Analysis of the Interstate Medical Licensure Compact (IMLC) and Implications for Participation by North Carolina

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Executive Summary

The Interstate Medical Licensure Compact (IMLC) is a partnership entity among state physician licensing boards for the purpose of promoting medical license portability. Its member states practice self-governance and set policies through representation in the IMLC Commission. The aims of IMLC are to improve healthcare access for underserved communities and to facilitate availability of telehealth services.

The Compact currently includes 29 member states, as well as the District of Columbia and the Territory of Guam. While relatively new, it has seen exponential growth in processed applications since 2017. Once a Letter of Qualification (LOQ) is obtained through the State of Primary Licensure (SPL), the program offers expedited process times and reduced application fees to obtain licenses in other states.

This report outlines healthcare disparities in North Carolina that IMLC participation may help to address. Analyses of participating states by telehealth utilization and underserved population profiles are presented. The results of a small sample size (n=10) survey among executive directors of participating state medical boards is also presented.

The NC General Assembly has already enacted laws approving participation in other interstate compacts for healthcare professionals. Based on recognized healthcare needs in NC, as well as the relatively positive experiences of other states, participation in IMLC may yield benefits for NC.

Background

The Need

Access to healthcare is an issue for many Americans due to geographic, socioeconomic, and technological barriers. The North Carolina Office of Rural Health reports that 66 of 100 counties have a shortage of primary care, dental, and behavioral health professionals (Exhibit 1).[1] Availability of healthcare in rural communities is tenuous with multifactorial threats, including decline of fee-for-service payment models, rising supply chain costs, requirements for capital expenditures for IT infrastructure and care management resources inherent in value-based care models, and increasing regulatory burdens. As a consequence, 11 rural hospitals have closed in NC since 2006.[2] Healthcare disparities in rural areas when compared to urban counterparts are particularly stark. Rural residents have higher rates of mortality from cancer, stroke, heart disease, injuries, and chronic lung disease.[3]

Rural North Carolinians have compound challenges due to limited penetration of broadband infrastructure in their communities that compromises their ability to take advantage of technological advances such as telehealth services. In its 2017 Report on Telemedicine Study and Recommendations presented to the NC Legislature's Joint Oversight Committee on Health and Human Services, NC Department of Health and Human Services (NC DHHS) recommends the following components of a state telehealth policy:[4]

- Require Prepaid Health Plans (PHP) to include telehealth services in their payment models
- Increase incentives for telehealth providers to reach underserved areas

- Join interstate licensure compacts for healthcare professionals

Additionally, NC DHHS advises expeditiously implementing the recommendations set forth by the 2017 Broadband Report by the NC Broadband Infrastructure Office (NC BIO). The plan sets a goal of 100% broadband availability to NC families by 2021.[5] Regarding telehealth, the report notes that the 640,000 rural North Carolinians without internet access are unable to capture the full potential of innovative care delivery models designed to promote access and efficiency.

The Framework

These challenges of provider shortages and geographic healthcare disparities are not unique to NC. In April 2013, the Federation of State Medical Boards (FSMB) approved a resolution to explore the creation of an Interstate Medical Licensure Compact (IMLC) in order to address these challenges, while also creating an adaptive model for telehealth.[6] The aims were to facilitate and expedite state medical licensing for physicians already practicing medicine in other states, to establish a framework for voluntary participation by states, as well as create a coordinated system among member states for self-governance and oversight.

By January 2015, nine state legislatures had formally introduced bills to adopt IMLC.[7] With seven states successfully enacting legislation, the IMLC Commission was seated in May 2015. The IMLC Commission is comprised of 2 voting representatives from each member state. The commission sets forth bylaws, policies, and advisory opinions within the purview of the Compact.

As of December 2019, 24 states and the Territory of Guam have enacted IMLC. Five states and the District of Columbia have passed legislation and are awaiting implementation (Exhibit 2).[8]

Criticism of IMLC

While IMLC has garnered strong support within the medical community as well as government and policy leaders, it has its detractors. Some state agencies have expressed concerns regarding increased administrative costs and burden to manage the program. Some professional organizations have also criticized IMLC for compromising the sovereignty of state licensing boards while also creating redundant licensing requirements.[9] The American Board of Physician Specialties (ABPS) has been a vocal opponent of IMLC, since IMLC requires specialists to be certified through other licensing organizations, the American Board of Medical Specialties (ABMS) or American Osteopathic Association/Bureau of Osteopathic Specialists (AOABOS).[10]

