HOD ACTION: Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-12

Subject: Interstate License Portability
(Resolution 313-A-10)

Presented by: David E. Swee, MD, Chair

Referred to: Reference Committee C
(J. Mack Worthington, MD, Chair)

INTRODUCTION

At the 2010 Annual Meeting, the AMA House of Delegates referred Resolution 313, introduced by the Medical Student Section:

> RESOLVED, That our American Medical Association study: a) the need for interstate license portability to allow physicians to volunteer in free clinics; b) the implications of current state policy in Tennessee, Oklahoma, and Arizona that allows for licensed physicians from other states to volunteer in their free clinics; and c) the effects on physician demographics, as well as the medical, financial, and legal implications, of interstate license portability for physician volunteers in free clinics.

This report provides background information on free clinics and physician volunteers, details license barriers to physicians providing *pro bono* services in states in which they do not have a full license, identifies current systems of license portability, highlights relevant AMA policy, and presents recommendations.

BACKGROUND

Free clinics provide care for 1.8 million patients annually and are an important component of the safety net for the uninsured. The large medically underserved component of the nation's population tends to experience poor mental and physical health, are less likely to receive medical care and prescription medication, have lower health literacy rates, and have difficulty accessing care.

The National Association of Free Clinics (NAFC) defines free clinics as volunteer-based health care organizations that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals, who are predominately uninsured.[1] According to a 2010 nationwide survey, over 1000 free clinics operate throughout the United States, providing care for approximately 1.8 million individuals through over 3.5 million visits.[2]

Although free clinics currently are providing a significant portion of care for indigent populations, lack of readily available volunteer personnel and resource shortages limit their effectiveness. The average wait time to schedule an appointment for a new patient and an existing patient is 12 and 11 days, respectively.[2]

With an average operating budget of under $300,000 annually, free clinics are dependent on maintaining a sufficient number of physician volunteers. The removal of barriers and streamlining of processes necessary for physicians to volunteer in clinics in states where they do not possess a full medical license could help address this issue.[2]

LIABILITY COVERAGE

Prior to 1996, the risks of potential medical malpractice lawsuits and the costs of malpractice insurance were barriers to practicing physicians seeking to volunteer their services in free clinics. However, the federal government removed this obstacle in 1996 through passage and subsequent funding of the Health Insurance Portability and Accountability Act (HIPAA), which granted medical malpractice coverage through the Federal Tort Claims Act to physicians volunteering in free clinics. The Affordable Care Act, passed in 2010, expanded the availability of this coverage to employees, officers, board members, and contractors of qualifying free clinics.

LICENSING

The Federation of State Medical Boards (FSMB) represents the 70 state medical licensing and disciplinary boards of the United States and its territories. The licensing process, which is under the purview of each state, is designed to ensure patient safety by affirming that physicians are educated and trained appropriately for the independent practice of medicine and that they practice in accordance with medical ethics and codes of conduct when treating patients. Although there is some similarity from one state to the next, each state has unique requirements based upon the stipulations of their Medical Practice Acts and their individual legislative, media, and public expectations.

To practice medicine as a volunteer, physicians must have a valid medical license in the state in which they wish to volunteer. To obtain licensure in a state, a physician must complete the particular state educational requirements and pay licensure fees. The time and financial commitments needed to receive licensure may present a deterrent to physicians otherwise interested in volunteering in states whose free clinics face physician shortages. Several states, hoping to remove these potential barriers, have programs to encourage interstate physician volunteers.

LICENSE PORTABILITY

As a result of a need to encourage additional volunteers, Arizona, Oklahoma, and Tennessee allow out-of-state physicians to volunteer their time across state borders by obtaining licensure through a special application process. In other states, the application processes for volunteers to obtain a license differ greatly from one jurisdiction to the next and require extensive time and expense.

