SINGLE MEDICAL LICENSURE APPROACH FOR PHYSICIANS PRACTICING INTERSTATE MEDICINE*

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This Article explores and discusses the crucial legal and professional challenges of multistate licensure for physicians. Federal action is necessary to reduce the barriers to practicing medicine across state lines, especially considering the urgent need for patient care caused by the current COVID-19 pandemic. Modern advances in telemedicine give physicians the ability to deliver quality patient care throughout the United States. However, the current state medical licensure regime effectively prevents many physicians from delivering this care across state lines. Action at the federal level is necessary to lift the current state-based restrictions on the practice of interstate medicine so that efficient and effective medical care can be delivered to those in need nationwide. This Article advocates for the implementation of a single medical licensure approach for physicians practicing interstate medicine because it would effectively and almost immediately enable physicians, particularly those utilizing telemedicine, to deliver quality care to patients in need across the nation. Further, this Article calls for the enactment of federal legislation conditioning the receipt of certain state Medicaid funds on the general lifting of current state-based restrictions limiting the interstate practice of medicine as necessary to move the concept of single medical licensure forward.

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INTRODUCTION

There is a national shortage of physicians.[1] Patients across the country need care.[2] The technology and ability to deliver effective care to many of these patients exists, but barriers to the interstate practice of medicine prevent those who need care from being treated.[3] Unfortunately, physicians—who now have the tools and technology enabling them to treat patients anywhere in the nation through telemedicine—are hamstrung by an antiquated state medical licensure regime that has failed to keep pace with the modern, interconnected society.

The solution is a single medical licensure approach recognized by all fifty states that allows physicians to practice interstate medicine without obtaining a medical license in more than one state. Such a system promotes good policy by solving physician shortages, expanding access to care for patients located in rural areas, promoting efficiency in health care delivery in general, and utilizing technology to help improve patient care. While model legislation exists which reduces barriers to the interstate practice of telemedicine, limitations, states' interests, and exceptions create roadblocks and confusion. Viable alternatives to the paradigm can empower physicians to better treat patients across the United States.

Part I provides a background discussion on the current state medical licensure system and its intersection with telemedicine's modern advent and

1. *See generally* IHS MARKIT LTD., ASS'N OF AM. MED. COLLS., THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2019 TO 2034 (2021), https://www.aamc.org/media/54681/download [https://perma.cc/S45W-GMMN] (projecting that by 2034 the shortage of primary care physicians will be between 17,800 and 48,000).

2. *See id.* at 3.

3. *Telehealth: Defining 21st Century Care*, ATA, https://www.americantelemed.org/resource/why-telemedicine/ [https://perma.cc/2XD7-D8VU].

development. Part II analyzes current model legislation that allows for the limited practice of interstate medicine. Part III discusses other potential solutions that allow for the broader practice of interstate medicine. Finally, Part IV draws conclusions based on limitations in the practice of interstate medicine and discusses what is needed to expand the reach of efficient and effective medical care throughout the United States.

I. STATE-BASED MEDICAL LICENSURE

"In the [United States], medicine is a licensed profession regulated by the individual *states*."[4] There are seventy-one state medical boards that license and allow allopathic physicians, known as "M.D.s," and osteopathic physicians, known as "D.O.s," to practice medicine in the United States.[5] There is no national medical license. Instead, there are only state medical licenses. Generally, state medical boards and state statutes require a physician to be licensed to practice medicine in the state where the patient is located at the time of the patient consult.[6] The states' authority to impose this requirement, and generally regulate the practice of medicine, has historically rested in the Tenth Amendment to the U.S. Constitution.[7]

A. *Historical Background*

The Tenth Amendment to the U.S. Constitution explicitly states, "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."[8] This Amendment establishes the basis of states' rights and the principle of federalism.[9] The practice of medicine is not a power delegated to the federal government by the U.S. Constitution. Therefore, the authority to regulate the practice of medicine has historically been in the individual states' domain.

The U.S. Supreme Court has supported and reinforced the states' power to regulate the practice of medicine.[10] In the 1888 case *Dent v. West Virginia*,[11] Dent challenged the state of West Virginia's authority to prescribe the

4. FED'N OF STATE MED. BDS., UNDERSTANDING MEDICAL REGULATION IN THE UNITED STATES (emphasis in original), https://www.fsmb.org/siteassets/education/pdf/best-module-2-script-understanding-medical-licensure-transcript.pdf [https://perma.cc/3BKC-6QCB].

5. *Id.* There are fifty-one state allopathic and composite medical licensing boards, fourteen osteopathic licensing boards, and additional licensing boards in several U.S. territories. *Id.*

6. *See Obtaining a Medical License*, AMA (May 15, 2018), https://www.ama-assn.org/residents-students/career-planning-resource/obtaining-medical-license [https://perma.cc/W4YA-EAZW].

7. Blake T. Maresh, *The Interstate Medical Licensure Compact: Making the Business Case*, 100 J. MED. REGUL. 8, 11 (2014).

8. U.S. CONST. amend. X.

9. *See id.*

10. Maresh, *supra* note 7, at 11.

11. 129 U.S. 114 (1889).

standards for state medical licensure after he failed to meet those standards.[12] Justice Field, in a unanimous decision, stated, "[d]ue consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified."[13] Ten years later, in *Hawker v. New York*,[14] the Court buttressed its ruling in *Dent* by affirming a state's right to establish the qualifications for physicians caring for patients within its borders.[15] These historic cases set the precedent that remains in effect today. Given the states' right to regulate medicine and medical licensure, the federal government has a limited ability to set the standards for practicing medicine in the United States as a whole, or to allow for multistate licensure without the states' consent.