IMLC supporters, such as the American Medical Association, argue that self-governance among member states mitigates the creation of a federal regulatory body that imposes binding rules.[11] They argue that IMLC offers a streamlined mechanism to expedited licensing that reduces administrative costs and overhead burden while maintaining high practice standards set by state medical boards.[12]

The Licensing Process

Eighty percent of practicing physicians meet initial eligibility criteria to obtain a license through IMLC.[13] To start the IMLC application process, a physician designates a State of Principal

Licensure (SPL) based on residency and medical practice guidelines. The SPL performs due diligence and conducts criminal background checks. Once approved, the physician receives an email notification to select the states in which licenses are desired. Separate application fees are set by each state, in addition to the $700 initial SPL fee. The process is outlined in Exhibit 3.[14]

The streamlined administrative process also offers a reduced fee profile for licenses obtained through IMLC. For example, a new medical license application in Alabama costs $485, compared to $75 through IMLC, while Nevada's application fee of $1050 is discounted to $375 for IMLC applicants.[15]

Licensing standards and ongoing physician practice oversight through IMLC complements and supports the existing governing authority of the granting member state boards. Physician applicants are required to meet all licensing requirements as set forth by the Medical Practice Acts within the license state. For regulatory oversight purposes, the patient's physical location at the time of the physician-patient encounter designates the jurisdiction. Additionally, the IMLC Commission coordinates an information exchange system among member states that shares disciplinary actions and investigations regarding their respective physician licensees.[16]

Analysis

IMLC Utilization and License Processing Data

As of July 2019, IMLC has granted 6,671 state medical licenses to 4,446 physicians.[17] Twenty-nine states, as well as Guam and the District of Columbia have enacted or passed IMLC

legislation. South Carolina and New Jersey currently have bills in progress. The rising trend in applications is likely related to several synergistic factors, including reinforcing network effects created through additional states joining IMLC, greater awareness of the program among physicians and health systems, and increasing demand and improved reimbursement for telehealth services.

The IMLC's 2nd Year Data Study finds that applicant physicians obtain an average of 3 licenses through the program, with 13% of participating physicians holding 7 or more licenses. Ten percent of applications do not meet eligibility criteria. Of those applications approved, the average length of time to obtain a letter of qualification from the SPL is 36 days, with 32% of applicants processed in less than 15 days. Once the approved applicant has selected states for licensure, the average time to issued license is 19 days, with 51% receiving a license in less than 7 days.[18]

A review of the ABMS certifications for physicians licensed through the Compact demonstrates that the majority of licenses are granted to primary care or behavioral health providers.[19]
The top eight specialties of IMLC license holders are listed below:

- Internal Medicine (30.7%)
- Family Medicine (11.5%)
- Psychiatry and Neurology (10.2%)
- Radiology (8.4%)
- Emergency Medicine (6.6%)
- Surgery (6.2%)
- Obstetrics and Gynecology (5.2%)
- Pediatrics (4.8%)

Early Adopters

Given IMLC's relatively brief history, observed data trends may be influenced by sampling bias from early adopter states, and not reflect expected outcomes of subsequent participants. For example, early adopters may have been highly motivated to "beta test" an interstate compact concept due to urgent healthcare needs within the state.

To test this theory, data on telehealth utilization collected in a national Medicare telehealth study conducted from 2013-2016 were used as a proxy for relative rates of telehealth utilization among states.[20] Limited comparative data is available on telehealth utilization, given disparate regulations and reimbursement policies among states. From the study data, the top ten states with the highest rates of telehealth utilization among fee-for-service Medicare recipients were compared to the lowest ten states in terms of likelihood of IMLC participation (Exhibit 4). Six of the top ten utilization states have enacted or passed IMLC legislation compared with five of the bottom ten, which was interpreted as essentially no difference in participation rates.

To examine if states with greater physician shortage rates participate at higher rates in IMLC, states were compared by the size of their populations living in designated primary care health professional shortage areas (HPSAs).[21] As seen in Exhibit 4, the likelihood of IMLC participation does not correlate with the magnitude of a state's population living in a HPSA. (For the purposes of the telehealth and HPSA analysis, US territories were excluded from the composite rankings.)

North Carolina's ranking is included in both consideration sets. NC ranks #11 in highest percentage of telehealth services rendered for Medicare recipients, whereas it ranks as the 14th highest state in the number of residents living in a designated HPSA. While the IMLC is intended to improve access to healthcare for underserved areas, as well as to facilitate telehealth adoption, the likelihood of adoption among states does not appear to necessarily correlate with their level of need.

