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The Veto Outside the Model

How Fifty State Medical Boards Quietly Govern Who Can Practice Medicine, Where, and When

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A Note From the Author

In intelligence work you are taught that the most dangerous thing in any system is not the threat you are tracking. It is the assumption sitting underneath the tracking itself, the one nobody wrote down because everyone already agreed it was true. Find that assumption and test it, and you usually find the failure before it happens. Leave it alone and you write beautiful analysis about the wrong thing.

Plato's Allegory of the Cave is usually read as a meditation on knowledge. It is also a warning about models. The prisoners are not irrational; they make judgments from the evidence available to them, observing shadows, identifying patterns, assigning meaning, and eventually constructing an internally coherent understanding of the world. Their mistake is not that the shadows are imaginary, because the shadows are real. Their mistake is assuming the shadows constitute the whole of reality.

Organizations do this too. We build models from the variables we can see, measuring physician supply, recruiting pipelines, credentialing workflows, processing times, reimbursement, demand, and revenue. We improve the model, automate it, and forecast against it, until it becomes sophisticated enough that we mistake our ability to measure a system for our ability to control it. But a model can be internally correct and operationally wrong, and that happens when a consequential variable sits outside it.

For physician deployment in the United States, that variable is state regulatory capacity. An organization can recruit the physician, execute the contract, complete the file, automate every workflow, commit the capital, and forecast the revenue. None of those actions confer the legal authority to practice medicine. That authority belongs to fifty state institutions with different staffing levels, funding structures, statutory authorities, and oversight mechanisms.

In the allegory, the shadows are not the deception. The fire and the objects behind it are doing the real work, and the prisoners simply cannot see them. The boards are not the shadows on the wall. They are what casts them.

The veto outside the model.

The Speed Illusion, Report 005, challenged the assumption that internal automation could compress time controlled by an external regulator. One Curve, Fifty Clocks, Report 006, showed that a national physician workforce still moves through fifty separate regulatory clocks. Report 007 asks the question that follows from both, which is what happens when we stop studying the shadows and examine the institutions casting them.

That question changed the direction of the research. The answer is not that America's state medical boards are uniformly failing, because they are not. Some are transparent, well resourced, and demonstrably improving. The finding is less convenient: the institutions governing physician entry vary materially in capacity, resilience, transparency, and design, while much of the healthcare economy plans as though that variance were administrative background. It is an external dependency sitting inside the operating assumptions of every enterprise deploying physicians across state lines.

There is a part of the allegory that is rarely quoted. The prisoner who leaves the cave and returns is not believed, because the others have no reason to trust an account contradicting everything visible on the wall. Any operator who finishes this report will face a version of that problem, holding a picture of institutional risk that appears nowhere in the model their organization uses. Every external dependency presents the same question, which is whether you understood it before it entered the forecast, or only after it broke the forecast.

Marcus J. Frazier

Abstract

Every organization operating in healthcare is running on a single, unexamined assumption, and nobody has ever gone back to check whether it actually holds. The assumption is this: that the data coming back from a state medical board, the entity standing between a physician and the first day they are legally allowed to see a patient, is itself current, accurate, and delivered on a schedule anyone can trust. Every credentialing vendor's marketing claim depends on it. Every internal thirty day target depends on it. This report is what happens when that assumption is finally treated as a hypothesis instead of a fact, and tested directly against the boards' own paper trail, their budget filings, their staffing reports, their own recorded meeting minutes. It does not hold.

The Medical Board of California, the licensing authority for the largest physician population in the country, told its own legislature, in writing, that its staff vacancy rate reached 17.37 percent in 2024, and separately disclosed borrowing ten million dollars in one fiscal year, then eight million, then six million more across the two years after, simply to keep the lights on. Texas's own legislative budget request asks for thirty and one half additional staff positions while simultaneously line itemizing money for physical document scanning, a detail that says more about the actual state of its operation than any press release ever could. Georgia's reference verification system quietly routes every professional reference straight into a general inbox, with no confirmation sent back to the applicant, a design that licensing services report produces the identical complaint over and over, a missing reference that was never actually missing. Connecticut's own licensing partners describe the entire process breaking down at the most human point possible: nobody picks up the phone.

California, Texas, Georgia, and Connecticut are not isolated failures. They are the visible edge of a pattern this report tracks across forty six states, with particular depth on New York, New Jersey, Connecticut, Florida, and Texas, the exact corridor where organizational expansion and institutional fragility collide hardest. The pattern holds with uncomfortable consistency: credentialing speed correlates far more closely with a board's own staffing, its funding structure, and its institutional design than with any technology an applicant, an employer, or a vendor can ever touch. The inverse holds just as cleanly, and it is the one fact that should unsettle every board that has not fixed itself yet. Illinois cut its own average processing time from seven and one half weeks to five and seven tenths weeks in a single year, the moment direct legislative and administrative pressure landed on one specific function. The bottleneck was never unfixable. It was simply never audited, by anyone, until now.

Executive Findings / Intelligence Assessment

State Medical Board Capacity as an Unmodeled Constraint on American Healthcare

KEY JUDGMENT

American healthcare has built national growth strategies on a regulatory dependency it does not control, does not measure consistently, and rarely subjects to the same diligence applied to capital, labor, technology, or reimbursement. State medical boards are not administrative background. They are part of the critical path. When their capacity weakens, the consequences move downstream into physician deployment, revenue timing, patient access, expansion plans, and institutional risk.

1 THE BOTTLENECK SITS OUTSIDE THE ENTERPRISE.

Healthcare organizations can automate internal credentialing and compress every step they control. They still cannot manufacture a state license. Across the states examined, board staffing, funding, institutional design, and external dependencies determine the pace at which physicians can legally enter a market. The most consequential variable in the timeline is the one no internal team owns.

2 THE SYSTEM IS FRAGILE IN WAYS THE MARKET DOES NOT PRICE.

California disclosed vacancy rates above 17 percent and repeated internal borrowing. Maryland's licensing operation fell, for a period, to a single employee. Iowa has operated against a fee structure frozen for nearly two decades. Michigan came within forty eight hours of losing compact practice authority for roughly a third of its physician workforce. These are not stress scenarios. They are documented operating conditions.

3 FIFTY STATES DO NOT CONSTITUTE ONE OPERATING ENVIRONMENT.

The same physician can encounter different agencies, staffing models, verification pathways, communication rules, compact dependencies, and oversight structures simply by crossing a state line. The resulting variance is not administrative noise. It is market structure. A national expansion plan that treats licensure as a standardized back office process is modeling a system that does not exist.

4 OPACITY IS ITSELF AN OPERATING RISK.

In multiple states, applicants and employers cannot reliably see what is happening inside the process that controls their timeline. Missing confirmations, unreachable analysts, delayed status windows, and uneven audit capacity create a recurring asymmetry: the organization carries the economic consequence of delay while possessing limited visibility into its cause. What cannot be observed cannot be forecast.

5 TECHNOLOGY CAN IMPROVE THE SYSTEM. IT CANNOT REPEAL INSTITUTIONAL REALITY.

Illinois and Wisconsin demonstrate that focused intervention can materially reduce processing time, and Arizona shows that transparency, performance measurement, and structural innovation can coexist. The conclusion is not that state board delay is inevitable. It is more consequential than that: speed is a policy and capacity outcome. Technology works when the institution behind it is resourced, designed, and accountable enough to let it work.

6 THE RISK COMPOUNDS AT SCALE.

A single state delay is an operational problem. A multi state growth strategy converts fifty different regulatory conditions into portfolio exposure. The organizations most vulnerable are not those operating inside one familiar jurisdiction. They are the organizations scaling across states while assuming that the next market will behave like the last. The larger the footprint, the more dangerous that assumption becomes.

7 THE STRATEGIC ADVANTAGE IS NOT SPEED. IT IS FORESIGHT.

Every organization eventually discovers how a state actually behaves. The only question is whether it learns before capital is committed, physicians are recruited, launch dates are promised, and revenue expectations are embedded in the forecast, or afterward. Koru's role is to move that discovery forward: turning fragmented public record into market intelligence before regulatory reality becomes an operating surprise.

BOTTOM LINE

The central risk identified in this report is not that every state medical board is failing. They are not. It is that healthcare has treated the condition of these institutions as an assumption rather than a variable. For organizations pursuing multi state growth, that assumption is no longer defensible.

Introduction: The Assumption Nobody Tested

Ask any healthcare executive what determines how quickly a physician gets credentialed, and the answer will almost always describe something internal, the organization's own credentialing team, its software, its process discipline. Ask a vendor selling automation, and the answer will describe the platform's own capability, how quickly it can move a file, flag a discrepancy, or route a document. Both answers are describing something real. Both are also describing less than half the actual system.

The other half of that system is a set of fifty state institutions, most of them chronically understaffed, several of them operating on funding models that have not kept pace with application volume, and at least one of them, by its own public disclosure, borrowing money to remain operational.

This report is the first attempt in this research series, and as far as this institute can determine, one of the first attempts anywhere, to treat those fifty institutions as the subject of the analysis rather than the invisible backdrop to it. The method used to find what follows is not complicated, and it is not proprietary. It comes from intelligence work, where the discipline is called pattern of life analysis, the practice of watching a system long enough to learn what normal looks like, so that the moment something deviates from it, the deviation itself becomes the signal. Applied here, the question stops being how fast does a state say it is, and becomes something harder and far more useful. What is this institution not saying. What does it publish once and never again. What number appears in a budget document that would never appear in a press release. Every finding in this report was located that way, in public record nobody had bothered to read against itself.

