received through the compact.			
Assumptions: Estimate 40 additional applications (an increase of 10% over calendar year 2014 licenses issued) in FY2016 (Anticipated Compact start-up year), and 80 additional applications in FY 2017 forward.			

	FY 2016	FY 2017	FY 2018
NON-ADMINISTRATIVE IMPACT			
Anticipated Expenditure increase			
SPECIAL REVENUE FUND	\$5,000	\$5,000	\$5,000
Source of expenditure increase: Two commissioners appointed to represent Wyoming would attend an annual meeting of the commission.			
Assumptions: This is the only anticipated expense outside of the Board of Medicine's normal budget and will be accommodated with the existing appropriation for FY2016.			

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 (Information provided by Kevin Bohnenblust, Board of Medicine, 307-778-7053)

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 84TH LEGISLATIVE REGULAR SESSION

March 9, 2015

TO: Honorable Myra Crownover, Chair, House Committee on Public Health

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB661** by Zerwas (Relating to the Interstate Medical Licensure Compact; authorizing fees.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for HB661, As Introduced: a positive impact of \$31,180 through the biennium ending August 31, 2017.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2016	\$40
2017	\$31,140
2018	\$54,695
2019	\$54,695
2020	\$54,695

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from <i>General Revenue Fund</i> 1	Probable Revenue Gain/(Loss) from <i>General Revenue Fund</i> 1	Change in Number of State Employees from FY 2015
2016	(\$228,960)	\$229,000	3.0
2017	(\$176,460)	\$207,600	3.0
2018	(\$131,505)	\$186,200	3.0
2019	(\$131,505)	\$186,200	3.0

Fiscal Analysis

The bill would amend the Occupations Code relating to the Interstate Medical Licensure Compact; authorizing fees. The bill enables member states to create the Interstate Medical Licensure Compact Commission in order to maintain and administer the compact. This compact creates a new pathway for licensure for physicians primarily licensed in Texas and for those who are primarily licensed out of state who wish to also practice medicine in Texas. The bill authorizes a state medical board to charge fees for the issuance and renewal of a Compact license. The bill requires the interstate commission to establish a coordinated information system that includes a database of all physicians with a Compact license. State medical boards that are members of the Compact are required to report licensing and enforcement data to the coordinated information system, which would be shared with other member states.

The bill would take effect September 1, 2015.

Methodology

According to information provided by the Texas Medical Board (TMB), the agency estimates that 100 existing or new physicians per year in Texas would apply for interstate compact licensure, for which the fee would be \$150 ($100 \times \$150 = \$15,000$ per year). The agency also anticipates processing 250 out of state applications for interstate licensure in Texas, for which the fee would be \$856, in fiscal year 2016 ($250 \times \$856 = \$214,000$ in 2016); TMB estimates 225 out of state applications in fiscal year 2017 ($225 \times \$856 = \$192,600$ in 2017); TMB estimates approximately 200 out of state applications per year thereafter ($200 \times \$856 = \$171,200$ per year).

In order to implement the provisions of the bill TMB indicates it would require an additional 3.0 Full-Time-Equivalents (FTEs) each fiscal year in the licensing division (3 License and Permit Specialist II at \$32,742 per FTE per fiscal year) to process applications and complete administrative tasks associated with the new license. TMB estimates the benefits and payroll contributions for these FTEs will total \$33,279 each year (\$66,558 biennially). In addition to salary and other costs associated with these FTEs, TMB estimates one-time start-up costs, including purchase of information technology equipment for the FTEs, would be \$2,470 per FTE in 2016 only (\$7,410 total in 2016). This analysis assumes that any increased costs to the agency, which is statutorily required to generate sufficient revenue to cover its costs of operation, would be offset by an increase in fee generated revenue.

The Office of the Attorney General, the Comptroller of Public Accounts, the Office of the Governor, the Office of Court Administration and the Department of Public Safety anticipate any costs related to implementing the provisions of this bill could be absorbed within current appropriations.

Technology

TMB assumes it would need to make changes to the agency's licensure database and website in order to receive and process applications for Interstate Compact licenses. The agency estimates these updates would require 1,500 hours of programming and business process analysis in order to ensure the secure exchange of data with the Interstate Compact Commission and the agency, at an estimated \$90 per hour of consultation and implementation (\$135,0000 total). TMB estimates the information technology costs would be divided into approximately \$90,045 in fiscal year 2016 and \$44,955 in fiscal year 2017.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 212 Office of Court Administration, Texas Judicial Council, 301 Office of the Governor, 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 405 Department of Public Safety, 503 Texas Medical Board

LBB Staff: UP, NB, NV, TWh, KVe

Maintenance of Licensing

WSBME

March 18, 2015

MOL Background

- 2010 Federation of State Medical Boards (FSMB) several states expressed intention to pilot new projects to implement Maintenance of Licensure (MOL)
- Process is to be evolutionary, not revolutionary
- “Determine what types of activities, beyond medical education (CME), physicians engage in to keep their knowledge and skills current.”
- “. . . Engage in more pilot projects to better determine how to move forward.”