Participation Outcomes

To examine the motivation for participation and preliminary results of IMLC implementation, a survey was conducted among 23 member states and the Territory of Guam which have enacted IMLC. While Minnesota also participates in IMLC, it was excluded from the survey since it issues IMLC licenses but does not act as a SPL to issue letters of qualification.[22] The survey was active from October 22, 2019 to November 1, 2019. A nine-question survey was sent electronically via the Survey Monkey platform to executive directors of member state medical boards that govern physician licensure. Ten completed responses were received. An email response was received from a director outside of the completed survey set noting that the data required to complete the survey was not available. The complete questionnaire is shown in Exhibit 5, with results shown in Exhibit 6.

While the survey is limited by its small sample size with a 42% response rate, some notable findings include:

1. Motivation for participation is consistent with IMLC's expressed purpose, with all respondents expressing a desire to either increase access to physicians for patients in underserved areas or facilitate license portability.
2. All respondents cite inadequate physician availability in their states for primary care, specialists, behavioral health, or a combination of the three.
3. The majority of respondents note telehealth services are more widely available in their states due to IMLC implementation, while half of all respondents report increased locum tenens availability and improved access to care in underserved areas.
4. A number of survey responses cite administrative resource allocation as a challenge in IMLC implementation, while most note the absence of significant challenges.
5. The overwhelming majority (90%) observe a net import effect, with more out-of-state physicians who seek licenses in their state compared to in-state physicians who seek licenses in other states.
6. On average, respondents predict future growth IMLC utilization in their states.
7. On average, respondents agree that IMLC has increased access to care in their states.
8. On average, respondents share that IMLC participation is slightly favorable in profitability compared to budget neutral.
9. Respondents note variable support for other interstate compacts for healthcare professionals such as nurses, physician assistants, and psychologists.

Issuance to Origination Among Member States

To further explore the net relationship in out-of-state physicians seeking licenses compared to in-state physicians seeking licenses in other states, IMLC's 2nd Year Anniversary data[23] were used

to derive an Issuance to Origination (I:O) Ratio, shown in Exhibit 7. While there is great variability among states, the median I:O Ratio of 2.3 indicates that states grant 2.3 licenses to out-of-state physicians for every 1 in-state physician seeking licensure outside of the state. Colorado and Illinois are the only states with I:O Ratios of < 1. Utah has the highest ratio of 11.5 of states represented, indicating significantly more interest in physicians who desire to practice in the state, compared to Utah physicians who seek privileges elsewhere.

Data Limitations

While IMLC application data are known, other statistics are not readily available and would be helpful to track as IMLC continues to grow with more member states. These include:

- Percentage of physicians who intend to use licenses primarily to deliver telehealth services
- Physician employer data, including percentage of physicians employed by telehealth firms, regional health systems, and independent physician practices
- Volume of services provided by IMLC-licensed physicians to patients in rural or underserved areas, defined as counties outside of a Metropolitan Statistical Area (MSA) or a geographic Health Professional Shortage Area (HPSA)
- Functional utilization of IMLC licenses (ie number of annual patient encounters in the state of licensure)
- Percentage of renewals following initial license approval through IMLC for each state
- Disciplinary actions taken by member states for physicians approved through IMLC

North Carolina Medical License

The concept of out-of-state physicians licensed to practice in the state of North Carolina is not new. Currently, 29% of all North Carolina MD/DO licenses are held by physicians residing in other states, accounting for 11,433 out of a total of 39,032 active licenses.[24]

License fees and processing times in NC are comparable to other states.[25] The initial license application fee is $400, with an annual renewal fee of $250.[26] The initial application process takes a minimum of 4 months, with increased processing times from March through August.[27] License and renewal fees comprise the bulk of NC Medical Board revenues, generating $11,999,000 in FY2018.[28]

Comparative Models

Several interstate compacts for healthcare professionals operate with similar governance structures to IMLC. These include the Enhanced Nursing Licensure Compact (eNLC), of which North Carolina is a member. Unlike IMLC, eNLC license recognition is reciprocated among member states, without the need for secondary license applications. As of July 2019, eNLC has 33 participating states.[29] NC joined eNLC in 2017 when Governor McCrory signed into law NC Legislation Article 9G, Chapter 90-171.80. Both chambers of the General Assembly passed the measure by unanimous vote.[30]

North Carolina is also a member of the Physical Therapy Compact (PT Compact).[31,32] With the purchase of a Compact Privilege from member state boards, eligible physical therapists are able

to practice in the respective states without additional licensing requirements. NC also has pending legislation which proposes participation in the Psychology Interjurisdictional Compact (PSYPACT).[33] PSYPACT would allow psychologists licensed in other states to provide telepsychology and temporary face-to-face treatment services to residents of NC.[34]

The majority of states that participate in IMLC also participate in eNLC, PT Compact, or PSYPACT, as shown in Exhibit 8. NC is only one of three states, along with Texas and Missouri, which has enacted or passed laws to join these three interstate compacts, but is currently not participating in IMLC.