The findings are organized in two parts. The first establishes the general pattern, staffing, funding, and structural accountability gaps that recur across states regardless of political geography. The second goes deep on five states specifically, New York, New Jersey, Connecticut, Florida, and Texas, the states where the operational consequences of this pattern land hardest for organizations actually trying to grow across state lines in the northeast corridor and the fastest growing retirement destinations in the country.

Part One: The General Pattern

Twenty findings recur across nearly every state examined for this report, regardless of size, political leadership, or reported processing time. Each is drawn directly from the relevant board's own public disclosure.

Finding 1

The Vacancy Rate Nobody Reports Publicly, Except When They Have To

The Medical Board of California is unusual among the boards examined for this report in one specific way. It is required, by its own administrative practice, to disclose detailed staffing and budget updates at every public board meeting. Because of that transparency, this report can show, in the board's own words, precisely what a real vacancy crisis inside a licensing authority looks like.

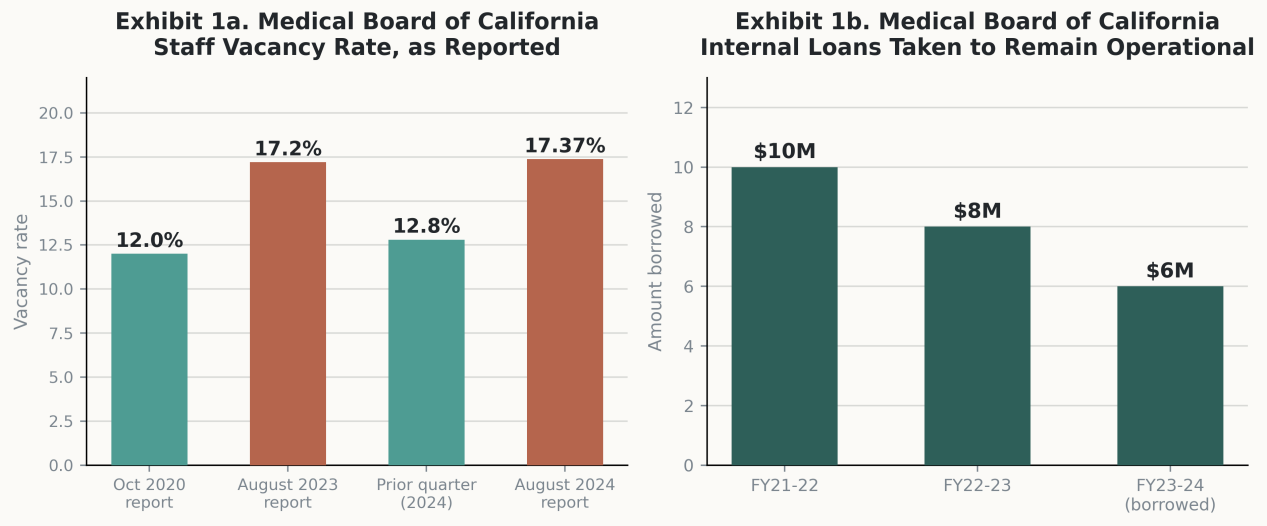

Exhibit 1. Medical Board of California staff vacancy rate and internal borrowing, drawn directly from the Board's own public administrative summary reports, 2020 through 2024.

Read one year at a time, these numbers look like ordinary turnover. Read across four, they look like something else entirely. The earliest disclosure this report located, an October 2020 staff report, shows a 12.0 percent vacancy rate. By August 2023 it had climbed to 17.2 percent, 31 unfilled positions out of 180.3 authorized. One year later, August 2024, 17.37 percent, 33 vacancies out of 189.6 authorized.

The Board's own report flagged that jump as a sharp increase over the prior quarter's 12.8 percent, and explained it plainly: staff had been pulled off their posts and reassigned to a newly created complaint

intake unit. That is the detail worth sitting with. The vacancy rate did not improve and then relapse by accident. It improved because people were moved, and it snapped back the instant they were moved again. This is not a staffing dip. It is a structural condition that has held near or above 17 percent for most of the period this report can document, and every physician waiting on a California license during those four years was waiting inside it, without ever being told.

California is not an outlier because its vacancy problem is unusually severe. It is an outlier because it is unusually transparent about a problem this report finds strong indirect evidence of in nearly every other state examined, just without the equivalent level of public disclosure to confirm it in the same detail. That transparency also reveals what a persistent vacancy costs beyond processing time. The Board's 2023 sunset legislation created a real accountability reform, a Complainant Liaison Unit required to interview a complainant before closing a quality of care complaint. The same legislation delays implementation until six months after the Board is allocated the staff to carry it out. A reform passed into law, contingent on staffing that may never arrive. Separately, in February 2026, the Board opposed a bill letting out of state applicants pay 250 dollars for expedited review, citing its own analysis finding only a modest difference between expedited and standard processing. The Board's own data confirms what this series has argued from outside: when the bottleneck is structural, paying for speed does not buy it.

Finding 2

A State Licensing Board, Literally Borrowing Money to Operate

The agency that decides whether a physician may legally practice in California has been borrowing money to stay open. Not once. Three times. Buried inside the same routine administrative summary reports, the Medical Board of California disclosed a ten million dollar loan from another department fund in fiscal year 2021 through 2022, repaid by 2023 through 2024, then eight million more in 2022 through 2023, then a further six million at the close of 2023 through 2024. Against a total reported revenue of 77.82 million dollars. Nobody announced this. It sat in a meeting packet, in public, waiting for someone to add it up. This is not a board facing a funding cliff in the abstract. This is the specific institution responsible for verifying every physician credential in the state carrying real, disclosed debt against its own operating fund, in the same years healthcare organizations across the state were budgeting credentialing timelines as though the verifying authority on the other end of every application was operating from a position of stability.

Finding 3

The Accountability Gap Hiding Inside Process Design

Not every failure in this system costs money. Some are free, built into the design of a process in a way that makes the institution structurally incapable of being proven wrong.

Georgia requires a physician's professional references to be emailed into a general board inbox. No confirmation goes back. No record exists that the applicant can access. Licensing services working directly with the Georgia board report the same conversation happening again and again: staff say the reference is missing, the applicant knows it was sent, and there is no mechanism on earth by which either party can

prove the other wrong. The applicant sends it again. The clock starts over. Nobody is at fault, which is precisely the problem.

Connecticut presents a different version of the same underlying problem. Licensing partners working directly with the Connecticut Medical Examining Board report that the single largest obstacle in an otherwise clearly defined process is simply reaching a licensure analyst by phone, calls routinely go to voicemail, and callbacks are described as infrequent. Confirming what is actually missing from a file, rather than assuming, requires repeated, often unsuccessful attempts to reach a specific person directly.

New York presents a third version again. Physician licensing in New York is not administered by a standalone medical board at all. It sits inside the State Education Department's Office of the Professions, an entirely different institutional structure than the dedicated consumer protection agencies that run licensing in California, Texas, Florida, and Georgia. The Office's own public guidance instructs applicants to wait a minimum of six weeks after submitting documentation before requesting any status update, and states plainly that status cannot be provided by phone under any circumstances.

New York is not alone in this structure. Tennessee administers licensure through a shared Division of Health Related Boards rather than a dedicated agency, Iowa folded its licensing function into the Department of Inspections, Appeals, and Licensing in 2023 alongside dozens of unrelated professions, and New Hampshire runs physician licensing through its Office of Professional Licensure and Certification, a shared body covering every regulated profession in the state, not physicians specifically. Nebraska administers licensure through the Licensure Unit of its Department of Health and Human Services, under a Board of Health governing multiple licensed professions together. Montana runs physician licensing through its Business Standards Division, under the Department of Labor and Industry, the same shared model. Alaska's State Medical Board is staffed by its Division of Corporations, Business and Professional Licensing, another shared body covering unrelated professions rather than a dedicated medical agency. Missouri's Board of Registration for the Healing Arts sits under a Division of Professional Registration comprising thirty eight separate professional boards together.

Virginia takes the pattern to its most extreme documented form of any state examined. The Commonwealth's Board of Medicine does not maintain its own dedicated executive director at all. A single Department of Health Professions employee simultaneously serves as executive director for five entirely unrelated boards at once, Psychology, Social Work, Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals, while separate single staff members each cover their own unrelated clusters, Optometry paired with Veterinary Medicine under one administrator, Audiology and Speech Language Pathology paired with Nursing Home Administrators and Funeral Directors and Embalmers under another. Pennsylvania runs physician licensing through its Bureau of Professional and Occupational Affairs, overseeing twenty nine separate licensing boards together, the same shared administrative model already documented across nine other states. Ten states now confirm the same real pattern, a structure genuinely common enough that it should not be mistaken for an exception.

Missouri's own State Auditor documented a fourth version, and used blunter language than any board's own public materials ever would. The audit found the Board of Registration for the Healing Arts relies

entirely on applicant self attestation for continuing education and certification requirements, no supporting documentation required, no periodic compliance review, the same underlying gap as Georgia's reference system, applied to license renewal instead of initial application.

Board meeting minutes for four separate meetings were not approved until at least a year after the meeting occurred. The auditor's own overall assessment states plainly that the entity needs to significantly improve operations, that the board indicated most recommendations would not be implemented, and that most recommendations from prior audits had also gone unimplemented. That is an independent state auditor documenting a repeated, multi cycle pattern, audited, found deficient, told directly what to fix, and not fixing it, more than once. Minnesota's own Office of the Legislative Auditor documented a fifth version of the same underlying gap. A 2014 evaluation of the state's health related licensing boards found the Board of Medical Practice did not adequately verify that licensees actually met continuing education requirements, the identical structural failure already documented in Missouri, a system that trusts a licensee's own claim of compliance without a real mechanism to check it. The same evaluation found eight of Minnesota's fifteen health related licensing boards had problems properly depositing and recording the fees they collected, a further, real accountability gap across the state's broader licensing system, even where the specific board responsible could not be confirmed from this research.