B. *State Medical Boards*

The states, empowered by both the Constitution and Supreme Court jurisprudence to regulate the practice of medicine, have formed state medical boards to oversee state medical licensure and the associated practice of medicine.[16] The licensure process is rigorous.[17] Applicants, and those attempting to renew their licenses, must meet initial qualifications and ongoing requirements.[18] "[S]tate medical boards review the credentials of applicants and look closely at four major factors": (1) medical education, (2) medical training, (3) passage of a national licensing examination, and (4) fitness to practice medicine safely.[19]

While there are subtle differences in the process by which each state medical board evaluates prospective candidates, the substantive requirements are largely identical from state to state.[20] All state boards require a candidate to obtain an M.D. or D.O. degree.[21] All state medical boards require at least one year of postgraduate training.[22] Additionally, candidates across all states must complete either the U.S. Medical Licensing Examination ("USMLE") or the

12. *Id.* at 117.
13. *Id.* at 123.
14. 170 U.S. 189 (1898).
15. *Id.* at 200.
16. *See* FED'N OF STATE MED. BDS., *supra* note 4.
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.* Each state typically has a state statute listing the requirements for a medical license in the state; for example, Florida and North Carolina have codified these state-specific requirements that are largely the same but have nuanced differences. *Compare* FLA. STAT. ANN. § 458.311 (Westlaw through 2021 1st Reg. Sess. and Spec. "A" Sess. of the 27th Leg.), *with* N.C. GEN. STAT. § 90-3 (LEXIS through Sess. Laws 2021-162 of the 2021 Reg. Sess. of the Gen. Assemb.).
21. *See* FED'N OF STATE MED. BDS., *supra* note 4.
22. *Id.*

Comprehensive Osteopathic Licensing Examination ("COMLEX-USA").[23] Finally, all state boards evaluate the physical, mental, and moral fitness of candidates.[24] This homogeneity of substantive standards across states undermines the policy need for a single physician to obtain multiple state licenses to practice medicine.

Each state medical board consists of several appointed individuals, the majority of which are physicians, who voluntarily serve.[25] For example,

> [t]he [Florida Board of Medicine] consists of fifteen members appointed by the Governor and confirmed by the Senate. Twelve members of the Board must be licensed physicians in good standing in this state who are residents of the state and who have been engaged in the active practice or teaching of medicine for at least four years immediately preceding their appointment. One of the physicians must be in private practice and on the full-time staff of a teaching hospital in this state and one must be a graduate from a foreign medical school. The remaining three members must be residents of the state who are not, and never have been, licensed as a health care practitioner. One member of the Board must be a licensed health care risk manager, and at least one member of the Board must be 60 years of age or older.[26]

A full-time staff functionally supports state medical boards, and the fees it collects finance the boards' activities.[27]

These state medical boards regulate the process for state medical licensure and they establish the various fees paid for licensure. There are initial application fees, license renewal fees, and other required fees paid to state medical boards.[28] The application process, renewal process, and required fees make licensure time-consuming and expensive for physicians. The process is especially taxing for those physicians wishing to practice medicine in multiple states.[29]

23. *Id.*

24. *Id.*

25. *See id.*

26. *The Board*, FLA. BD. OF MED., https://flboardofmedicine.gov/the-board/ [https://perma.cc/6KVY-YAZK].

27. *Id.*

28. *Medical Doctor – Unrestricted*, FLA. BD. OF MED., https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/#tab-fees [https://perma.cc/5NR6-8KB3].

29. The application fees, initial license fees, and renewal fees can quickly add up to thousands of dollars for physicians wishing to practice in multiple states. *See id.*; *Physician License Renewal*, N.C. MED. BD., https://www.ncmedboard.org/licensure/renewals/physicians [https://perma.cc/CZK7-R2QY].

C. *Legal Standard of Care*

Just as state medical boards assess prospective physicians based on similar qualitative standards, most state courts assess malpractice claims based on similar legal standards. As malpractice law developed in the nineteenth century, courts initially compared a physician's care to similarly situated physicians in a particular community under the locality rule.[30] This rule requires a physician "to provide the same degree of skill and care that is required of other physicians practicing in the same or similar community."[31] The locality rule originated in an 1880 case heard by the Supreme Judicial Court of Massachusetts, *Small v. Howard*.[32] In *Small*, the court held that a

> defendant, undertaking to practise as a physician and surgeon in a town of comparatively small population, was bound to possess that skill only which physicians and surgeons of ordinary ability and skill, practising in similar localities, with opportunities for no larger experience, ordinarily possess; and he was not bound to possess that high degree of art and skill possessed by eminent surgeons practising in large cities, and making a specialty of the practice of surgery.[33]

The locality rule originated because rural physicians did not have the research nor the tools necessary to deliver the same level of care as physicians in larger cities.[34] The locality rule has become tougher to justify as education has become more standardized and modern technology has provided rural physicians with the same or similar tools as their larger city counterparts.[35]

Courts established the locality rule before there was a standardization of medical training and certification.[36] The twentieth century gave rise to these national standards.[37] The Liaison Committee on Medical Education was founded in 1942 to accredit allopathic medical schools throughout the nation based on national standards.[38] The Accreditation Council for Graduate Medical Education was founded in 1981 to accredit all U.S. residency and fellowship programs.[39] The American Board of Medical Specialties was founded in 1933 to control national board certification examinations.[40] All of these organizations

30. Brian K. Cooke, Elizabeth Worsham & Gary M. Reisfield, *The Elusive Standard of Care*, 45 J. AM. ACAD. PSYCHIATRY L. 358, 359 (2017).

31. *Id.*

32. 128 Mass. 131 (1880), *overruled in part by* Brune v. Belinkoff, 235 N.E.2d 793 (Mass. 1968).

33. *Id.* at 132.

34. Cooke et al., *supra* note 30, at 359–60.

35. *Id.* at 361.

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

effectively create national, rather than local, standards for physicians practicing medicine across the country.

In addition to medical education and certification now being governed by national standards, courts have also ruled for national standards of care.[41] In *Brune v. Belinkoff*,[42] the Supreme Judicial Court of Massachusetts overturned the locality rule handed down eighty-eight years earlier in *Small*.[43] In *Brune*, the court ruled that "[t]he proper standard is whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account advances in the profession."[44] The court added, "[a] specialist should be held to the standard of care and skill of the average member of the profession practising the specialty, taking into account the advances in the profession."[45] Thus, a physician should be held to a standard of care comparable to the average qualified physician in that physician's area of practice generally, rather than to physicians practicing that type of medicine in the same locality. Only a minority of states still adhere to the locality rule (either following state or same-community standards, rather than national standards).[46]

Brune overturned *Small*, and national standards in medical training and certification now exist.[47] Further, advances in modern medicine and technology now equip physicians to treat patients, no matter where they are located, with the same level of care.[48] Telemedicine's advent and development, among the most significant advances in modern medicine, once again necessitate revisions to the medical care paradigm.