Legislative Action in Other States

IMLC Commission has model legislation available for review by states considering adoption. Legislative action in IMLC member states has generally garnered broad, bipartisan support. A sampling of the legislative vote in states that have enacted IMLC is shown in Exhibit 9.

Conclusions and Recommendations

North Carolina, like many other states that have implemented IMLC, has challenges of regional healthcare disparities and opportunities to capture the value of emerging technology and innovative care delivery models in healthcare. In evaluating the merits of IMLC participation by North Carolina, the following conclusions are rendered:

- Survey outcomes from member states support the intended goals of IMLC to improve access in underserved areas and to facilitate telehealth through license portability
- On net, member states benefit from an increased number of physicians seeking licenses in the state, compared to in-state physicians seeking licenses elsewhere
- The majority of IMLC licenses are awarded to primary care and behavioral health providers
- IMLC reinforces licensing board jurisdictions and upholds compliance of all relevant licensing requirements established by each member state
- On average, the program is budget neutral or budget favorable for state medical boards
- Average processing times for obtaining an IMLC license is significantly shorter compared to the average time required for a new NC license
- A significant number of out-of-state physicians currently hold an active NC medical license
- North Carolina has already adopted other interstate compacts for healthcare professionals-- eNLC and PT Compact, and is considering PSYPACT in the current legislative session
- As neighboring states like Tennessee and South Carolina formally enact or move towards IMLC adoption, the network effects will be favorable for NC to participate in the Compact
- Even with IMLC adoption, value drivers include broadband infrastructure in rural areas to delivery telehealth services, as well as telehealth reimbursement by insurers

Based on this assessment, recommendations include:

- Sharing this report with key stakeholders including NC DHHS, and members of NC House Health Standing Committee, NC Senate Healthcare Standing Committee, NC Medical Board, NC Medical Society
- Reaffirming NC DHHS recommendations to include telehealth reimbursement requirements for Medicaid Prepaid Health Plans
- Supporting NC Broadband Information Office's goals to provide broadband access in all parts of NC