MOL

- Who are the stakeholders?
 - Department of Public Safety
 - Wisconsin State Board of Medical Examiners
 - Every physician licensed in the State of Wisconsin
 - WMS
 - Specialty groups
 - WHA
 - Citizens of Wisconsin
 - ABMS/AOABOS
 - Other accrediting organizations

MOL Framework

- As a condition of license renewal, physicians should provide evidence of participating in a program of professional development and lifelong learning that is based on the general competencies model:
- medical knowledge
- patient care
- interpersonal and communication skills
- practice based learning
- professionalism
- systems based practice

Three Components of Life Long Learning in Medicine

1. Reflective Self Assessment (What improvements can I make?)
2. Assessment of Knowledge and Skills (What do I need to know and be able to do?)
3. Performance in Practice (How am I doing?)

MOL: Key Questions

1. What current problems are we trying to address?
2. What future problems are we trying to avoid or have the capacity to address?
3. How will we help the safety of Wisconsin's residents?
4. What infrastructure changes will it take to accommodate this process?
5. How much time and money will it demand of physicians?
6. Who is going to pay?
7. How will we enforce?

MOL and MOC/OCC

- MOL
 - Based on Maintenance of (Board) Certification (MOC)
 - Reflective self assessment-What improvements can I make?
 - Assessment of knowledge and skills-What do I need to know and be able to do?
 - Performance in practice-How am I doing?
- https://www.fsmb.org/Media/Default/PDF/FSMB/Foundation/FSMB_MOL_Task_Force_on_CPD_Activities-FINAL_report.pdf

MOL and MOC/OCC

- MOC/OCC
 - Hold a valid, unrestricted medical license
 - Life long learning
 - 50 hours of CME per year
 - 1 unit of questions and case study per year
 - Cognitive expertise
 - Test every 10-13 years
 - Practice performance assessment
 - Demonstrate quality of care compared to peers and national benchmarks then apply best evidence to improve care using follow-up assessments
 - Continuous membership in osteopathic community (OCC only)

MOL: Does it work?

- ABIM
 - Improved performance
 - Improved knowledge assessment
 - 2015 update:
 - Due to member feedback, Part IV, the practice assessment (CQI/CPD) piece has been temporarily put on hold
 - ABIM has been problematic since it was introduced

MOL: What do we have now?

- Licensing process
- Organizational culture
 - Hospital credentials
 - Infection rates/Complication rates/procedure numbers/blood utilization/C-section rates/other OB/records completion
 - Patient satisfaction (5 components)
 - Productivity (3 components)
 - Patient and staff complaints
 - Peer review
 - Record Reviews/over reads
 - OPPI/FIPI
 - System credentials: similar to above and more
 - System “required training”
 - The Alphabet: ALSO, BLS, ACLS, NRP, ATLS, PALS
 - “Quality indicators” 12 items and counting
 - MOC
 - Tort system

MOL: “Categories” to monitor

- Board Certified-MOC
- Board Certified, Life time certification-no MOC
- Hospital based, not BC
- System affiliated, not BC
- Non hospital based, non system affiliated, not BC
 - “Clinically isolated physicians”
- Clinically inactive administrators
- Clinically inactive
 - Retired
 - Other

MOL: “Categories” to monitor

- Board Certified-MOC
- Board Certified, Life time certification-no MOC
- Hospital based, not BC
- System affiliated, not BC
- Non hospital based, non system affiliated, not BC
 - “Clinically isolated physicians”
- Clinically inactive administrators
- Older physicians
- Clinically inactive
 - Retired
 - Other

MOL: Challenged Groups

- Clinically Isolated Physician, not BC
 - This group has less access to CPD certified activities
 - Available to those with academic or larger system affiliation
 - CPD activities are becoming available in CME format
- “Older Physicians”
 - Who is “older” 70, 75, ??
 - Should there be assessment based on age?
- Clinically Inactive
 - What options are available?



MOL: Where do we go from here

What problem are we trying to solve or prevent?

What problems could we create (access-especially mental health)?