Alabama's own 2024 sunset report supplies a sixth version, with real numbers behind it. Surveying complainants directly, the report found forty one percent waited more than thirty days for the Board to make any contact at all after filing, thirty three percent were never told the outcome of their own complaint's investigation, and sixty one percent believe the Board did not do everything it could to resolve their complaint, against an average resolution time of 135 business days.

The same report documents a separate, real governance failure with no parallel elsewhere in this research. The Board entered into confidential severance agreements with five former employees, totaling 288,130.88 dollars, without the legal authority to do so, since only the state Attorney General may authorize this kind of settlement, and attached non disparagement clauses limiting what those employees could say about it afterward. A separate, structural detail is worth noting for any organization tracking board level decision making capacity directly, Alabama's own statute requires a higher quorum, at least five Commission members physically present, specifically before any vote to suspend or revoke a license can occur, a concrete illustration that a board's capacity to act depends on more than its staff alone.

Six states, six entirely different mechanisms, one identical outcome. An applicant with a genuine question about their own file has no reliable way to get a straight answer, and the institution bears no real cost for that opacity.

Vermont adds a different structural variation entirely, splitting a single profession into two separate regulatory pathways by degree type. Physicians holding an MD are licensed through the Board of Medical Practice, under the Department of Health, and are statutorily required to sit for a personal interview before a license is issued. Physicians holding a DO are licensed through an entirely different board, administered by the Secretary of State's Office of Professional Regulation, described as more documentation driven, with no equivalent interview requirement.

West Virginia confirms this is a real, recurring choice rather than a one state anomaly, maintaining the identical split, a separate Board of Medicine for MDs and a separate Board of Osteopathic Medicine for DOs.

New Mexico confirms it a third time, splitting licensure between the New Mexico Medical Board and a separate New Mexico Board of Osteopathic Medicine, each operating under different state agencies with different applications, fees, and continuing education requirements. Licensing services working directly with New Mexico report a concrete, recurring consequence of this design, physicians occasionally file with the wrong board entirely, because both boards' application portals surface in the same search results and the distinction is not obvious until the wrong file has already been started. Washington confirms a fourth time, one of only fourteen states nationally that regulate medical and osteopathic physicians through entirely separate boards. Two physicians, licensed in the identical state, can face genuinely different regulatory experiences based entirely on which degree they hold, a distinction an organization hiring across both would need to know before assuming either applicant's timeline predicts the other's.

Maine shows the opposite instinct can be just as real. As of 2026, Maine has an active Board of Licensure in Medicine and Board of Osteopathic Licensure Merger Feasibility Workgroup underway, alongside pending legislation specifically written to combine the two boards into one. Where Vermont and West Virginia keep the split permanent, Maine is actively moving toward consolidation in the same year.

Washington's own State Auditor reached the identical conclusion through a formal performance audit, recommending its smaller osteopathic board be merged into the larger medical board, and named the exact mechanism behind the recommendation: the smaller board shares its investigative staff across fourteen other unrelated professions, while the larger board maintains its own dedicated investigators, leaving the smaller board structurally slower at the one function that matters most to a patient who has filed a complaint. There is no national consensus on which structure actually serves applicants better, only different states independently arriving at opposite answers to the identical question, and at least one state's own auditor concluding the split itself is the problem.

The same Washington audit surfaced a smaller, sharper failure worth including on its own. The state's public tool for looking up a licensed provider requires searching by first name, and the audit itself notes this fails for physicians who do not professionally use the first name on file. A transparency tool built to help the public verify who is treating them cannot reliably find a doctor unless the searcher already knows exactly how that doctor registered their own name, a concrete, specific illustration of a system designed without the person actually meant to use it in mind.

Finding 4

Proof This Is Solvable, Not Just Describable

Illinois found out its physician assistants were leaving. Not retiring, not changing careers, leaving, crossing a state line specifically because a neighboring board would license them faster. Reporting exposed it, the legislature applied direct pressure to one named function, and the Department of Financial and

Professional Regulation cut average physician assistant license processing from 7.5 weeks in 2024 to 5.7 weeks in 2025. License renewal, in the same year, dropped to twenty four hours. This is the most important finding in Part One, and it is the only one that is not a failure.

This is the finding that should reframe every other one in this section. Board level processing delay is not an immovable structural fact of American healthcare regulation. It is a function of attention, staffing, and accountability, and when a state applies real pressure to a specific, named bottleneck, the bottleneck measurably moves. The states examined in depth in Part Two have, for the most part, not yet received that pressure.

Finding 5

Two States Are Currently Operating Without a Budget At All

As of this report, Pennsylvania and Michigan are the only two states in the country that had not passed a state budget for the current fiscal year, Pennsylvania entering its third consecutive month without one, Michigan reported to be weeks from a potential government shutdown. Every state agency in both states, including each state's medical board, is currently operating without a confirmed annual budget. This is not a staffing statistic pulled from a board meeting. It is the entire funding foundation underneath physician licensing in two major states, in question at the time this report was written.

Pennsylvania offers a counterpoint worth holding alongside this finding. In the same period of budget uncertainty, the state activated three licensure compacts, physician, nursing, and physical therapy, and eliminated a 35,000 person Medicaid enrollment backlog. Institutional dysfunction and real operational progress are not mutually exclusive. In Pennsylvania they are happening at the same time.

Finding 6

The Compact Does Not Eliminate the Bottleneck. It Relocates It.

The compact is the fix everyone points to, including this institute in its own sixth report. It deserves one correction, and the correction is uncomfortable. Before a physician can use the compact to reach a new state, their home state must first issue a Letter of Qualification, and that home state's own capacity decides how long that takes. In documented cases, four to six months. Which means the compact, in those cases, is slower than simply applying to the destination state directly, the exact thing it was designed to replace. The compact does not remove the bottleneck this report has documented. It relocates it, from the destination state to the origin state, and an organization evaluating compact eligible hiring should evaluate the physician's home state board with exactly the same scrutiny as the destination state, not treat compact membership itself as a guarantee of speed.

This finding also reframes which states carry the most structural exposure nationally. California, New York, and Oregon, three of the largest physician populations in the country, remain entirely outside the compact system. A physician licensed in any of these three states seeking compact eligible expansion elsewhere cannot use that license as an entry point into the compact at all, regardless of how quickly their home state processes anything else.

Rhode Island's own 2025 Annual Report reveals a version of this relocation this report had not yet documented, a bottleneck that moves not to another state, but to the federal government. The Board states directly that its compact implementation remains stalled because it requires the Federal Bureau of Investigation's authorization to perform fingerprint background checks, and notes this exact requirement has delayed multiple other states' compact rollouts. Rhode Island passed its enabling legislation years ago and remains not operational regardless. Unlike Michigan's near lapse in Finding 9, there is no resolution date in sight, because the dependency sits inside a federal agency's authorization queue, outside the control of the state waiting on it.

Alabama's own 2024 sunset report reveals a third, genuinely distinct version of this same federal dependency. Where Rhode Island is waiting on an authorization that has never arrived, Alabama had one, then lost it. In April 2023, the Federal Bureau of Investigation ordered Alabama's law enforcement agency to stop conducting the background checks required to verify Letters of Qualification for Alabama physicians, specifically because the FBI had never been properly notified when Alabama passed its own compact legislation.

As a direct result, Alabama physicians cannot currently obtain Letters of Qualification at all, meaning they cannot use the compact to seek licensure anywhere else, despite Alabama's own legislature having passed the enabling law years earlier. The Board pursued two separate legislative fixes and remains unable to resolve the issue as of this report. A procedural notification failure, not a funding gap, a staffing shortage, or any state level dysfunction this report has otherwise documented, is enough on its own to strip an entire state's physicians of compact access.

Wyoming shows what board scale looks like at its most extreme. The entire Board of Medicine operates with exactly five staff members, handling every license application, board meeting, disciplinary matter, renewal, and public or interstate inquiry for an entire state's physician population, according to the Board's own published staffing description. One real, positive counterweight exists alongside that scale. Wyoming offers a self service Pending Application Status tool, letting applicants check their own file online directly, a transparency feature this report has documented in only a small number of the states examined.

Kansas discloses a real, multi year budget trajectory for its own Board of Healing Arts, sixty seven authorized full time equivalent staff for fiscal year 2025, and a budget rising from 7,608,410 dollars that year to 7,730,179 dollars in fiscal year 2026 and 8,094,127 dollars in fiscal year 2027, against a licensee population exceeding 34,000 across sixteen regulated health professions. The Board's own FY2025 submission explicitly states it maintains full staffing at current pay levels with no salary increases included, a real board budgeting to hold wages flat even as its total funding grows, the same wage stagnation theme already documented in Louisiana and Iowa, confirmed here from the board's own official source rather than a third party estimate.

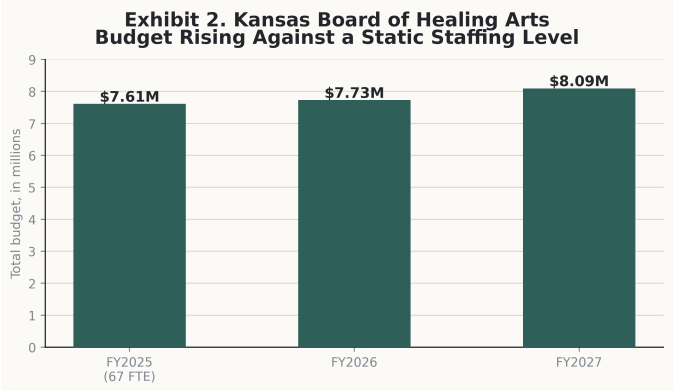

Exhibit 2. Kansas Board of Healing Arts total budget, fiscal years 2025 through 2027, against a staffing level of 67 full time equivalent positions held flat across the same period. Drawn directly from the Board's own official budget submission.