Appendix

Exhibit 1

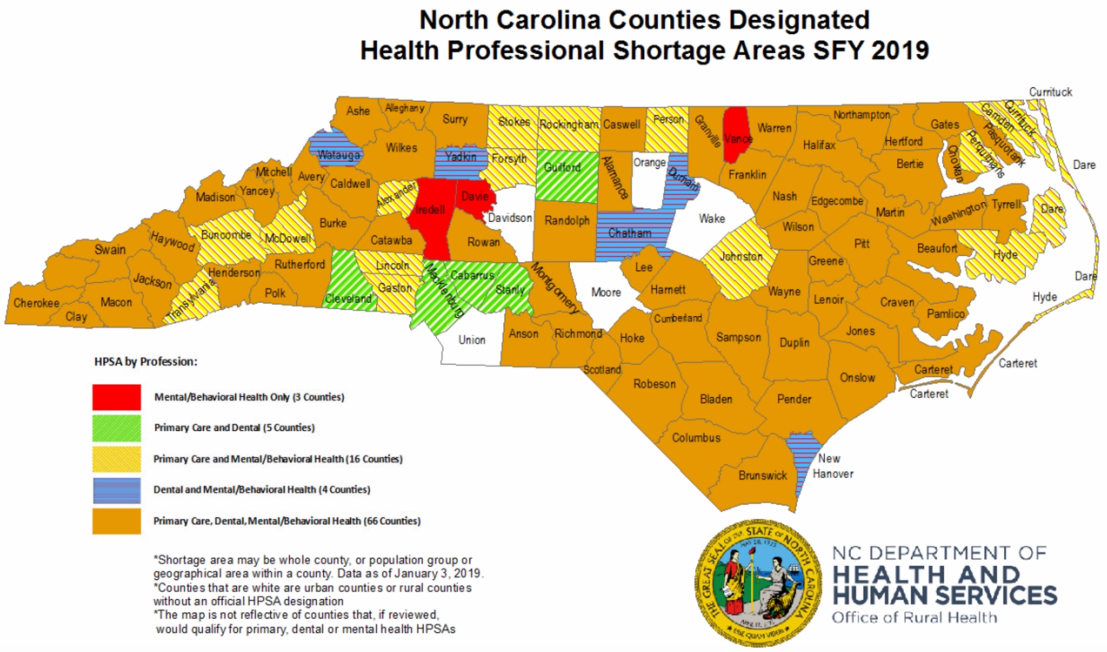


Exhibit 2

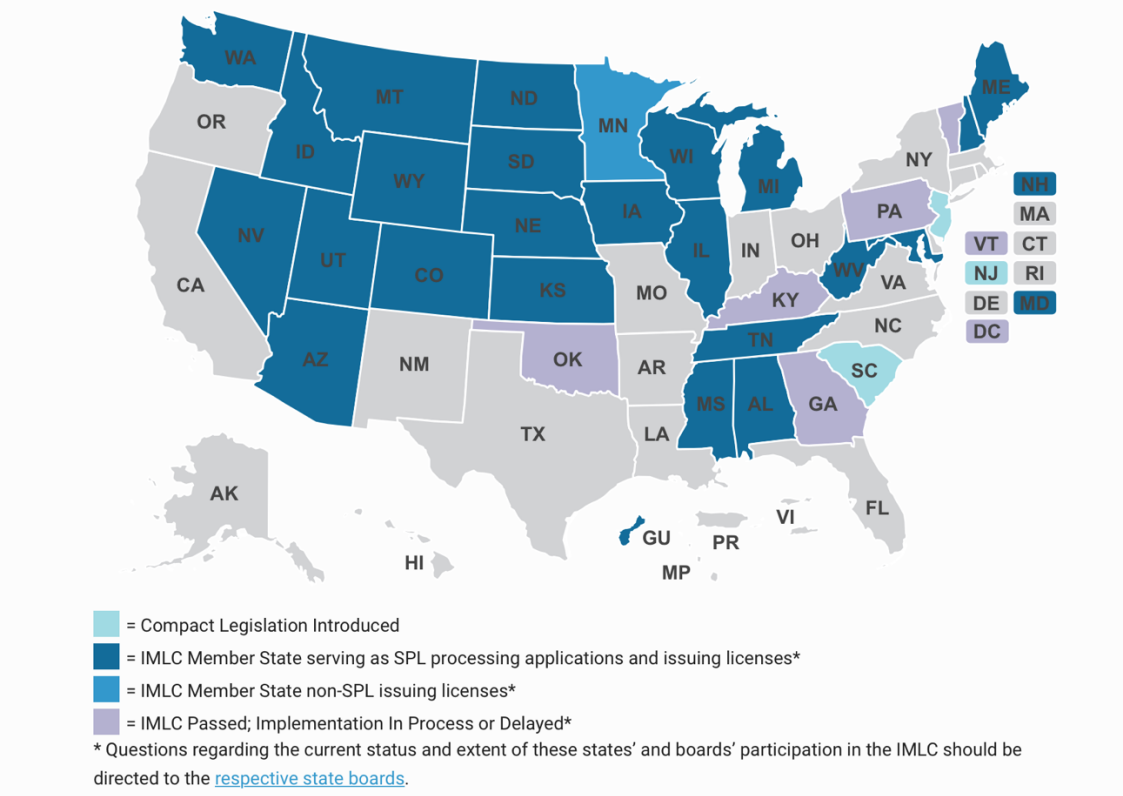


Exhibit 3

IMLC Application Process

https://imlcc.org/what-is-the-process/

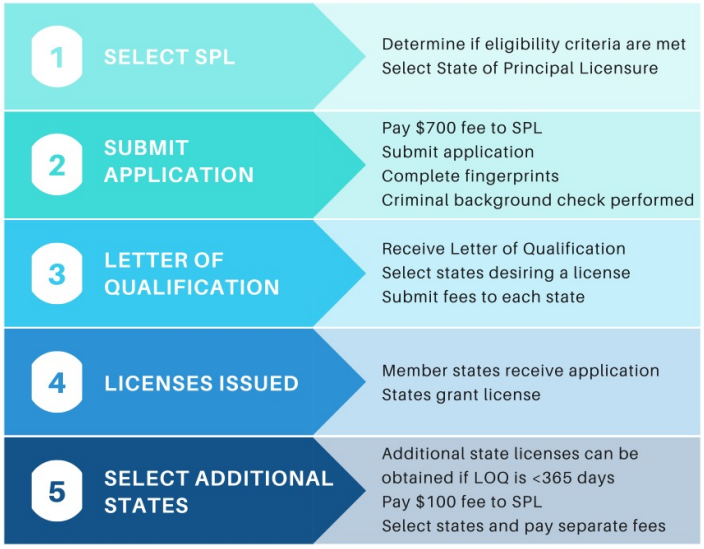


Exhibit 4

IMLC Participation by Telehealth Utilization and Health Professional Shortage Areas