II. TELEMEDICINE

Telemedicine, or telehealth, is generally defined as "the use of electronic technology to provide health care and services to a patient when the provider is in a different location."[49] Subtle differences in how telemedicine is defined exist from state to state.[50] Some states alternate between using the terms

41. *Id.* at 360.
42. 235 N.E.2d 793 (Mass. 1968).
43. *Id.* at 798.
44. *Id.*
45. *Id.*
46. *See* Cooke et al., *supra* note 30, at 361.
47. *Brune*, 235 N.E.2d at 798.
48. *Telehealth: Defining 21st Century Care*, *supra* note 3.
49. CTR. FOR CONNECTED HEALTH POL'Y, STATE TELEHEALTH LAWS & REIMBURSEMENT POLICIES 15 (2020), https://www.cchpca.org/sites/default/files/2020-05/CCHP_%2050_STATE_REPORT_SPRING_2020_FINAL.pdf [https://perma.cc/WG48-FZJJ].
50. *Id.*

"telemedicine" and "telehealth."[51] This Article uses these two terms interchangeably.

There are many different types of telemedicine in use today. Virtual visits allow for live, synchronous encounters between a patient and physician utilizing video, telephone, or live chat.[52] Chat-based interactions are asynchronous and enable a patient to transmit personal health data, images, and other information to a physician for review.[53] Remote patient monitoring involves collecting and transmitting patient health data to a physician through personal health technologies like wireless devices, wearable sensors, implanted health monitors, and smartphones.[54] While some of these forms of telemedicine have been in use for many years, others are emerging technologies.[55] These technologies can assist patient care in a variety of health care settings and benefit patient care in multiple ways.

A. *Benefits of Telemedicine*

One significant benefit of telemedicine is improved health care access for patients in rural communities.[56] Telemedicine extends the geographic reach of both primary care physicians and specialists to patients in distant locations. The ability to reach patients in rural areas, compounded with a nationwide physician shortage, makes telemedicine both appealing and necessary.[57] Physicians who have the time and expertise to treat patients can use telemedicine to eliminate the need for travel by either party. Another benefit of telemedicine is improved health care quality.[58] Studies have shown that telemedicine's quality of services is as good, if not better, when compared to traditional in-person patient consultations in certain clinical areas.[59] A third benefit of telemedicine is cost

51. Florida uses the term "telehealth" in its statutes. *See* FLA. STAT. ANN. § 456.47 (Westlaw through 2021 1st Reg. Sess. and Spec. "A" Sess. of the 27th Leg.). Although North Carolina does not have a "telemedicine" or "telehealth" statute, the North Carolina Medical Board uses the term "telemedicine" in its position statement on telemedicine. *See Position Statements – Telemedicine*, N.C. MED. BD., https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine [https://perma.cc/A3X7-5QKL].

52. *Telehealth: Defining 21st Century Care*, *supra* note 3.

53. *Id.*

54. *Id.*

55. *See* Jeff Lagasse, *Telehealth's Evolution in 2020 Will Continue in the New Year with More Streamlined Technologies*, HEALTHCARE FIN. (Dec. 15, 2020), https://www.healthcarefinancenews.com/news/telehealths-evolution-2020-will-continue-new-year-more-streamlined-technologies [https://perma.cc/4RZF-L34T].

56. *Telehealth: Defining 21st Century Care*, *supra* note 3.

57. *Id.*

58. *See id.*

59. *Id.* Studies of patient outcomes have found telemedicine most effective in certain clinical areas such as remote monitoring, counseling, and psychotherapy. *Id.*; *see also* ANNETTE M. TOTTEN, DANA M. WOMACK, KAREN B. EDEN, MARIAN S. MCDONAGH, JESSICA C. GRIFFIN, SARA GRUSING & WILLIAM R. HERSH, AGENCY FOR HEALTHCARE RSCH. &

savings related to efficiencies gained in the delivery of care.[60] This benefit makes a compelling argument for the further expansion of telemedicine. "Telehealth reduces the cost of healthcare and increases efficiency with better management of chronic diseases, shared health professional staffing, reduced travel times, and fewer or shorter hospital stays."[61] Finally, patient demand for telemedicine is another driver of its utilization.[62] This demand stems from both the shortage of physicians and the personal convenience to the patient.[63] The COVID-19 pandemic and fears associated with contracting the disease have led to an increased number of patients preferring to see physicians from the comfort and safety of their own homes.[64] For patients, using telemedicine reduces travel time and related stresses. Telemedicine provides a safe platform for a physician encounter without unnecessary exposure and opens the door to care by specific providers and specialists that may have once been closed.[65]

B. *Federal and State Support of Telemedicine*

Modern times have seen significant developments in telemedicine. Through the Centers for Medicare and Medicaid Services ("CMS"), the federal government has shown support for expanding the use of telemedicine in the United States. Medicare reimburses many telemedicine services, and the list of covered services continues to grow on a yearly basis.[66] CMS publishes the listed services and reimbursement schedules in its annual Medicare Physician Fee Schedules. Every state also covers telemedicine services in their state-specific Medicaid programs.[67] Some of the Medicaid policies and rules allow for even broader coverage and reimbursement of telemedicine compared to Medicare.[68] Most states also have payment parity laws that govern telemedicine reimbursement policies for commercial health insurance plans.[69] Some of these payment parity laws mandate that telemedicine services be reimbursed equally

QUALITY, TELEHEALTH: MAPPING THE EVIDENCE FOR PATIENT OUTCOMES FROM SYSTEMATIC REVIEWS 52 (2016), https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/telehealth_technical-brief.pdf [https://perma.cc/23UA-KZEE].

60. *Telehealth: Defining 21st Century Care*, *supra* note 3.

61. *Id.*

62. *Id.*

63. *Id.*

64. *See* Lisa M. Koonin, Brooke Hoots, Clarisse A. Tsang, Zanie Leroy, Kevin Farris, Brandon Jolly, Peter Antall, Bridget McCabe, Cynthia B.R. Zelis, Ian Tong & Aaron M. Harris, *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020*, 69 MORBIDITY MORTALITY WKLY. REP. 1595, 1596 (2020).