Ohio's own state medical association put the same underlying stakes into a single, direct line of formal testimony. Its resolution supporting deeper compact participation states plainly that individual board verification, the pathway every applicant faces outside the compact, takes time and effort and delays licensure, sometimes indefinitely. That is a professional association's own word choice, not this report's characterization, and it captures precisely why the compact's appeal is real even where this report has found its actual protections incomplete.

Finding 7

Arizona Shows What Transparency and Structural Innovation Together Actually Look Like

Most boards in this report are documented by what they failed to disclose. Arizona is documented by what it volunteered. Its Medical Board publishes staff turnover by department in its own annual report, and in fiscal year 2024 it recorded seven departures, six full time and one part time, a 14.9 percent turnover ratio, two of them from inside the Investigations unit. That level of specific, self reported detail matches California's transparency, but Arizona pairs it with something this report did not find documented anywhere else: a genuine structural fix already operating at scale.

Arizona's Universal Recognition pathway grants licensure to any physician holding a license in another state for at least one year, without requiring primary source re verification of training and employment history. This is broader than the interstate compact, since it works regardless of which state issued the original license, not only compact members. In fiscal year 2024 alone, the Board received 92 Universal Recognition applications and issued 82. The Board has also built internal KPI dashboards specifically to track performance and support data driven decisions, the same operational discipline this report argues every board needs and most visibly lack. Arizona's own applicant guidance asks for fifteen days before requesting a status update, against New York's six weeks. Arizona's Auditor General has also published independent performance audits of the Board across multiple years, 2015, 2017, and an active review underway as of this report, an external oversight mechanism this research did not find documented for any other state examined.

Read alongside Illinois in Finding 4, Arizona confirms the same conclusion from a different angle. The fix is not hypothetical, and it does not require new technology nobody has built yet. Universal Recognition and Illinois's compressed processing time are both existing, operating, documented proof that a board can choose to be fast and transparent, and some already have.

South Carolina, examined briefly for this report, adds one further structural detail worth noting. The state mandates use of the Federation Credentials Verification Service for primary source verification, which licensing services report adds real time on top of the Board's own review, and requires a physical, in person interview in Columbia before a full license is issued, a distinct, additional friction point not documented in any of the other states this report examined.

Finding 8

A Public Employee Roster More Granular Than Any Other State Discloses

Louisiana publishes something no other state examined in this report makes public: a complete, named roster of every employee at its State Board of Medical Examiners, with individual salaries and job titles, through a standing state transparency database.

This is a materially different kind of disclosure than California's aggregate vacancy percentages or Arizona's turnover ratios. It is not a summary statistic. It is fifty four actual names, actual titles, and actual dollar figures, available to anyone willing to look. Read as a staffing ratio, seventeen of those fifty four employees, roughly thirty one percent of the entire board, are dedicated specifically to licensing analysis, fourteen Licensing Analysts and three supervisors. A separate compliance and investigations function accounts for roughly ten more. Very few states examined in this research disclose enough detail to calculate this ratio directly, which means Louisiana is, paradoxically, among the only states this report can actually confirm has enough dedicated licensing staff, or whose staffing gap, if one exists, could actually be proven with public evidence.

Kentucky's own annual report discloses a comparable roster, and the number it produces is sharper still. Four staff carry dedicated licensure and verification titles, three Licensure Coordinators and a Verifications and CME Coordinator. Against that, the Board processed 1,607 new license applications and more than 25,000 renewals, in state and out of state combined, in a single fiscal year, nearly twenty seven thousand licensing transactions absorbed by four dedicated coordinators. This is not a coincidence specific to one unusually transparent state. It is what happens whenever a board actually discloses at this level of detail, a real, calculable workload ratio instead of an aggregate percentage, and it appeared identically in two separate states that have no apparent connection to each other beyond both choosing to publish it.

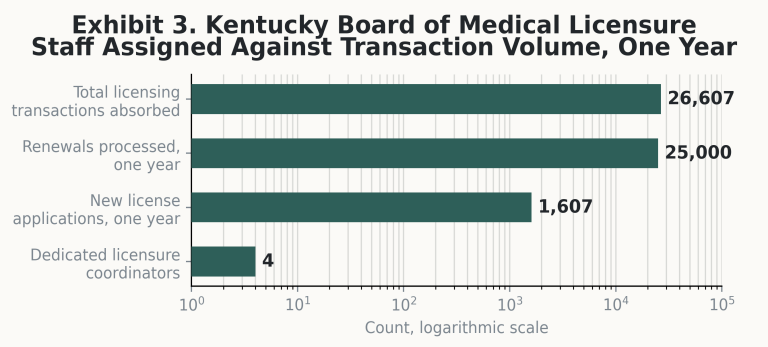

Exhibit 3. Kentucky Board of Medical Licensure, dedicated licensure staff against annual transaction volume, shown on a logarithmic scale given the size of the gap. Source: Kentucky Board of Medical Licensure Annual Report. See References.

The investigative side of Kentucky's operation carries a real, material risk this report can quantify precisely, not estimate. Of the 360 grievances opened in the most recent fiscal year, only 114 became full investigative reports, meaning a simple division of total grievances by five investigators meaningfully overstates the actual load. The real figure, drawn directly from an investigator's own published account, is worse in a different way.

Bonnie Reitz, a Kentucky Board investigator covering the eastern part of the state, described carrying twenty five to thirty active investigations at any given time, concurrently, not annually, while simultaneously supervising forty seven people already under board issued orders, confirming compliance, verifying suspended or revoked physicians have actually stopped practicing. Investigation and post disciplinary supervision are, for Kentucky's investigators, the same job, carried by the same small team at the same time. This is not a hypothetical strain. It is a named professional's own description of the workload behind the numbers, published in a peer reviewed regulatory journal, and it identifies limited manpower and resources as a recognized, industry acknowledged constraint at boards generally, not a condition unique to Kentucky.

> *“We might have 25 to 30 investigations that we're conducting at one time. In addition, I'm currently supervising 47 people in my region.”*
>
> Source: Bonnie Reitz, Kentucky Board investigator, Journal of Medical Regulation

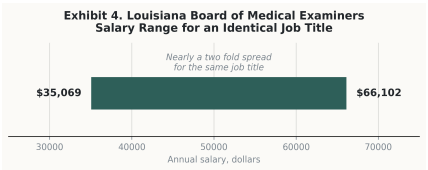

Exhibit 4. Salary range for the Licensing Analyst title, Louisiana State Board of Medical Examiners public salary table. Source: Louisiana State Board of Medical Examiners standing transparency database. See References.

The more striking detail sits inside the numbers themselves. Employees holding the identical title of Licensing Analyst earn between 35,069 and 66,102 dollars, nearly a two fold spread for the same job. That

gap most plausibly reflects tenure, employees who have stayed long enough to reach the top of a pay band earning nearly double what a new hire earns for identical work. Read that way, it raises a real, specific question this report cannot answer with the data available, but can now at least ask precisely: whether entry level pay near the bottom of that range is itself driving the kind of early departures that produce the vacancy and turnover patterns documented elsewhere in this report, in states that do not disclose enough to check.

The identical Licensing Analyst position at this board has been posted and reposted across multiple separate job listings, a real, concrete sign of ongoing churn in exactly the role this finding is built around. Direct testimony from former employees, posted publicly, states the pattern more plainly than any board disclosure could: no one stays, and new hires are asked directly whether they will leave too, because everyone already knows they usually do. The same reviews describe the agency as waiting to stabilize once a new executive director is in place, suggesting the turnover extends beyond entry level staff into leadership itself. A wage spread in a public salary table is a real, quantified signal. A former employee stating plainly that turnover is common knowledge inside the building is the same finding, confirmed by the people who actually lived it.

> *“Four people tell you how no one ever stays there so they want to know if you'll leave also. Never catch on that it's the work environment that makes people leave.”*
>
> Source: Former Louisiana State Board of Medical Examiners employee, public review

Louisiana's own Legislative Auditor has also published financial reports specifically on this board, an external oversight mechanism this research also found in Arizona but nowhere else. Real transparency and real external audit appear to travel together. States that disclose more also appear to be checked more, and states that disclose least are, by definition, the hardest to hold accountable to anyone outside them.

Finding 9

An Entire State's Compact Membership Nearly Disappeared Over Two Days

Everything documented so far in this report is chronic. A vacancy rate that persists for years. A reference system that fails the same way every time. A wage gap that never closes. Slow damage, absorbed quietly, by people who never learn why their file took so long. Michigan in early 2026 produced something else entirely, acute, existential, and resolved with forty eight hours to spare. Eight thousand physicians, roughly a third of the state's workforce, came within two days of losing their compact practice authority because a legislature ran out of time. It happened in the same state already documented in Finding 5 for operating without a passed budget at all.

Michigan's 2018 compact legislation carried a sunset clause, previously extended once to March 28, 2025. When the legislature failed to act again, the underlying law was repealed, triggering a twelve month withdrawal process from the Interstate Medical Licensure Compact scheduled to conclude on March 28,

2026. Real advocacy groups warned that more than eight thousand physicians, roughly a third of

Michigan's entire physician workforce, stood to lose compact based practice authority, with an estimated one hundred thousand patient appointments a day at risk, concentrated hardest in rural areas and in psychiatry, a specialty this report has already documented as critically exposed nationally. The state House and Senate deadlocked for months over which of two competing bills should move forward, with no resolution in sight as the deadline approached.