Arizona

An applicant for a pro bono registration to practice medicine needs to submit the following:

- Certified copy of the a medical degree;
- Certified copies of internship, residency, and fellowship certificates;
- Photocopy of any current license to practice medicine in another state, territory, or possession of the United States or the District of Columbia, along with a letter from the medical board issuing the license, certifying that the license is current and in good standing;
- Certified copy of ECFMG certificate, if applicable;
- Application fee;
- AMA physician profile;

- FSMB disciplinary search; and
- Verification of licensure from every state in which the applicant has ever held a license.[3]

Oklahoma
Physicians who wish to donate their expertise for medical care and treatment may apply for a Special Volunteer Medical License. Eligibility requirements:
- Have previously been issued a full and unrestricted medical license in Oklahoma or another state;
- Have never been the subject of disciplinary action;
- Only provide medical care to needy and indigent persons in Oklahoma or persons in medically underserved areas of Oklahoma; and
- Not receive or have the expectation to receive any payment or compensation, either direct or indirect, for any medical services provided.[4]

Application requirements:
- Completed application;
- Verification of education, and notarized copy of diploma must be completed and submitted (unless the applicant previously held an Oklahoma medical license) by the medical school of graduation;
- Verification of licensure must be completed and submitted by every state that has ever issued the applicant a medical license; and
- Volunteer practice setting information form must be completed, signed, and notarized.

Tennessee
Any physician licensed to practice medicine in any state who has not been disciplined by any medical licensure board may have their license converted to or receive a Special Volunteer License, which will entitle the licensee to practice without remuneration solely within a free health clinic at a specified site or setting by doing the following:
- Submission of a Special Volunteer License application, along with any required documentation; and
- Having the licensing authority of every state in which the physician holds or ever held a license to practice medicine submit directly to the board the equivalent of a "certificate of fitness" which shows that the licensee has never been subjected to any disciplinary action, and is free and clear of all encumbrances;
- For physicians who have not been licensed in Tennessee, comply with all the provisions and paragraphs of the Health Care Consumer Right-To-Know Act; and
- Submitting the specific location of the site of the free health clinic in which the licensee intends to practice along with proof of the clinic's private and not-for-profit status.[5]

Although each of these states have opened the door to physicians practicing in their clinics from other states, their data indicate that the majority of volunteer license applications come from physicians already licensed within that state.

CURRENT AMA POLICY

Our AMA has consistently supported a licensure system that is state-based rather than nationalized, (AMA Policy H-480.969, "The Promotion of Quality Telemedicine," AMA Policy Database) while also supporting mechanisms that enable physicians to move between licensing jurisdictions, so long as such movement does not have a detrimental impact on the health, safety and welfare of the public (AMA Policy H-275.978, "Medical Licensure").

Furthermore, our AMA recognizes the importance of free clinics as providers of care for the uninsured and indigent populations (AMA Policy H-160.953, “Free Clinics”), and has consistently acknowledged the existence of an ethical obligation for physicians to provide care for the indigent (AMA Ethical Opinion E-9.065).

Through these guiding policies, our AMA currently encourages the FSMB to develop a process among the various state licensure boards that would make it possible for a physician who holds an unrestricted license in one state/district/territory to participate in short term (less than 90-day) medical volunteerism in another state/district/territory in which the physician volunteer does not hold an unrestricted license (AMA Policy H-275.922, “Short-Term Physician Volunteer Opportunities Within the United States”). Additionally, our AMA supports reducing barriers to retired physicians practicing in free clinics (AMA Policy H-160.940, “Free Clinic Support”).

CONCLUSION

Our AMA has consistently supported and encouraged the involvement of all physicians in volunteer activities to serve the indigent and uninsured through free clinics. In keeping with the AMA’s firm belief that licensure should remain a state-based system, we support appropriate measures at the state level to initiate programs that permit out-of-state physicians to volunteer their professional services at free clinics and to increase the efficiency of existing state programs.

RECOMMENDATIONS

The Council of Medical Education, therefore, recommends the following be adopted in lieu of Resolution 313-A-10 and the remainder of this report be filed.

1. That our American Medical Association (AMA) reaffirm the following policies: H-160.953 “Free Clinics”; H-160.940 “Free Clinic Support”; H-275.978 “Medical Licensure”; H-480.969 “The Promotion of Quality Telemedicine”; D-275.994 “Facilitating Credentialing for State Licensure”; D-275.992 “Unified Medical License Application.”

2. That our AMA amend Policies H-160.940 and H-275.922 by insertion and deletion as follows:

   H-160.940 Free Clinic Support: Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians and physicians licensed in other jurisdictions.