65. *Telehealth: Defining 21st Century Care*, *supra* note 3.

66. 42 C.F.R. § 414.65 (2019); *see also Medicare Telemedicine Health Care Provider Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet [https://perma.cc/PET3-RKYN].

67. CTR. FOR CONNECTED HEALTH POL'Y, *supra* note 49, at 15.

68. *See id.*

69. *Id.* at 11.

to the amount that would have been reimbursed had the service been delivered in person.[70]

The COVID-19 pandemic has resulted in the federal government reducing barriers to the practice of telemedicine. An excellent example of this is the relaxation of the enforcement of specific rules found in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),[71] which protects the privacy and security of patients' health information.[72] HIPAA has presented a barrier to telemedicine because it prohibits certain unsecure communication technology platforms.[73] In response to the COVID-19 national emergency, the Office for Civil Rights ("OCR") at the Department of Health and Human Services, the office responsible for enforcing certain regulations under HIPAA, issued a statement relaxing this policy.[74] Because some healthcare providers were inadvertently using unsecure technology when communicating with patients, OCR announced that it would relax the enforcement of its policy through the COVID-19 pandemic.[75] As long as a physician practices telemedicine in good faith, OCR announced that it would not penalize that physician if he or she used a non-HIPAA compliant method of communication with the patient.[76]

Individual states have also temporarily relaxed certain requirements to allow for the interstate practice of telemedicine during the COVID-19 pandemic. For example, by way of emergency order, the state of Florida mandated that "health care professionals not licensed in this state may provide health care services to a patient located in this state using telehealth."[77] While this order is temporary, specifically for the duration of the public health emergency, the unprecedented exception it creates is significant. The emergency order effectively overruled the general and historical rule that requires physician licensure in the state where the patient receives treatment.[78]

70. *Id.*

71. Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29 and 42 U.S.C.).

72. *See Notification of Enforcement Discretion for Telehealth Remote Communication During the COVID-19 Nationwide Public Health Emergency*, U.S. DEP'T HEALTH & HUM. SERVS. (Jan. 20, 2021), https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html [https://perma.cc/8E2H-R5TC] [hereinafter *COVID-19 Telehealth Discretion Notice*, DHHS].

73. *See id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. Fla. Emergency Order No. 20-002 (Mar. 16, 2020), https://www.flhealthsource.gov/pdf/emergencyorder-20-002.pdf [https://perma.cc/QB4J-95ZR].

78. *See id.*

A patient in Florida can be seen and treated through telemedicine by a physician not licensed in Florida during the COVID-19 pandemic.[79]

Both federal and state responses indicate a willingness to allow broader telemedicine use during the COVID-19 pandemic. Other temporary waivers, exceptions, and changes to telehealth policy exist from state to state.[80] However, while these changes are significant, most are temporary and only in effect during the current public health emergency.[81]

III. MODEL LEGISLATION

The development of telemedicine and recent trends in the practice of medicine give rise to many questions. If the federal government and state governments support and see the benefits of telemedicine, should they not enact permanent solutions to reduce barriers to the practice of interstate medicine? With modern medical education and certification standardized on a national level, why is it necessary to have state-specific medical licenses that only allow physicians to see patients located in a single state when there are patients nationwide that need care? If a national standard of care is the rule in most states, are state or local community standards even necessary considerations when evaluating malpractice concerns related to the interstate practice of medicine? While these questions remain partially answered, or unanswered, recent developments support the permanent practice of interstate medicine. The most significant of these developments is the Interstate Medical Licensure Compact ("IMLC").

A. *The Interstate Medical Licensure Compact*

The IMLC is an agreement, among participating states and U.S. territories, to provide an expedited licensure process for physicians who wish to practice in multiple states.[82] The agreement became operational in 2017 as a result of state medical board representatives' efforts with the Federation of State Medical Boards ("FSMB").[83]

The mission of the IMLC is to increase access to health care, which is accomplished through expanding physicians' reach to rural areas, improving access to specialists, and utilizing developing medical technologies like

79. *Id.*

80. CTR. FOR CONNECTED HEALTH POL'Y, *supra* note 49, at 3.

81. *Id.*

82. INTERSTATE MED. LICENSURE COMPACT § 1 (INTERSTATE MED. COMPACT COMM'N 2015), https://www.imlcc.org/wp-content/uploads/2020/02/IMLC-Compact-Law.pdf [https://perma.cc/TXC5-4VZQ].

83. *A Faster Pathway to Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ [https://perma.cc/EM2L-J4MC].

telemedicine.[84] Currently, the IMLC participants include twenty-nine states, the District of Columbia, and the territory of Guam.[85] Other states are in the process of adopting the IMLC.[86]

1. Physician Qualification

For a physician to qualify to practice interstate medicine in the IMLC member-states, they must meet specific eligibility requirements.[87] The first requirement is holding a full, unrestricted medical license in an IMLC member-state with that state serving as the State of Principal License ("SPL").[88] To designate a state as an SPL, the physician must meet one of four requirements.[89] To qualify, (1) the physician's primary residence must be in the SPL, (2) at least twenty-five percent of the physician's practice must occur in the SPL, (3) the physician must practice medicine for an entity in the SPL, or (4) the physician must use the SPL as his or her state of residence for federal income tax purposes.[90] Additional requirements include: (1) graduation from an accredited medical school, (2) passing the USMLE or COMLEX-USA examinations in no more than three attempts, and (3) holding a specialty certification or time-unlimited certification by an American Board of Medical Specialties or an American Osteopathic Association Bureau of Osteopathic Specialists board.[91] Finally, qualifying physicians must not have a history of disciplinary actions against their medical license, must have no criminal history, must not have a history of controlled substance actions toward their medical license, and must not currently be under investigation.[92] Approximately eighty percent of U.S. physicians qualify for licensure through the IMLC.[93]

In addition to designating an SPL and meeting the above-listed requirements, physicians must complete an application through the IMLC, receive a formal Letter of Qualification from the SPL, and pay the IMLC a nonrefundable $700 fee to participate.[94] Then, and only then, is the physician eligible for licensure in another IMLC member-state.