Governor Whitmer signed House Bill 5455 into law on March 26, 2026, two days before the withdrawal would have taken effect. Existing compact licenses remained active throughout, and the state's licensing department confirmed membership continued without interruption. The new law is genuinely stronger than what it replaced: it carries no sunset clause at all, meaning this specific failure mode cannot recur in Michigan again.

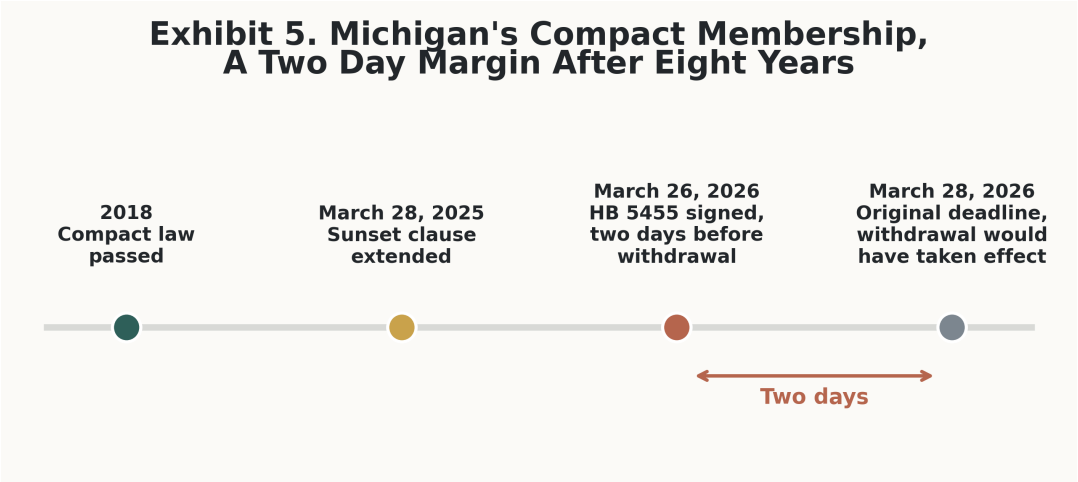

Exhibit 5. Michigan's compact membership timeline, from the original 2018 enabling legislation through the 2026 signing that permanently removed the sunset clause, two days ahead of the original withdrawal deadline.

Read alongside Finding 5, Michigan is the clearest illustration in this report of compounding fragility, a state operating without a passed budget and, in the same year, coming within two days of stripping a third of its physician workforce of practice authority through legislative inaction alone. Neither failure required a disaster or bad faith. Both came from the same pattern: institutions that assume their own continuity until the moment that assumption is tested.

Finding 10

A Number That Would Mean the Wrong Thing Without Its Own Audit

Nevada disciplines physicians at a higher rate than thirty nine other state medical boards, 26 sanctions per 1,000 licensed physicians against a 22 per 1,000 national average, according to a formal comparative analysis conducted by the Federation of State Medical Boards. Read alone, that number tells a specific, alarming story, Nevada physicians misbehaving more than their peers elsewhere. That story would be wrong, and the same audit that produced the number also explains why.

Nevada is documented, in the same report, as unique among its peers in one specific way, it investigates every reported malpractice claim without exception, regardless of how many claims a physician has faced or how the case resolved. Most state boards apply a threshold before opening a formal investigation. Nevada does not. A higher discipline rate produced by a board that investigates everything is not evidence of worse physicians. It is evidence of a more complete process catching what a threshold based process would have filtered out before anyone counted it.

This distinction only exists in this report because Nevada's board was subject to a genuinely different kind of external check than any other state examined so far, a formal external audit conducted not by a state government auditor, as in Arizona and Louisiana, but by the Federation of State Medical Boards itself, the profession's own national body, commissioned directly by Nevada's Legislative Commission. That audit also documented real staffing growth, from 31 employees in 2012 to 38 in 2020, explicitly validated by outside reviewers as appropriate to the board's actual caseload, and confirmed Nevada as a fourth state, alongside Minnesota, Kentucky, and Louisiana, funded entirely through licensing fees rather than general tax appropriations. New Hampshire underwent a similar review by the same national body, concluding in a February 2025 report with fourteen recommendations, confirming this is a standing practice the Federation applies across multiple states, not a one time engagement unique to Nevada.

Indiana shows what the absence of that capacity looks like. A direct academic study of state legislative oversight structures confirms Indiana's own State Auditor does not conduct performance audits of state agencies at all, functioning instead as the state's financial officer, and that the State Board of Accounts, Indiana's closest equivalent institution, directs its audit authority almost entirely toward local government, counties, cities, and schools, not state agencies such as the Medical Licensing Board. The same study ranks Indiana's legislature 40th nationally in professionalism. A state that lacks the institutional capacity Arizona, Louisiana, and Nevada each used to check their own boards is not simply a state this report could not find a document for. It may be a state with no real external mechanism capable of producing one in the first place, which means whatever staffing or discipline questions apply to Indiana's board specifically may never be independently tested at all.

Delaware shows a third version of this same underlying question, absent capacity in Indiana, present but untested capacity in most states, and in Delaware's case, capacity that was actively contested. In 2022, Delaware's own Department of Justice argued in court that the State Auditor's Office lacked the legal authority to conduct a performance audit of a state health agency, in that case the Division of Medicaid and Medical Assistance. A judge ultimately ruled the Auditor's Office did have that authority, but only after nearly two years of active legal resistance from within the state government itself.

This report found no evidence this specific dispute involved the Delaware Board of Medical Licensure and Discipline, and this finding should be read as general context about the state's institutional posture toward independent oversight of health related agencies, not as evidence about the board itself. A state where an auditor's basic right to examine a health agency was contested rather than assumed is a state where the kind of check that worked in Arizona, Louisiana, and Nevada cannot simply be taken for granted either.

This research also confirmed real, functioning audit capacity in Arkansas, New Jersey, Oregon, North Dakota, and Hawaii, each with an active state auditor or comptroller conducting genuine performance reviews of state agencies, without locating a specific completed report naming the medical board itself. This is a distinct category from Indiana's structural absence of capacity, and it should be read as exactly that, confirmed capacity where a report may exist without having surfaced in this research, not evidence the board in question has never been examined at all.

The finding underneath the finding is the one that matters most for any organization reading raw regulatory statistics from any state. A discipline rate, a processing time, a vacancy percentage, none of these numbers mean anything reliable without the process that produced them attached. Most states in this report do not publish enough to make that correction possible. Nevada's only reason this report can correct the record here rather than repeat a misleading number is that an independent audit happened to exist, was commissioned, and was made public. The states without one are not necessarily performing better or worse. They are simply the ones where a number like this would have gone unexamined.

Finding 11

Self Funded Is Not the Same as Adequately Funded

Four states in this report fund their boards entirely through licensing fees, insulated by design from the kind of political budget standoff that left Pennsylvania and Michigan operating without one at all. That insulation is real. It is also not the same thing as safety, and Iowa is where the difference becomes visible. A board can be perfectly protected from a legislature and still be dying, slowly, from a decision nobody has revisited in eighteen years.

Iowa's Board of Medicine has not raised its licensure fees since fiscal year 2007, according to the Board's own report, nearly two decades of frozen pricing set against two decades of rising costs. The consequence shows up directly in the Board's own numbers: a fiscal year 2023 expense budget of 6,547,197 dollars against anticipated licensure fee revenue of only 3,377,464 dollars, a gap the Board's own report states is covered using rollover funds rather than current income. A board that cannot pass a budget fails loudly and immediately, the way Pennsylvania and Michigan did in Finding 5. A board whose fee schedule has quietly gone stale for eighteen years fails slowly, invisibly, funded by reserves until the reserves themselves run out.

Iowa's own legislative fiscal notes make the practical consequence concrete. When the legislature adds a new licensing responsibility, a 2023 program for internationally trained physicians, a 2024 provisional license category, the Board cannot absorb the added work inside its existing budget. Each mandate requires a separate fiscal note, a separately requested full time position, and a new, narrow fee built specifically to fund it, one clerk specialist here, a fraction of a director's time there. The Board is not planning capacity. It is assembling it, one legislative mandate at a time, because the base funding underneath everything else has not moved in almost twenty years.

Self funded and adequately funded are not the same claim, and this report should not have implied otherwise in Finding 10. A frozen fee schedule is a slower, quieter version of the exact institutional

fragility this entire report documents, an assumption of continuity that goes untested for years, right up until an organization depending on that board discovers the gap between what the board can fund and what it is actually being asked to do.

Finding 12

A Regulator That Can Only Suspend, Never Fine

Mississippi's Board of Medical Licensure states directly, in its own strategic plan, that it may be the only regulatory agency in the state that lacks the statutory authority to fine its own licensees. Its entire disciplinary toolkit runs through a single lever, suspension, an all or nothing choice between letting a violation pass with no real consequence or removing a physician from practice entirely, in a state this report has already documented as having one of the lowest physician to patient ratios in the country. The Board's own 2025 legislative request asks for the authority to impose financial sanctions specifically so it can discipline a physician while keeping them working, a middle option that does not currently exist.

The same document contains an admission worth reading in full. Large, multi state corporate medical entities, the Board states directly, increasingly deploy larger and more sophisticated legal teams specifically to overwhelm its disciplinary counsel through sheer numbers and resources. This is not this report's inference. It is a state regulator's own written acknowledgment that it is structurally outmatched by the scale of the organizations it is responsible for policing, precisely the kind of asymmetry this entire research series has argued compounds quietly until it becomes visible at the worst possible moment.