	Telehealth Utilization in Medicare Study Population		
		% Using Telehealth	
1	Texas	11.8%	
2	Iowa	5.0%	
3	California	4.9%	
4	Missouri	4.6%	
5	Michigan	4.4%	
6	Minnesota	4.0%	
7	Wisconsin	3.9%	
8	Georgia	3.8%	
9	Virginia	3.5%	
10	Kentucky	3.5%	
11	North Carolina	3.4%	
42	Idaho	0.2%	
43	Massachusetts	0.2%	
44	New Jersey	0.2%	
45	Utah	0.2%	
46	Vermont	0.1%	
[47-51]	Delaware	0.4%	(data combined)
	Rhode Island		
	Hawaii		
	Connecticut		
	District of Columbia		

	Primary Care Health Professional Shortage Areas (HPSAs)	
		Population of HPSAs
1	California	7,579,564
2	Texas	6,475,991
3	Florida	5,964,139
4	New York	4,614,026
5	Georgia	3,214,540
6	Illinois	3,164,103
7	Arizona	2,839,275
8	Michigan	2,768,243
9	Tennessee	2,494,850
10	Alabama	2,295,274
14	North Carolina	1,953,770
42	Delaware	233,863
43	North Dakota	191,107
44	Wyoming	187,903
45	Rhode Island	159,827
46	Alaska	105,032
47	New Hampshire	96,317
48	Maine	95,094
49	New Jersey	28,731
50	Vermont	22,764
51	Nebraska	19,053

Enacted Legislation
Passed Legislation
Introduced Legislation

Information on Medicare Telehealth
Centers for Medicare and Medicaid Services

Primary Care Health Professional Shortage Areas
Kaiser Family Foundation

Exhibit 5

Interstate Medical Licensure Compact (IMLC) Survey

1. What are your state's main motivations of participating in IMLC?

2. How would you characterize the availability of physicians in your state? (Check all that apply)

- ☐ Adequate physician availability
- ☐ Overall physician shortage
- ☐ Regional disparities in physician availability
- ☐ Shortage of primary care providers
- ☐ Shortage of specialists
- ☐ Shortage of mental health providers

3. What has been an outcome of IMLC implementation in your state? (Check all that apply)

- ☐ Telehealth services are more widely available in the state
- ☐ More locum tenens physicians practice in the state
- ☐ More physicians are providing care in underserved areas
- ☐ Other (please specify)

4. What has been a challenge of IMLC implementation? (Check all that apply)

- [ ] Enforcement of state regulations for physicians
- [ ] Maintaining quality of care delivered by physicians
- [ ] Allocating administrative resources required for the program
- [ ] Other (please specify)

5. What is the trend in IMLC licenses granted in your state?

- ◯ More in-state physicians seek licenses in other states
- ◯ Net neutral
- ◯ More out-of-state physicians seek licenses in my state

6. How do you view the future utilization of IMLC in your state?

No/Minimal change compared to current number of physician applications — Significant increase in the number of physicians applying through IMLC

7. IMLC has improved access to healthcare providers in my state.

Strongly Disagree — Neutral — Strongly Agree

8. What has been the financial impact from IMLC participation to your state medical board?

Net Loss: More administrative burden not offset by fees — Neutral — Net Profit: Revenue from fees collected outweigh administrative cost

9. Does your medical board support interstate licensure for the following healthcare practitioners? (Check all that apply)

- [ ] Nurse Practitioners
- [ ] Registered Nurses
- [ ] Physician Assistants
- [ ] Clinical Psychologists
- [ ] None of the above

Exhibit 6

IMLC Survey Results

1. **What are your state's main motivations of participating in ILMC?**

   Answered: 10 Skipped: 0

   - *Make it easier for physicians with clean records to get a license.*
   - *Reductions in barriers to trade.*
   - *License portability.*
   - *Facilitate physician licensure.*
   - *To increase the access of appropriate healthcare for our citizens and to reduce the roadblocks in regard to licensure portability.*
   - *To provide licensure portability and increase patient care in underserved areas of Utah.*
   - *increase access to health care for patients*
   - *Guam's physician resources is challenging with our location and underserved population. We had to find ways for easy accessibility to our Island.*
   - *To expedite healthcare to underserved areas.*
   - *To maximize physician coverage of Idaho, which has a very large rural population, by providing expedited licensure for physicians who qualify for the IMLC.*