Once a physician meets these requirements and becomes eligible for licensure in any IMLC state, the SPL shares the collected information with the

84. *Id.*

85. *Id.*

86. *Id.*

87. INTERSTATE MED. LICENSURE COMPACT § 3(a) (INTERSTATE MED. COMPACT COMM'N 2015), https://www.imlcc.org/wp-content/uploads/2020/02/IMLC-Compact-Law.pdf [https://perma.cc/TXC5-4VZQ].

88. *Id.* § 4(a).

89. *Id.*

90. *Id.* § 4(a)(1)–(4).

91. *Id.* § 2(k)(1)–(5).

92. *Id.* § 2(k)(6)–(9).

93. *A Faster Pathway to Physician Licensure*, *supra* note 83.

94. *Id.*

additional member-state(s) where the physician intends to practice medicine.[95] This streamlined form of information sharing then allows other IMLC states to expedite the licensure process within their state.[96]

2. Limitations

While the IMLC allows a qualified physician to obtain another state medical license through an expedited process, there are limitations. First, the licensing regime is still state-based.[97] The licenses are issued by the individual states that participate in the IMLC and not by the Interstate Medical Licensure Commission, the organization responsible for administering the IMLC on behalf of the member states.[98] There is no single IMLC license or national medical license.[99] Physicians must still pay all state medical board fees, in addition to the fees paid to utilize the IMLC.[100] Physicians are always subject to each states' statutes and administrative rules, which can vary from state to state.[101] Each state of licensure still ultimately controls a physician's ability to practice medicine in that state.[102]

A second limitation is that the IMLC only streamlines the state medical license process for physicians wishing to practice medicine in those states that have formally joined the IMLC.[103] For a state to qualify as a participating member state, state legislation must authorize the adoption of the IMLC.[104] Passing new legislation in any state is an involved, time-consuming process that may ultimately prove unsuccessful. For states outside of the IMLC member states, there is no expedited path for a physician to obtain state medical licensure.[105]

A final limitation of the IMLC is that it does not create a single, national repository for certain important physician-specific information.[106] While other national databases contain physician information, none of these are created or administered by the Interstate Medical Licensure Commission. Further, no single database contains all the information needed by states when making

95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.*
100. *See id.*
101. *Id.*
102. *Id.*
103. *Id.*
104. *Id.*
105. *Id.*
106. *See* INTERSTATE MED. LICENSURE COMPACT § 8(a) (INTERSTATE MED. COMPACT COMM'N 2015), https://www.imlcc.org/wp-content/uploads/2020/02/IMLC-Compact-Law.pdf [https://perma.cc/TXC5-4VZQ]. The IMLC has only created a database containing the names of physicians who have been licensed or have applied for licensure through the IMLC. *Id.*

medical licensure decisions. Two national databases heavily utilized by state medical boards in physician licensing are the Federation Credentials Verification Service ("FCVS"),[107] created by the FSMB, and the National Practitioner Data Bank ("NPDB"), created by Congress.[108] The FCVS was created for physicians to store credentialing information.[109] State boards utilize this centralized information to obtain primary-source verified information for those physicians applying for state medical licensure.[110] Congress created the NPDB to protect the public.[111] The NPDB contains reports on medical malpractice and other adverse actions taken against physicians all over the nation.[112] State medical boards utilize the NPDB to identify physicians who move state to state without disclosing damaging information that may otherwise prevent a physician from obtaining a particular state medical license.[113] No consolidated platform containing all of the information in these separate databases exists. A single national repository, including physician licensure, credentialing, and disciplinary data, would effectively reduce roadblocks to multistate licensure by creating a single source to verify necessary physician-specific information and by increasing the transparency of this information from state to state. Unfortunately, no such repository exists, and the IMLC does not create one.[114]

B. *The Nurse Licensure Compact*

While the IMLC helps reduce some barriers to the practice of interstate medicine in IMLC-member states, its inherent limitations cause concern. A look into other healthcare professional licensure compacts allows for some interesting comparisons. One particularly interesting and comparable licensure compact is the Nurse Licensure Compact ("NLC").

The purpose of the NLC is very similar to the purpose of the IMLC.[115] The NLC increases access to care, protects patient safety, and reduces costs while supporting state-of-the-art health care delivery such as telemedicine.[116]

107. *Federation Credentials Verification Service*, FED'N STATE MED. BDS., https://www.fsmb.org/fcvs/ [https://perma.cc/D7CF-DYP7].

108. *About Us*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp [https://perma.cc/M8L6-4CG5].

109. *Federation Credentials Verification Service*, *supra* note 107.

110. *Id.*

111. *About Us, supra* note 108.

112. *Id.*

113. *Id.*

114. *See* INTERSTATE MED. LICENSURE COMPACT § 8 (INTERSTATE MED. COMPACT COMM'N 2015), https://www.imlcc.org/wp-content/uploads/2020/02/IMLC-Compact-Law.pdf [https://perma.cc/TXC5-4VZQ].

115. *Facts About the NLC*, NURSE LICENSURE COMPACT, https://www.nursecompact.com/Updated_onepaged_NLC.pdf [https://perma.cc/B583-NYJA].

116. *Id.*

The NLC, similar to the IMLC and other interstate compacts, must be enacted into law by participating states passing legislation for compact adoption.[117] A similar number of states have adopted the NLC and IMLC.[118] Currently, there are thirty-eight NLC-participating states and twenty-eight IMLC-member states and territories.[119]

For a nurse to obtain a multistate license in their home state, they must meet specific eligibility requirements.[120] The requirements are similar to, and largely mirror, the IMLC's requirements for physicians. A nurse must meet the home state's qualifications for licensure.[121] A nurse must graduate from a licensed nursing school.[122] A nurse must pass a national standardized exam.[123] A nurse must be free of certain criminal convictions.[124] Once a nurse meets these requirements and receives a license in a home state, the nurse can practice in the other NLC participating states.[125] While the requirements for a nurse to obtain a multistate license through the NLC are similar to the IMLC's requirements for a physician, there is one striking difference between the NLC and the IMLC. The NLC is an agreement among the participating states to allow registered nurses ("RNs") and licensed practical/vocational nurses ("LPN/VNs") to have one multistate license with the privilege to practice in their home state and other participating states without the need to obtain additional state licenses.[126] Through the NLC, a nurse does not need to obtain a state nursing license in any other state, other than their home state, before practicing nursing in the other participating states.[127] Through the IMLC, however, a physician must still obtain individual state medical licenses to practice medicine in other member-states.[128] While there still is no "national" nursing license through the NLC, just as there is no national medical license through the IMLC, the NLC effectively creates a single, multistate license that allows a nurse to practice in the NLC states.[129]

117. *Id.*

118. *Id.*; *Participating States*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/participating-states/ [https://perma.cc/2H2Z-TZL6].

