The Interstate Medical Licensure Compact
Attending to the Underserved

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The Interstate Medical Licensure Compact (IMLC), which has been rapidly gaining ground since its operational inception in 2017, has been endorsed by most, if not all, of the remaining states and territories of the US in the interim, several leading national organizations have supported the IMLC initiative, including the American Medical Association, the American Academy of Family Physicians, and the Council of Medical Specialty Societies. The Centers for Medicare & Medicaid Services (CMS), for its part, concluded that the “interstate license compacts...will be treated as a valid, full license for the purposes of meeting federal license requirements.”

Before the institution of the IMLC, the interstate licensing process was widely viewed as an onerous administrative chore. Interstate licensing through the IMLC, in contrast, is being reduced to a single uniform set of eligibility requirements. The first such requirement is a formal letter of qualification from the state of principal license (SPL) that is to be shared with those states wherein a physician seeks to be licensed. IMLC-eligible physicians must hold a full unrestricted medical license in their SPL. The absence of prior disciplinary actions, criminal history, substance abuse, or an ongoing investigation must also be affirmed. Prospective applicants must also submit fingerprints to the designated criminal justice agency in their SPL to enable the conduct of a criminal background check. For physicians who choose to relocate their SPL and office to another state, a “redesignation” of the SPL may follow. The IMLC is a step removed from a bona fide national licensure system, and is best viewed as a decentralized interstate alliance intent on simplifying the cumbersome interstate licensing model. The primary licensing function is to remain a state-based responsibility. It follows that state medical boards are to retain full autonomy within their state borders wherein they are to serve as the custodians of the SPL of each physician.

By facilitating interstate telemedicine, the IMLC is intent on increasing “access to health care—particularly for patients in underserved or rural areas.” Extending the virtual reach, actual reach, or both of physicians across state lines is a step in the right direction. Attending to the needs of impoverished and disadvantaged communities and their attendant health disparities could not be timelier. Achieving these goals, however, will challenge the IMLC to overcome the persistent geographic redistribution of medical professionals. Estimates of the Health Resources and Services Administration suggest the existence of as many as 7203 Health Professional Shortage Areas (HPSAs) in primary care alone. The corresponding Medically Underserved Area/Population of more than 81 million citizens is projected to require in excess of 15 000 primary care practitioners in family medicine, pediatrics, and internal medicine. Comparable shortfalls

Telemedicine, which is likely to become an enduring legacy of the COVID-19 pandemic, invariably is in conflict with the interstate physician licensing process. This obstacle is being progressively overcome by the IMLC, which has been rapidly gaining ground since its operational inception in 2017. Intent on streamlining physician licensure across state lines, this little-known national construct has facilitated the issuance of more than 11 000 out-of-state medical licenses, with many more likely to follow. According to the IMLC, approximately “80% of U.S. physicians meet the criteria for licensure through the Compact.”

The benefits of this much-needed overhaul of the interstate licensure process are apt to be considerable. First, the IMLC stands to advance the application of telemedicine across state lines, as well as streamline out-of-state locum tenens arrangements in support of underserved rural communities. Second, the IMLC stands to enhance patient protection by requiring criminal background checks on prospective licensees, as well as cross-jurisdictional sharing of disciplinary records. This Viewpoint reviews the inception of the IMLC, traces its progression, discusses its missions, explores the related challenges, and suggests that states that have not yet joined the IMLC should prioritize their consideration of doing so.

The IMLC was developed by the Federation for State Medical Boards and constitutes a “voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states.” In September 2014, the federation released its model IMLC state legislation for review and consideration by its member state medical boards. Broad endorsement, as well as several legislative sponsorships, followed in due course. States that wished to join the IMLC would have to enact authorizing legislation. On February 27, 2015, Governor Matthew H. Mead of Wyoming signed the IMLC bill into state law, the first governor to do so. As of March 25, 2021, a total of 29 states, the territory of Guam, and the District of Columbia have enacted comparable statutes. Bills are pending in New York, Ohio, and Pennsylvania. Expectations are that the IMLC will soon be endorsed by most, if not all, of the remaining states and territories of the US...
It is unlikely that the aforementioned HPSA challenges will be wholly resolved by the IMLC initiative alone. A more likely scenario would have the IMLC complementing and augmenting ongoing federal HPSA relief efforts such as the National Health Service Corps, the Nurse Corps, and the Health Center Program. It is unlikely that the aforementioned HPSA challenges will be wholly resolved by the IMLC initiative alone. A more likely scenario would have the IMLC complementing and augmenting ongoing federal HPSA relief efforts such as the National Health Service Corps, the Nurse Corps, and the Health Center Program. Moreover, the IMLC could help address the current scarcity of primary care and mental health practitioners in medically underserved areas. Moreover, by facilitating the licensing of out-of-state physicians, the IMLC could help address the current scarcity of primary care and mental health practitioners in medically underserved areas. Viewed collectively, the rigor added by the IMLC to the interstate licensing process will serve to enhance the existing licensure models. Viewed collectively, the rigor added by the IMLC to the interstate licensing process will serve to enhance the existing licensure models. Although the IMLC is an important step, it leaves in place several legal challenges for telemedicine. For example, for medical malpractice, states do not agree about whether the standard of care expected of physicians is the same as that for in-person care of a patient. What is more, although Hawaii has required malpractice insurers to provide equal coverage for telemedicine encounters, that is not true in many states such that physicians sued for malpractice may find themselves uninsured. There is also a lack of clarity about how much interaction is needed in a telemedicine context to establish a patient-physician relationship from which legal obligations flow. Although during the COVID-19 pandemic CMS has expanded what it will deem telemedical services under Medicare, it is not clear that these arrangements will persist after the pandemic or that all private insurers will robustly reimburse for such services.

The IMLC has become especially timely and more important with the expansion of telemedicine, including across state lines, during the COVID-19 pandemic. The US Department of Veterans Affairs has reached a similar conclusion, considering that its health care professionals are frequently required to deliver health care services across state lines. The IMLC could help address the current scarcity of primary care and mental health practitioners in medically underserved areas. Viewed in this light, the adoption of the IMLC by all US states and territories should not be delayed. The ever-important HPSA relief efforts require nothing less—and not a moment too soon.

### ARTICLE INFORMATION

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### REFERENCES