2. **How would you characterize the availability of physicians in your state? (Check all that apply)**

   Answered: 10 Skipped: 0

Adequate physician availability	0%	0
Overall physician shortage	60%	6
Regional disparities in physician availability	60%	6
Shortage of primary care providers	60%	6
Shortage of specialists	60%	6
Shortage of mental health providers	60%	6

3. **What has been an outcome of IMLC implementation in your state? (Check all that apply)**

   Answered: 10 Skipped: 0

Telehealth services are more widely available in the state	80%	8
More locum tenens physicians practice in the state	50%	5
More physicians are providing care in underserved areas	50%	5
Other (please specify)	10%	1

- *We have not yet determined the impact*

4. What has been a challenge of IMLC implementation? (Check all that apply)

Answered: 9 Skipped: 1

Enforcement of state regulations for physicians	0%	0
Maintaining quality of care delivered by physicians	11%	1
Allocating administrative resources required for the program	44%	4
Other (please specify)	67%	6

- *No problems*
- *Fairly new to compact*
- *None*
- *We have not encountered any challenges that are unique to implementation of the IMLC.*
- *Ensuring that physicians who are licensed through the IMLC pathway are aware of state specific requirements.*
- *The logistics of the licensure and renewal processes and interfacing with the other states technologically.*

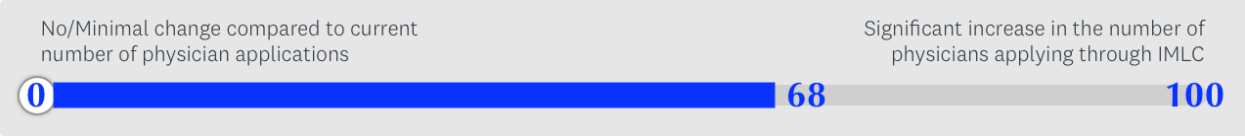
5. What is the trend in IMLC licenses granted in your state?

Answered: 10 Skipped: 0

More in-state physicians seek licenses in other states	10%	1
Net neutral	0%	0
More out-of-state physicians seek licenses in my state	90%	9

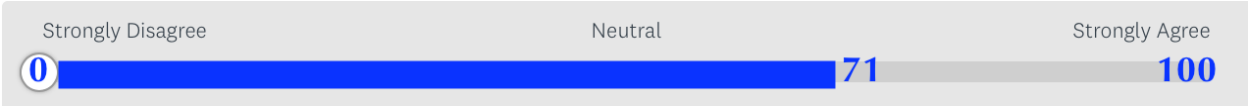
6. How do you view the future utilization of IMLC in your state?

Answered: 10 Skipped: 0



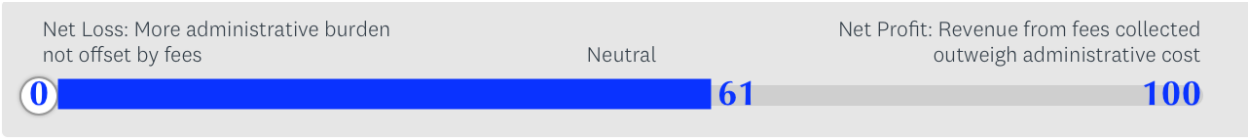
7. IMLC has improved access to healthcare in my state.

Answered: 10 Skipped: 0



8. What has been the financial impact from IMLC participation to your state medical board?

Answered: 10 Skipped: 0



9. Does your medical board support interstate licensure for the following healthcare practitioners? (Check all that apply)

Answered: 7 Skipped: 3

Nurse Practitioners	43%	3
Registered Nurses	57%	4
Physician Assistants	43%	3
Clinical Psychologists	57%	4
None of the above	29%	2