The Board is stretched on more than one front at once. Its public relations and communications function currently runs through an outside contractor, Cornerstone Government Affairs, rather than dedicated staff, and the Board is requesting a Public Relations Specialist II specifically to bring that function in house for faster response time. Investigation costs have risen 33 percent in just two years, driven by rising expert review and hearing testimony expenses. Mississippi is not alone in this dependency. New Hampshire's licensing office has begun building its own bank of contracted outside specialists specifically to review cases requiring specialized medical expertise, a second state now confirmed relying on outside contractors to cover a core regulatory function rather than dedicated staff. None of these gaps exist in isolation. A board without fining authority, facing corporate legal teams built to outlast it, relying on a contractor for its own public communications, and absorbing rising investigation costs is a board absorbing pressure from every direction at once, not one.

This is not a dynamic unique to state regulatory bodies. A peer reviewed 2026 study of 2,099 United States acute care hospitals found that contract labor reliance in 2024 was significantly associated with lower patient experience performance the following year, and identified a nonlinear relationship, the negative association was strongest at low to moderate reliance and measurably diminished at higher levels, with a turning point near 26 to 33 percent of labor expense depending on the metric used. That study examined hospitals substituting contracted clinical labor for permanent staff, not regulatory boards substituting contracted expertise for dedicated employees, and the two are not the same institution or the same outcome. The underlying mechanism is the same one this report documents in Mississippi and New

Hampshire, an organization leaning on outside contractors to cover a function it has not staffed internally carries a real, measurable performance cost, whether the institution in question is a hospital or a state board.

One genuine counterweight belongs in the same finding, for balance. The Board's own strategic plan claims its portion of the license process has been reduced to one week, a real, fast figure, though it covers only the Board's share of the timeline, not necessarily the full applicant experience. A regulator can move quickly on the paperwork in front of it while still lacking the legal tools and institutional capacity to act meaningfully once a real violation is found. Those are two different questions, and this report found real evidence that Mississippi answers them very differently.

Finding 13

A Licensing Board Reduced to a Single Employee

In November 2023, the licensing authority for every physician in the state of Maryland was, for a period of months, one person. Not one person short. One person. The Board states this directly, in its own operating budget testimony to the state legislature, describing a usual staff of four, including the Executive Director, collapsing to a single office secretary. Its own words describe the consequence plainly: a severe impact on licensing operations. That is a state licensing authority self reporting that it was operating at roughly a quarter of its intended staff.

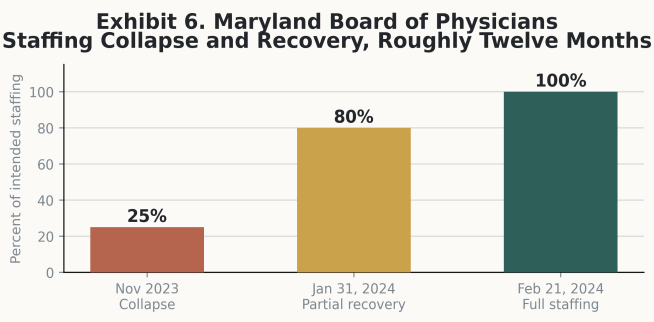

Exhibit 6. Maryland Board of Physicians staffing level, from the Board's own budget testimony. See References.

The recovery took nearly a year. By January 31, 2024, the Board reported reaching eighty percent staffing. Full staffing followed on February 21, 2024, which the Board's own testimony describes as the first time it had been fully staffed in a year. For roughly twelve months, every physician, hospital, and organization depending on Maryland licensure was operating against a board that had quietly lost most of its capacity to process anything, with no reason to know that was the cause behind a slower timeline, since board staffing collapses are not the kind of thing that appears on an applicant's status page.

This belongs alongside Finding 9's account of Michigan, not Finding 1's account of California. California's vacancy rate is chronic, a sustained condition documented across four years of board meetings. Maryland's collapse was acute, a real, severe crisis with a beginning, an end, and a recovery, the same category as Michigan's near lapse of compact membership, not a symptom of the slow, persistent understaffing documented elsewhere in this report. Maryland also shows the recovery side of that category working as

intended. The state ran targeted salary adjustments across dozens of job classifications in fiscal years 2023 and 2024 specifically to address recruitment and retention, and reports those adjustments as effective. Maryland's Board of Nursing separately underwent an independent evaluator's review of its own investigation timeliness under legislative mandate, suggesting the state was not looking away from this pattern once it became visible.

One small, real corroboration of that timeline surfaced during this research, worth noting for exactly what it is and no more. A job listing for an MBP Compliance Analyst position in the Board's Investigations function carries the word REPOST directly in its official title, meaning the role had already been posted once and failed to fill, requiring a second attempt, in the same general era as the staffing collapse documented above. This is a modest, procedural signal, not the kind of first person testimony available for other states in this report, but it sits consistently with everything else Maryland's own budget testimony already establishes.

The honest conclusion is not that Maryland failed and then fixed itself. It is that a licensing board can fall to a single employee, cause real harm, and recover within a year, entirely outside the visibility of anyone whose timeline it quietly extended. No state publishes staffing data in real time for anyone to check.

Finding 14

The Institutions Themselves Are Being Impersonated, and That Is Not a Coincidence

In April 2024, a Vermont physician's phone rang, and the caller ID showed the state medical board's own published number. It was not the board. The caller told the physician they were under investigation and demanded payment. The number had been spoofed, which means the single verification step most people would think to perform, checking who is calling, had already been defeated before the physician picked up. Eight state medical boards examined for this report, Missouri, Indiana, Nevada, Utah, Mississippi, Vermont, Idaho, and South Dakota, have independently issued public warnings about scammers impersonating board staff or law enforcement, calling licensed physicians directly, claiming they are under active investigation, and demanding immediate payment or personal identifying information to avoid losing their license.

This is not eight unrelated incidents. It is the same fraud pattern, executed independently against eight different states' physician populations, and it works precisely because of the conditions this report has spent thirteen findings documenting. A physician who has already experienced a six week silence from a licensing authority, or watched a colleague's file sit unresolved for months with no reliable way to check its status, has real, learned reason to believe an unexpected call claiming urgent regulatory trouble could be genuine. Opacity does not just slow down legitimate applicants. It creates exactly the uncertainty a scammer needs to be believed.

Idaho's own legislative budget testimony adds a real, quantified reason why that opacity keeps compounding rather than closing. The Board reported that applications processed grew 22 percent over seven years, while complaints filed more than doubled across the same period, and cited those exact

figures to justify requesting new administrative staff. A board absorbing complaint volume growing faster than its own headcount is a board with less capacity each year to close the exact communication gaps this fraud pattern depends on, not more.

No organization examined in this report treats this as a shared, national problem requiring a coordinated response. Each state discovered it independently, warned its own licensees independently, and none of the eight public notices this report located reference the other seven states experiencing the identical pattern. The same fragmentation this report has documented in credentialing timelines, staffing disclosure, and disciplinary authority extends to fraud response as well. Fifty separate institutions are separately re learning the same lesson, one state at a time, because there is no single body responsible for connecting what each of them has already found.

Finding 15

The One State Where the Software Really Was the Fix

This report has spent fourteen findings documenting institutions that could not move. Wisconsin moved. Its Legislative Audit Bureau was directed to investigate the Department of Safety and Professional Services after complaints about long occupational licensing waits reached the state legislature, and what the auditors found was not another failure. Average health care license processing time had dropped to 59 days, more than twice as fast as the preceding two fiscal years, when the same licenses took over 120 days on average. That is the single sharpest improvement documented anywhere in this report, a genuine, more than fifty percent reduction inside one audit cycle.

This finding needs to be stated honestly, including the part that complicates rather than confirms this report's own argument. The auditors attributed the improvement in significant part to a new online health care licensing system Wisconsin rolled out in May 2022, not to new staffing. The same reporting on the audit notes the legislature has not granted all the licensing positions the governor requested in recent budget cycles, meaning this improvement arrived substantially without the staffing increases every other proof of concept in this report has depended on.

This does not refute the central argument running through this report, that credentialing speed is a policy outcome rather than a technology outcome, but it does complicate the simpler version of that argument. Choosing to fund and deploy a new licensing system is itself a policy decision, a deliberate resource allocation a state makes or declines to make, the same category of choice as funding additional staff. Wisconsin shows that lever can work, and can work dramatically, even without a corresponding staffing increase. What this report cannot responsibly claim is that Wisconsin's specific outcome generalizes, one state's successful technology investment is not proof that software alone resolves the staffing, funding, and accountability gaps documented everywhere else in this report. It is proof that the solvable category identified in Finding 4 is broader than staffing and legislative pressure alone, and that a state genuinely committed to fixing its own bottleneck has more than one real lever available to pull.

Finding 16

When the Constraint Is a Choice, Not a Shortage

Every funding failure documented so far in this report shares one excuse: the money was not there. Oklahoma removes that excuse. Its own State Auditor documented license and fee revenue climbing from 3,573,696 dollars in fiscal year 2015 to 4,295,672 dollars in fiscal year 2016, roughly twenty percent in a single year. Personnel spending across that identical period moved from 1,790,046 dollars to 1,796,233 dollars. Three tenths of one percent. Effectively nothing. The money existed, it grew, and it went somewhere other than the people doing the work.