   H-275.922 Short-Term Physician Volunteer Opportunities Within the United States
   Our AMA encourages the Federation of State Medical Boards to develop ~~a process~~ model policy for ~~among the various~~ state licensure boards to streamline and standardize the process by which ~~that would make it possible for~~ a physician who holds an unrestricted license in one state/district/territory may ~~to~~ participate in ~~short-term (less than 90 day)~~ physician volunteerism in another U.S. state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10)

Fiscal Note: Less than $500.

REFERENCES

1. The National Association of Free and Charitable Clinics. What is a Free Clinic. Accessed at: http://www.nafcclinics.org

2. Darnell, J. Free Clinics in the United States: A Nationwide Survey. Archives of Internal Medicine 2010 (June 14). 946-953.

3. Arizona Revised Statutes. Arizona Administrative Code § R4 (16)(105). Available at: http://www.azsos.gov/public_services/Title_04/4-16.htm#ARTICLE%202.%20DISPENSING%20OF%20DRUGS

4. Oklahoma Statutes §59-493.5. Available at: http://www.oklegislature.gov/

5. Free Health Clinic, Inactive Pro Bono and Volunteer Practice Requirements. Rules of the Tennessee Board of Medical Examiners. 0880-02-.22 (2010) Available at: http://www.state.tn.us/sos/rules/0880/0880-02.20100620.pdf

Policy Appendix

H-160.940 Free Clinic Support
Our AMA supports: (1) organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics; and (2) efforts to reduce the barriers faced by physicians volunteering in free clinics, including medical liability coverage under the Federal Tort Claims Act, liability protection under state and federal law, and state licensure provisions for retired physicians. (Sub. Res. 113, I-96; Reaffirmed: BOT 17, A-04; CMS Rep. 1, A-09)

H-160.953 Free Clinics
The AMA: (1) encourages the establishment of free clinics as an immediate partial solution to providing access to health care for indigent and underserved populations; (2) will explore the potential for a partnership with state and county medical societies to establish a jointly-sponsored free clinic pilot program to provide health services and information to indigent and underserved populations; and (3) will develop strategies that will allow the AMA, along with one or more state or county medical societies, to join in partnership with private sector liability insurers and government - especially at the state, county, and local levels - to establish programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent. (BOT Rep. 27-A-94; Reaffirmed: BOT 17, A-04)

H-275.978 Medical Licensure
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with

the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; and (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10)

H-480.969 The Promotion of Quality Telemedicine
(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties

should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10)

H-275.922 Short-Term Physician Volunteer Opportunities Within the United States
Our AMA encourages the Federation of State Medical Boards to develop a process among the various state licensure boards that would make it possible for a physician who holds an unrestricted license in one state/district/territory to participate in short-term (less than 90 day) physician volunteerism in another state/district/territory in which the physician volunteer does not hold an unrestricted license. (Sub. Res. 915, I-10) D-275.991 License Reciprocity Between States
Our AMA will work jointly with the Federation of State Medical Boards, through its Committee on Portability, to examine license reciprocity between states in order to improve the ability of physicians to practice in other states. (Res. 307, I-01; Reaffirmation A-05)

D-275.984 Licensure and Liability for Senior Physician Volunteers
Our AMA (1) and its Senior Physician Group will inform physicians about special state licensing regulations for volunteer physicians; and (2) will support and work with state medical licensing boards and other appropriate agencies, including the sharing of model state legislation, to establish special reduced-fee volunteer medical license for those who wish to volunteer their services to the uninsured or indigent. (BOT Rep. 17, A-04)

D-275.994 Facilitating Credentialing for State Licensure
Our AMA will: (1) encourage the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) work with the Federation of State Medical Boards and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; and (3) encourage the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license. (Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11)

D-275.980 Simplifying the State Medical Licensure Process
Our AMA Board of Trustees will assign appropriate individuals from within the AMA to work with the Federation of State Medical Boards and keep the AMA membership apprised of the FSMB's actions on developing a standardized medical licensure application, and the individuals assigned by the AMA Board of Trustees regarding the FSMB's work on standardized medical licensure application will report back to the AMA on a yearly basis beginning at the 2005 Annual Meeting, until decided by the Board of Trustees that this is no longer necessary. (Res. 324, A-04)

D-275.992 Unified Medical License Application
Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications. (Res. 308, I-01; Reaffirmed: CME Rep. 2, A-11)