Exhibit 7

Issuance: Origination Ratio for Member States

Licensing Board	LOQ	Licenses Issued	ISSUANCE : ORIGINATION
Alabama Board of Medical Examiners	134	282	2.1
Arizona Medical Board	286	279	
Arizona Osteopathic Board	24	52	
Arizona Total			1.1
Colorado Medical Board	333	316	0.9
Idaho Board of Medicine	55	202	3.7
Illinois Dept of Financial and Professional Regulation	345	306	0.9
Iowa Board of Medicine	141	320	2.3
Kansas State Board of Healing Arts	112	242	2.2
Maine Board of Osteopathic Licensure	1	107	
Maine Board of Licensure in Medicine	53	14	
Maine Total			2.2
Minnesota Board of Medical Practice		387	
Mississippi Board of Medical Licensure	47	240	5.1
Montana Board of Medical Examiners	67	190	2.8
Nebraska Board of Medicine and Surgery	59	211	3.6
Nevada Board of Osteopathic Medicine	14	283	
Nevada Board of Medical Examiners	51	38	
Nevada Total			4.9
New Hampshire Board of Medicine	47	166	3.5
South Dakota Board of Medical and Osteopathic Examiners	94	115	1.2
Tennessee Board of Medical Examiners		39	
Utah Division of Occupational and Professional Licensing	16	184	11.5
Washington Baord of Osteopathic Medicine	11	46	
Washington Medical Commission	203	248	
Washington Total			1.4
West Virginia Board of Medicine	33	134	
West Virginia Osteopathic Board	14	24	
West Virginia Total			3.4
Wisconsin Medical Examining Board	333	418	1.3
Wyoming Board of Medicine	71	209	2.9
TOTAL	**2544**	**5052**	
Average			3.0
Median			2.3
Standard Deviation			2.4

Exhibit 8

State Participation in IMLC and Other Interstate Compacts

IMLC States	PSYPACT	eNLC	PT PACT
Enacted			
Washington			■
Idaho		■	
Montana		■	■
Nevada	■		
Utah	■	■	■
Wyoming		■	
Colorado	■	■	■
Arizona	■	■	■
North Dakota		■	■
South Dakota		■	
Nebraska	■	■	■
Kansas		■	
Iowa		■	■
Wisconsin		■	
Illinois	■		
Michigan			
Tennessee		■	■
Alabama		■	
Mississippi		■	■
Maine		■	
New Hampshire	■	■	■
West Virginia		■	■
Maryland		■	
Guam			
Minnesota			

IMLC States	PSYPACT	eNLC	PT PACT
Passed			
Oklahoma	■	■	■
Kentucky			
Pennsylvania	■		
Vermont			
DC	■		
Georgia	■	■	
Introduced			
New Jersey			■
South Carolina		■	■
Non-Participating			
Delaware	■	■	
Missouri	■	■	■
Texas	■	■	■
North Carolina	■	■	■
Arkansas	■	■	
Florida	■	■	
Kentucky	■	■	■
Virginia	■	■	
Louisiana	■	■	■
Oregon	■		■
Georgia	■	■	
Indiana	■	■	
New Mexico	■	■	
Oklahoma	■	■	

■ Enacted Legislation
■ Passed Legislation
■ Introduced Legislation

Association of State and Provincial Psychology Boards
https://www.asppb.net/mpage/legislative

National Council of State Boards of Nursing (NCSBN)
https://www.ncsbn.org/11281.htm

American Physical Therapy Association
https://www.apta.org/StateIssues/InterstateLicensureCompact/

Exhibit 9

IMLC State Legislation and Votes by Chamber

STATE	ENACTED LAW	HOUSE APPROVAL	VOTE	SENATE APPROVAL	VOTE
Washington	Revised Code of Washington RCW 18.71B.110	2/15/17	94-3	4/19/17	49-0
Idaho	Idaho Statutes Title 54 Chapter 18 Section 54-1853	3/3/15	66-1-3	3/17/15	34-0-1
Montana	Montana Code Annotated 37-3-356	3/9/15	96-3	3/20/15	43-3
Nevada	Nevada Revised Statutes 629A.100	5/18/15	40-0-2	4/15/15	20-0-1
Utah	Utah Code 67b	2/25/15	66-0-9	2/11/15	26-0-3
Wyoming	Chapter No. 62 Session Laws of Wyoming 2015	2/6/15	59-0-1	2/25/15	29-0-1
Colorado	Chapter 245 Session Laws of Colorado	5/9/16	64-0-1	5/6/16	32-1-2
Arizona	Arizona Revised Statutes Section 32-1422.01	5/4/16	41-19-0	4/25/16	21-8-1
North Dakota	North Dakota Century Code Chapter 43-17	3/25/19	87-3-4	4/2/19	47-0-0
South Dakota	SDLRC Codified Law 36-4-44	3/3/15	63-4	1/29/15	24-10
Nebraska	Nebraska Revised Statute 38-3602	(unicameral)		4/24/17	49-0-0
Kansas	Kansas Statutes Annotated 65-28,133	4/30/16	71-42	4/29/16	30-9

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