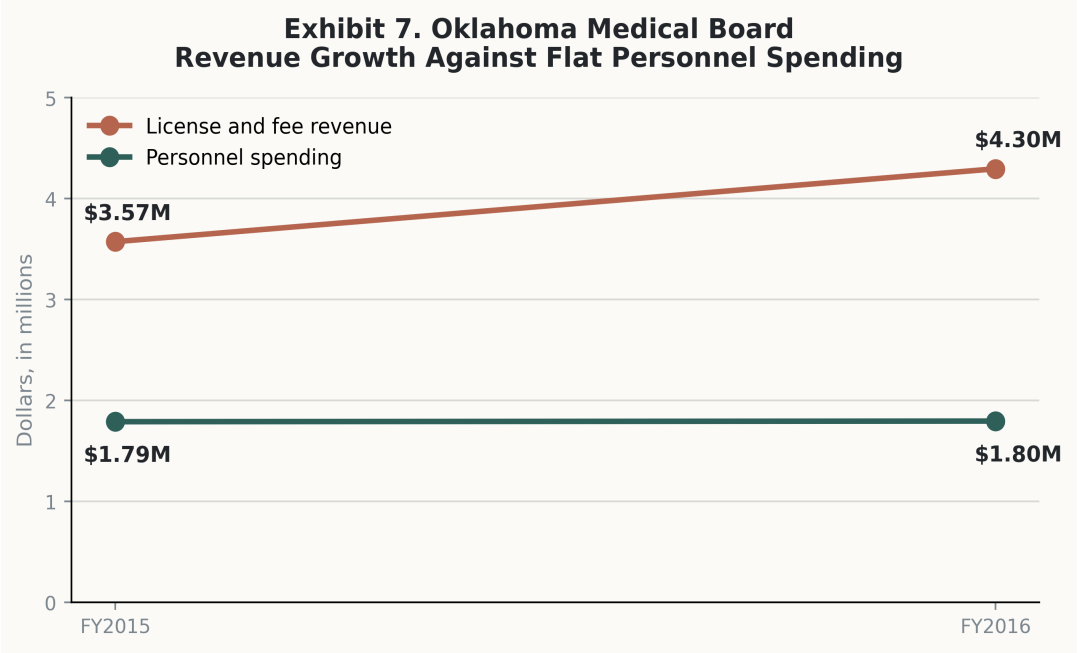

Exhibit 7. Oklahoma Board of Medical Licensure and Supervision, license and fee revenue against personnel spending, fiscal years 2015 and 2016. Drawn directly from the state auditor's own operational audit.

The same audit documented two real internal control weaknesses worth noting alongside this. Roughly ten percent of the Agency's revenue arrived as physical checks or cash, and the audit found no independent reconciliation confirming that money was actually deposited, a real, documented opening for funds to be misappropriated without detection. A second finding showed the same staff could both authorize and post payments without independent review. In both cases, the Board's own documented response confirms the recommended fix was implemented, a genuine, positive pattern of correction closer to Illinois and Arizona than to Missouri's documented pattern of ignoring its own auditor.

Colorado's own 2025 sunset review confirms the same underlying pattern in a genuinely current document, not a historical one. The Division's own breakdown shows expenditures associated with the Medical Practice Act rising steadily from fiscal year 2021 through 2023, while the number of full time equivalent staff dedicated to the Board remained flat across the same period. The same review confirms the Board's program is entirely cash funded through licensee fees, meaning the growing expenditures reflect real

revenue the Board itself controlled, not appropriations set by someone else.

What makes this finding distinct from every funding related finding elsewhere in this report is that it cannot be explained away by a legislature withholding appropriations or a statute nobody updated. The revenue was there, disclosed in the board's own accounting records, growing at a real and substantial rate. The decision not to direct a meaningful share of that growth toward staffing was made somewhere inside the organization itself, not imposed on it from outside. Oklahoma's audit predates the current reporting period by nearly a decade, and should be read as evidence of a pattern rather than current condition on its own, but Colorado's 2025 review confirms the identical mechanism happening in real time. The underlying distinction it reveals is a real one: some boards cannot afford to staff adequately, and at least two boards this report examined chose not to, while the money to do otherwise was sitting in their own accounts.

Finding 17

A Safety Program With No One Confirming It Works

Somewhere in Massachusetts right now, a physician the state has formally identified as impaired is being monitored by an organization the state has no contract with. A 2020 performance audit by the

Massachusetts State Auditor found the Board of Registration in Medicine has no formal, contracted relationship with Physician Health Services, the organization it relies on to manage physicians with potentially impairing health conditions, substance use disorders, mental health conditions, and physical illness that could compromise a physician's ability to safely practice. Physicians may enter this program voluntarily or be required to as part of the Board's own disciplinary action, meaning some of the cases involved are physicians the Board has already identified as a genuine risk.

The audit states the consequence plainly: without a formal contract, the Board has no real oversight of due process, protocols, or performance standards governing how the program actually operates. It is standard practice for state medical boards to refer potentially impaired physicians to an outside provider. It is not standard, the audit notes directly, for a board to do so without any contract addressing how that provider is expected to perform. Massachusetts is not confirming whether the program managing its highest risk physicians is actually working. It is assuming so.

Utah's own Division of Occupational and Professional Licensing shows the same pattern from a different angle. A legislative performance audit found DOPL, which oversees over seventy occupations on a 7.7 million dollar budget and 96 full time equivalent staff, actually processed license applications timely and consistently, a genuine, independently verified positive finding, not a claim the division made about itself. The same audit found DOPL should be enforcing its own diversion program requirements more effectively and that investigations needed improved management review, the identical category of gap documented in Massachusetts, a board performing well on the metric everyone checks first while an oversight function tied to impaired or at risk licensees goes unmanaged underneath it. A more recent legislative review adds a present day version of the same blind spot, Utah's licensing renewal process collects workforce data from licensed professionals on a voluntary basis only, and the state's own auditors state directly that Utah may be at a disadvantage understanding its own workforce trends as a result.

Montana's own Legislative Audit Division confirms the same underlying pattern a third time, and with the most severe consequence documented anywhere in this report. A chaotic two year transition between contractors monitoring impaired healthcare providers may have allowed some of those providers to practice without any oversight at all during the gap, according to the audit's own findings, covering dozens of nurses, doctors, dentists, and pharmacists being monitored for substance use disorders and mental illness. The audit itself states the transition and communication breakdowns fostered real distrust and instability within the program, and calls directly for comprehensive data recovery efforts, meaning records were apparently lost or compromised during the handoff. State auditors warned explicitly of real risk to public safety and real liability exposure for Montana's own licensing boards as a direct result.

This is a different kind of gap than every other finding in this report. It is not a staffing shortage, a funding constraint, or a missing disciplinary tool. It is an oversight blind spot sitting inside the exact function most directly tied to whether a physician the board has already flagged as impaired actually stops posing a risk to patients, confirmed independently in three states. Massachusetts and Utah have not otherwise featured in this report as states in visible distress, no vacancy crisis, no funding standoff, no compact delay, and Montana's own appearance elsewhere in this report is a neutral structural note, not a crisis. That is precisely what makes this finding worth including. A board can look entirely stable, even genuinely well run, on every measure this report has used elsewhere, and still be quietly unable to confirm that its own safety net for its highest risk licensees has a floor.

Finding 18

The Delay Does Not End When the License Clears

Everyone starts seeing patients once the license posts. Insurance always catches up. That is what onboarding coordinators tell incoming physicians, in nearly identical words, across separate organizations, and a physician transition guide records it because the physicians hearing it needed to be warned. Maybe it is true. Maybe it is not. The guide's own advice is blunt: never see a patient before your malpractice confirmation is in your hand.

Every finding in this report until now has ended at the moment a state board issues a license. This one begins there, and finds the delay does not stop. Only seven states, Colorado, Connecticut, Kansas, Massachusetts, New Jersey, Rhode Island, and Wisconsin, legally require malpractice insurance as a direct condition of licensure. In the other forty three, that requirement sits entirely outside the state board this report has examined, enforced instead by individual hospital credentialing committees under Joint Commission standard MS.06.01.03, which requires proof of coverage before granting a physician actual privileges to see patients.

That handoff is where the pattern this report has spent seventeen findings documenting at the state level reappears, one step downstream, wearing different clothes. An assumption treated as settled fact until someone finally checks. The difference is what sits on the other side of it this time. Not a delayed start date. A physician seeing patients without confirmed coverage, at the exact moment a cleared license was supposed to mean everything was finally in order.

The mechanism carries a real, concrete timeline cost independent of anything a state board does. Hospital credentialing committees typically meet on a monthly cycle, and a physician who misses a single submission deadline, even by one day, often waits a full additional month for the next meeting before privileges are granted. A state board can resolve a license in the fastest window this report has documented anywhere, and a physician can still lose an entire month at the very next step, through a handoff no state board, compact, or piece of credentialing software has any control over.

This report was built to test whether credentialing speed is a policy outcome rather than a technology outcome, and every finding before this one has answered that question by examining a single institution, the state board. This finding extends the same test one step further. The handoff between a cleared license and an actual first patient encounter runs through an entirely different institution, a hospital's own credentialing committee, operating on its own calendar, verifying a requirement most states never made the board's responsibility in the first place. An organization that has fully solved every friction point this report has documented inside a state board can still lose real time, and carry real risk, at the exact moment a physician is supposed to finally begin work.

A separate, real trend compounds this same bottleneck, and it deserves precise framing rather than alarm. The Medical Liability Monitor's own annual rate survey shows eleven consecutive years in which the majority of malpractice rate filings moved up rather than down, and the National Association of Insurance Commissioners' most recent countrywide figures show losses, defense costs, and premiums all rising again in 2025 compared to 2024.

The American Medical Association's own current assessment states plainly that seven straight years of increases is not yet a crisis, though the direction is clear, a meaningfully different situation than the historical malpractice insurance crises of the 1970s, the mid 1980s, and the early 2000s, when carriers actually withdrew from entire states and states had to build joint underwriting associations as insurers of last resort. Nothing in current data shows that same severity recurring. What current data does show is coverage becoming steadily more selective by carrier and by specialty, a real pressure that makes the binding process this finding has already documented slower and more contested precisely where it intersects the states and specialties already under the most strain elsewhere in this report.