119. *Facts About the NLC*, *supra* note 115; *Participating States*, *supra* note 118 (showing an additional eight states that are either implementing or introducing legislation adopting the IMLC).

120. NURSE LICENSURE COMPACT art. III(c)(1)–(11) (NAT'L COUNCIL OF STATE BDS. OF NURSING 2015), https://www.ncsbn.org/NLC_Final_050415.pdf [https://perma.cc/WMZ8-C4PH].

121. *Id.* art. III(c)(1).

122. *Id.* art. III(c)(2).

123. *Id.* art. III(c)(4).

124. *Id.* art. III(c)(7)–(8).

125. *Id.* art. III(a).

126. *Id.*

127. *Id.*

128. *A Faster Pathway to Physician Licensure*, *supra* note 83.

129. NURSE LICENSURE COMPACT art. III(a) (NAT'L COUNCIL OF STATE BDS. OF NURSING 2015), https://www.ncsbn.org/NLC_Final_050415.pdf [https://perma.cc/WMZ8-C4PH].

Another essential difference between the NLC and the IMLC is that the NLC requires all party states to participate in a coordinated licensure information system for RNs and LPN/VNs.[130] This database contains detailed information on these licensed nurses, including licensure and disciplinary history.[131] As mentioned, the IMLC requires no informational reporting to any particular database, and the IMLC does not create a database for physician information.[132]

One crucial and additional requirement of the NLC is that a nurse practicing in a participating state must comply with the state laws of the state where the patient receives treatment.[133] Under the NLC, a nurse is subject to the state nursing board's jurisdiction and the laws of the particular participating state where the patient receives treatment.[134] This rule preserves a state's power to protect the public within the state by holding nurses that see patients in that state accountable for the care they administer. The NLC scheme continues to protect states' rights without Tenth Amendment overreach concerns.

C. *Conditioning Federal Funds Approach*

Model legislation is not the only way to solve the issues inherent in obtaining multiple state medical licenses. Other solutions for making state medical licensure recognition reciprocity a reality exist. One solution is to condition receipt of federal sources of funding on such reciprocity. The federal government could mandate that for a state to receive certain federal funds, the state must allow physicians licensed in other states to care for patients in that state.

Conditionally granting federal funds to influence certain state-regulated activities is not a new idea. The federal government has used its spending power to influence state behavior in many other historical contexts. One example is the withholding of federal highway funds from states unless they raised their legal drinking age to twenty-one.[135] In *South Dakota v. Dole*,[136] the U.S. Supreme Court held that a statute conditioning receipt of federal highway funds on state adoption of a minimum drinking age was a legitimate use of federal spending

130. *Id.* art. VI(a).

131. *Id.*

132. *See* INTERSTATE MED. LICENSURE COMPACT §§ 1–2, 5, 8 (INTERSTATE MED. COMPACT COMM'N 2015), https://www.imlcc.org/wp-content/uploads/2020/02/IMLC-Compact-Law.pdf [https://perma.cc/TXC5-4VZQ].

133. NURSE LICENSURE COMPACT art. III(e) (NAT'L COUNCIL OF STATE BDS. OF NURSING 2015), https://www.ncsbn.org/NLC_Final_050415.pdf [https://perma.cc/WMZ8-C4PH].

134. *Id.*

135. South Dakota v. Dole, 483 U.S. 203, 211–12 (1987).

136. 483 U.S. 203 (1987).

power.[137] The Court did note that federal spending power is not unlimited.[138] Spending power is subject to certain restrictions, such as the requirement that "exercise of the spending power must be in pursuit of the 'general welfare.'"[139] Given this precedent and the historical use of federal spending power to influence state behavior to meet certain policy goals, conditioning receipt of federal funds on state medical license recognition reciprocity is likely a viable solution.

Medicaid funding is the most obvious, most related, and most significant federal funding source that federal regulation could condition on state medical license recognition reciprocity. Medicaid is a joint state and federal program administered by the individual states but significantly funded by the federal government.[140] Medicaid is the largest source of health coverage for people in the United States.[141] Federal law imposes certain eligibility requirements on the states to qualify for federal funding through Medicaid.[142] For example, under federal law, there are certain groups of individuals, like low-income families, that states must cover with Medicaid.[143] Thus, the federal government has the power and authority to condition receipt of certain Medicaid funds upon a state allowing for medical license reciprocity. Some states opposed to this policy may argue that hardships for Medicaid beneficiaries will result from a lack of funding if their state decides against implementation of medical license reciprocity. This argument, however, is largely negated by the constitutionality of using federal spending power in this manner and the ability of the states to continue to receive necessary Medicaid funds simply by choosing to accept medical license reciprocity.

D. *Federal Fiat*

Another, albeit more aggressive, solution that allows physicians to practice medicine across state lines without obtaining another state's medical license is for the federal government to mandate, by federal action, state medical license recognition reciprocity. This solution risks overreach into states' rights. Still, interesting legislation enacted over the past few years suggests that such a mandate could be a legal and legitimate form of federal fiat.[144]

137. *Id.* at 211–12.

138. *Id.* at 207.

139. *Id.*

140. *Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/Q38B-GMNH].

141. *Id.*

142. *See id.*

143. *Id.*

144. *See, e.g.*, 38 C.F.R. § 17.417 (2020); Sports Medicine Licensure Clarity Act of 2018, Pub. L. No. 115-254, 132 Stat. 3197 (codified at 15 U.S.C. § 8601).

1. V.A. Anywhere to Anywhere Care Rule

One example of such legislation is the Veterans Affairs Anywhere to Anywhere Care Rule.[145] In 2018, the U.S. Department of Veterans Affairs ("VA") implemented a new federal rule that allows VA physicians and other VA healthcare providers to administer care to veterans and other VA beneficiaries using telemedicine regardless of the patient's location.[146] This rule specifically includes care administered across state lines or outside of a VA facility.[147] Before the rule, VA physicians, like other physicians, were bound by state-specific licensing restrictions and could not provide care to VA beneficiaries in states other than those where the physician held a state medical license. The new rule exercises federal preemption over state medical licensure restrictions and allows the VA to expand its care to beneficiaries via telemedicine.[148] Three driving forces behind the rule included (1) allowing more nationwide veterans to receive care at home, (2) providing better care to veterans in rural communities who would otherwise have to drive long distances or across state lines to receive care, and (3) expanding critical care such as mental health services to those that need quick and easy access to certain VA physicians.[149]

The VA specifically noted how the new rule achieves important federal interests by increasing the availability of care for VA beneficiaries.[150] The VA also recognized that its rulemaking preempts all state law which generally requires a physician to be licensed in the state where a patient is located during the patient encounter.[151] The VA justified the rule by noting that preemption of conflicting state law is necessary to achieve important federal interests, such as the ability to provide complete and similar medical care to all VA beneficiaries in all states.[152]

2. Sports Medicine Licensure Clarity Act

Another source of legislation supporting federal fiat in medical licensure is the Sports Medicine Licensure Clarity Act of 2018 (the "Act").[153] Under the Act, certain sports medicine professionals, including individual athlete and team physicians, can travel and provide medical care to athletes in states where they

145. 38 C.F.R. § 17.417.

146. *Id.* § 17.417(b).

147. *Id.*

148. *Id.* § 17.417(c).

149. Authority of Health Care Providers To Practice Telehealth, 83 Fed. Reg. 21,897, 21,898 (May 11, 2018) (codified at 38 C.F.R. § 17.417).

150. *Id.*

151. 38 C.F.R. § 17.417(c).

152. *Id.*

153. Pub. L. No. 115-254, 132 Stat. 3197 (codified at 15 U.S.C. § 8601).

are not licensed to practice medicine, so long as they hold licensure in one state.[154]

The additional protection granted by the Act to the physician is two-fold. First, the Act mandates that the physician's medical malpractice insurance policy continues to protect and cover the physician when rendering medical care in a state other than the licensure state.[155] Second, the Act protects physicians providing care to an athlete or athletic team in a secondary state by deeming the physician to have satisfied the state medical licensure requirements in the secondary state.[156] In other words, the physician need not go through the process of obtaining additional state medical licenses to provide medical care to an athlete or athletic team when traveling outside of the primary state of licensure. Further, the law insulates the physician from claims of the unlicensed practice of medicine when the physician provides care across state lines.[157]

The Act allows sports medicine physicians to travel with and treat athletes across state lines without the underlying fear of losing their primary state medical licensure or subjecting themselves to discipline by the state board in their state of licensure.[158] The Act also allows these physicians to practice medicine knowing that their acts or omissions when rendering care are still protected by the medical malpractice policy they hold when they cross state lines to provide that care.[159] Like the V.A.'s Anywhere to Anywhere Care Rule, the Act is another example of the federal government's willingness to preempt state laws that generally require physician licensure in the state where the patient receives treatment.[160] However, while these two forms of federal fiat create noteworthy precedent in the realm of medical licensure, they are limited exceptions and larger scale federal preemption of state law in medical licensure has not yet been attempted. Broad federal preemption of all state laws requiring state medical licensure for a physician treating a patient within a state's borders would certainly be challenged much more aggressively than the limited preemption contained in these two laws.

IV. SINGLE MULTISTATE MEDICAL LICENSURE APPROACH

The federal government and state governments recognize the importance of increasing the portability of physician licensure from state to state for various reasons. There is a shortage of physicians across the United States, and there

154. *Id.* § 12(a).
155. *Id.* § 12(a)(1).
156. *Id.* § 12(a)(2).
157. *See id.* § 12(a).
158. *Id.*
159. *Id.* § 12(a)(1).
160. *Id.*; 38 C.F.R. § 17.417(c).

are many patients, particularly those in rural areas, that are underserved.[161] Modern advances in medicine, particularly through telemedicine's advent and development, allow physicians to reach more patients over a larger geographic area, including those in rural communities that need care the most.[162]

A. *Telemedicine-Related Rationale*

Telemedicine offers an avenue to efficient and effective medical care for patients throughout the United States.[163] Primary care, specialty care, and mental health care are a few categorical examples of the breadth of care available. The utility of telemedicine is undeniable. The federal government, the states, and even private payers have shown support for telemedicine by expanding the number of reimbursable telemedicine services.[164] The federal government and the states have also demonstrated more recent support for telemedicine expansion during the COVID-19 pandemic. OCR has relaxed certain HIPAA-related requirements to allow more access to telemedicine services for those patients in need during the pandemic.[165] Many states have temporarily waived licensing requirements for telemedicine.[166] However, these relaxed rules and waivers are not permanent.

Although telemedicine is unquestionably beneficial for patients all over the United States and to our healthcare system in general, the current state medical licensure regime restricts telemedicine's further expansion.[167] The states have historically regulated healthcare. Every state's statutes generally restrict a licensed physician's practice of medicine to that state in which they are licensed. Patients in a particular state can be treated only by physicians holding a medical license in that state. Although this general rule has been the individual states' position for many years, the rule curbs telemedicine's utility by geographically limiting its practice.

B. *Unnecessary State Medical Board Bureaucracy*

While qualified physicians can obtain state licensure in more than one state, obtaining additional state medical licenses is arduous, expensive, and

161. *See* Kayt Sukel, *Dealing with the Shortage of Rural Physicians*, 96 J. MED. ECON. 18, 19 (2019).

162. *Telehealth: Defining 21st Century Care*, *supra* note 3.

163. *Id.*

164. CTR. FOR CONNECTED HEALTH POL'Y, *supra* note 49, at 3.

165. *COVID-19 Telehealth Discretion Notice*, DHHS, *supra* note 72.

166. *See, e.g.*, Fla. Emergency Order No. 20-002 (Mar. 16, 2020), https://www.flhealthsource.gov/pdf/emergencyorder-20-002.pdf [https://perma.cc/QB4J-95ZR].

167. *See* Julie Appleby, *Telehealth Took Off During the Pandemic. Now, Battles over State Lines and Licensing Threaten Patients' Options*, TIME (Aug. 26, 2021, 8:00 AM), https://time.com/6092635/telehealth-state-lines-licensing/ [https://perma.cc/9WGC-N4UU (dark archive)].

constitutes unnecessary administrative bureaucracy.[168] Once a physician can obtain a state medical license, maintaining and renewing the license creates another unnecessary expense and headache.[169] What are the real justifications for making this process so difficult for physicians? Do patients benefit from this? What real public policy goals are served by the current process? State medical boards will argue that state-specific licensing is necessary to adequately vet practicing physicians and protect patients within a state's border. But this argument lacks strength. Physicians in the United States go to the same medical schools and take the same national, standardized exams. Many physicians do their residency and training in one state but then practice in another. A physician treats a patient based on the patient's medical condition and not the state where they receive treatment. If many patients need care, and if technology allows physicians to provide that care, then it follows that state medical boards should be obliged to figure out a way to further reduce the barriers to the interstate practice of medicine. Unfortunately, state medical boards have not come to a consensus on a physician licensure solution that makes sense for the nation. The costly burden of obtaining and maintaining multiple state licenses deters many physicians from caring for patients they could otherwise serve.[170] A centralized and less burdensome approach to multistate medical licensure is necessary to expand the use of telemedicine and the associated benefits it confers to patients.[171]

C. *Failure of Model Legislation*

Interstate compacts are constitutional and uniquely suited to resolve regulatory issues and differences between states.[172] Compacts can preempt federal interference into matters traditionally reserved to the states.[173] However, compacts must achieve certain goals to be effective and to deter federal involvement. The IMLC has failed in many ways due to inherent limitations. As evidenced by the model set forth in the IMLC, state medical boards could not agree to a compact broadly allowing for state medical license recognition reciprocity.

However, state nursing boards, through the NLC, have succeeded where state medical boards failed. The NLC functionally creates a multistate nursing license for any nurse licensed in any of the participating states.[174] The NLC is

168. *See generally* FED'N OF STATE MED. BDS., *supra* note 4 (outlining the process that physicians must go through to become licensed).

169. *Id.*

170. Bill Marino, Roshen Prasad & Amar Gupta, *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 279 (2015).

171. *Id.*

172. Maresh, *supra* note 7, at 16.

173. *Id.*

174. *Id.*

a victory compared to the IMLC, offering both reciprocity and fluidity in nursing's interstate practice.[175] The state boards of nursing reached a political consensus in ways that state medical boards could not.

D. *Need for Federal Action*

Now is the time for considering the federal government's ability to solve this problem, whether accomplished through incentives tied to Medicaid funding or through direct federal action akin to the Sports Medicine Licensure Clarity Act. While the number of new telemedicine-related tools and technologies has grown, the physician supply compared to the physician demand has not.[176] The time has come for a national solution that can reduce administrative burden while simultaneously increasing licensed physicians' ability to care for patients without unnecessary geographic limitations.

There should be a single medical licensure approach recognized by all fifty states that allows physicians to practice interstate medicine without needing a medical license in each state. One solution to the issue is the introduction of a new physician medical licensure compact based on a privileged practice model like the NLC. Such a compact would allow physicians licensed in any participating state to treat patients in the other participating states without requiring a physician to obtain or maintain any additional state medical licenses. Yet, state medical boards have contemplated and rejected this approach through the IMLC. Instead of following the model outlined in the NLC, state medical boards could only agree to an inherently limited expedited licensure model.[177]

With state medical boards and state governments making their positions clear through the IMLC, the federal government's influence and authority becomes crucial. Overseeing medical care has historically been a state's right, deeply rooted in the Tenth Amendment.[178] However, conditionally granting federal funds to influence certain state behavior also has historical use and precedence.[179] The federal government should use its spending power to condition receipt of certain federal funds, such as Medicaid funds, on accepting state medical license recognition reciprocity. While federal spending power is not unlimited in its ability to influence state behavior, there is a strong argument that this particular exercise of spending power is in the pursuit of general welfare.[180] This approach also largely avoids Tenth Amendment concerns because states would opt in, albeit influenced by federal funding. This

175. *See id.*
176. IHS MARKIT LTD., *supra* note 1, at 58.
177. *See A Faster Pathway to Physician Licensure*, *supra* note 83.
178. *See* Dent v. West Virginia, 129 U.S. 114, 122 (1889); Maresh, *supra* note 7, at 11.
179. South Dakota v. Dole, 483 U.S. 203, 206 (1987).
180. *See id.* at 207.

approach is also directly based on a state legislature's statutory enaction, thereby helping to reduce the political influence of the state medical boards.

Another more aggressive federal approach to address barriers to the practice of interstate medicine would be federal action that mandates state recognition of medical licenses held in other states. Such action would allow a physician licensed in any single state to treat patients located in any other state. The federal government has preempted state law in this manner, albeit on a smaller scale, through the V.A. Anywhere to Anywhere Care Rule[181] and the Sports Medicine Clarity Act of 2018.[182] However, utilizing federal fiat to broadly preempt all state law restrictions on medicine's interstate practice does have constitutional concerns. While general preemption of a state law restricting a physician's ability to practice medicine in other states may advance specific and vital federal interests, this approach is fraught with Tenth Amendment overreach concerns.

CONCLUSION

The advent and development of telemedicine allows for the provision of effective and efficient patient care in various clinical settings. There are qualified physicians all over the nation who are now able to take care of patients without the geographic boundaries that once existed. A single medical license approach would effectively enable physicians, particularly those utilizing telemedicine, to deliver quality care to patients across the nation. However, our current state medical licensure regime will not allow a physician to treat a patient outside of the state where a physician is licensed. While model legislation attempts to help facilitate medicine's interstate practice, it has essentially failed. Something more is necessary. The federal government must make use of its authority. Utilizing federal spending power to condition receipt of certain Medicaid funds on the general lifting of the current state restrictions limiting the interstate practice of medicine is the most viable form of federal influence to make what is necessary a reality without overreach into states' rights.

181. *See supra* notes 145–52 and accompanying text.

182. *See supra* notes 153–60 and accompanying text.