Finding 19

A Vote Cast Without the Evidence That Produced It

The people voting to discipline a Tennessee physician were, by the Board president's own admission, frequently not in the room when the case against that physician was made.

Tennessee's Comptroller, through its Office of Research and Education Accountability, investigated the state's Board of Medical Examiners directly in 2020, following a high profile case involving an East Tennessee nurse practitioner and a legislative mandate under Public Chapter 978 to examine how the state's health boards had disciplined prescribers identified as statistical outliers, twenty four physicians, nine advanced practice nurses, five physician assistants, and twenty four dentists in the sample reviewed.

The finding underneath that investigation is a genuinely different kind of accountability gap than anything else in this report. The Board's own president told investigators directly that most board members had never attended the case review meetings, where consultants and department staff actually discuss the evidence in depth before a disciplinary settlement is proposed. Board members were voting to approve or reject those settlements without having witnessed the deliberation that produced them. The president stated plainly that board members who had never seen that discussion may find it more difficult to trust the consultant's settlement decisions, an admission that the people casting the actual vote were, in a meaningful sense, voting blind.

Every other finding in this report examines whether the public, an applicant, or an outside organization can get a straight answer from a board. This finding examines something upstream of that question entirely, whether the board's own members have the information needed to exercise the authority the public has entrusted to them. A licensing system can have adequate staff, a generous budget, and a functioning compact relationship, and still produce disciplinary outcomes decided by people who were not in the room when the case against a physician was actually made.

Finding 20

A Board That Cannot Always Vote on Its Own Business

A licensing board can be fully staffed, fully funded, and still unable to legally hold a vote. Colorado's own 2025 sunset review documents exactly that, a bottleneck this report had not yet measured anywhere, sitting not in a budget line or a headcount but in the precise wording of two separate statutes. The Board's President holds full voting membership on both of its inquiry panels, the bodies that handle complaints and disciplinary hearings, because the specific statute governing those panels grants that authority explicitly. A separate statute governing the licensing panel, the body that actually reviews and approves license applications, does not grant the President the same standing. The review states the consequence directly: even when the President is present at a licensing panel meeting, they cannot be counted toward the quorum required to convene it.

This is not a hypothetical risk sitting in statutory language. The same review states plainly that in recent years there have been actual challenges establishing quorum on this panel, attributed to scheduling conflicts and board member vacancies working together. When a licensing panel cannot convene because it lacks enough countable members in the room, license applications waiting on that panel's review do not move, regardless of how well staffed the board's administrative office is or how quickly the underlying paperwork was processed.

Every bottleneck documented until now lives inside staffing, funding, or design, capacity a board could buy with the right budget. This one lives inside the wording of two statutes governing who counts as present in a room.

Indicators and Warnings

Twenty findings across forty six states establish what has already happened. They do not answer the question an operator actually needs answered, which is not which boards have failed but which board fails next, and whether the state currently sitting in an expansion plan is showing the signs before it does.

Intelligence work has a standard answer to that problem. You do not wait for the event. You identify the observable conditions that reliably precede it, you monitor them, and you treat their accumulation as a warning rather than a coincidence. Applied to state medical boards, every condition below appears somewhere in this report as part of a documented failure, and every one of them is visible in public record before the failure becomes visible in a timeline.

Structural Indicators

A fee schedule unchanged for a decade or more. Iowa's has not moved since fiscal year 2007, and the Board now covers a structural annual gap from reserves rather than current income. A frozen fee schedule is the slowest moving failure in this report and the easiest to observe from outside.

A board that has never been examined by an independent auditor. Nevada's discipline rate only means what it appears to mean because an audit existed to explain it. Arizona, Louisiana, Washington, Missouri, Colorado, Montana, Utah, Wisconsin, and Massachusetts all produced findings in this report because someone was empowered to look. Indiana produced none, and this report found that its State Auditor does not conduct agency performance audits at all. Absence of findings is not evidence of health.

Licensing administered through a shared, multi profession office rather than a dedicated board. Ten states in this report route physician licensing through an agency that also handles unrelated professions. Virginia's Board of Medicine does not maintain its own executive director. That structure correlates, throughout this research, with thinner public disclosure and slower applicant facing communication.

A compact dependency that terminates. Michigan's membership carried a sunset clause and came within two days of lapsing for roughly eight thousand physicians. Any compact authority with an expiration date is a scheduled risk, and the date is public.

Capacity Indicators

An executive director vacancy, or recent turnover in that seat. Maryland's collapse to a single employee began when a new executive director arrived. Louisiana's public employee reviews describe an agency waiting to stabilize until a new executive director is in place. The seat itself is a load bearing position, and its vacancy is observable.

Rising expenditures against flat headcount. Oklahoma's revenue grew twenty percent in a single year while personnel spending moved three tenths of one percent. Colorado's 2025 sunset review documents expenditures rising across three fiscal years while dedicated staff stayed flat. Kansas budgets full staffing at current pay with no salary increases while its total budget climbs. Money entering an institution is not the same as capacity entering it.

Complaint volume growing faster than staff. Idaho's own legislative testimony reports applications up twenty two percent over seven years while complaints filed more than doubled. A board absorbing rising volume against static headcount has less capacity each year, not more, regardless of what its processing average currently says.

Reliance on outside contractors for a core regulatory function. Mississippi outsources public communications. New Hampshire contracts specialists to review complex cases. Montana's contracted monitoring transition may have left impaired practitioners unsupervised for a period. Contracted capacity is real capacity, but it is capacity the board does not directly control.

Governance Indicators

Quorum requirements that can fail. Colorado's licensing panel cannot count its own Board President toward quorum, and the state's own sunset review reports actual difficulty convening. This risk lives in statutory language, not in a budget line, and no staffing increase resolves it.

Disciplinary authority that is structurally incomplete. Mississippi's board may be the only regulator in the state without power to fine, leaving suspension as its only lever against organizations its own strategic plan says are built to outlast it.

Fee revenue that does not stay with the board. Texas, Georgia, and Alabama all show, through three entirely different sources, a board's own collected revenue targeted for diversion. Alabama's sitting members described it in writing while it was happening.

Reading the Indicators

No single indicator predicts failure. California has carried a vacancy rate near seventeen percent for four years and continues to function. The signal is accumulation. A state showing one indicator warrants a note in a file. A state showing four or five, particularly across more than one category, is a state where the published processing average is describing a system under load that the average itself will be the last thing to reflect.

Every indicator above was located in public record, most of it in documents the board published about itself. None of it required privileged access, a source inside an agency, or anything an operator cannot obtain in an afternoon. The reason these conditions go unnoticed is not that they are hidden. It is that nobody has been assigned to watch for them.

A Note on Methodology and Confidence

This report distinguishes explicitly between three tiers of evidence, and readers should weight each finding accordingly. The highest tier, applied to California, Texas, Georgia, Illinois, Pennsylvania, Arizona, Louisiana, Kentucky, Nevada, Iowa, Mississippi, Maryland, Rhode Island, New Hampshire, Vermont, Idaho, Missouri, Washington, Wisconsin, Indiana, Oklahoma, Massachusetts, Utah, Minnesota, Montana, Colorado, Alabama, Delaware, Kansas, Maine, New Mexico, Tennessee, Virginia, West Virginia,

Wyoming, Alaska, Nebraska, South Dakota, and the five states examined in depth in Part Two, reflects direct board level disclosure, meeting minutes, legislative budget submissions, or documented operational reporting. The second tier, applied to Ohio, Michigan, North Carolina, South Carolina, Arkansas, Hawaii, North Dakota, Oregon, and several states referenced in national comparisons, reflects confirmed status on specific, narrow questions, compact membership, a specific legislative change, a specific annual report figure, without the same depth of surrounding operational detail. The third tier, applied to compact status mapping across all fifty states, reflects confirmed public record on a single, binary question, membership status, and should not be read as a claim of operational depth equivalent to the first two tiers. Every figure in this report is labeled, in text, by which of these a given claim rests on.

Confidence Grading

Tiering the evidence is not the same as grading the finding. A tier describes where information came from. A confidence level describes how much weight a specific conclusion can carry, which depends on the source, its age, whether it was corroborated, and whether the institution in question was describing itself or being described by someone else.

Every finding in this report is graded below. High confidence means the finding rests on an institution's own documented statement about itself, or on an independent audit of it, with figures that can be located and checked. Moderate confidence means the finding rests on a dated source read as pattern rather than current condition, on a source outside the institution, or on an attribution that reflects an auditor's judgment rather than an isolated measurement. No finding in this report is graded low, because findings that would have been graded low were not included.

Finding	Basis	Confidence
Finding 1	Board's own quarterly staff reports, four consecutive years, direct disclosure	**High**
Finding 2	Board's own administrative summary reports, specific loan amounts and fiscal years	**High**
Finding 3	Six states. Missouri, Minnesota, and Alabama from state audits and sunset reports. Georgia, Connecticut, and New York from licensing services operating directly with those boards	**Moderate**
Finding 4	State agency's own published processing time data, before and after	**High**
Finding 5	Contemporaneous public reporting on two state budget standoffs, conditions current as written	**High**
Finding 6	Compact Commission member list, Rhode Island and Alabama board disclosures, licensing service accounts of Letter of Qualification timing	**High**
Finding 7	Board's own annual report, Universal Recognition figures, Auditor General reviews	**High**

Finding	Basis	Confidence
Finding 8	State transparency database with named employees and salaries. Kentucky annual report. Investigator caseload from a named professional in a peer reviewed journal	**High**
Finding 9	Legislative record, signed bill, dated deadline. Advocacy figures on affected physicians are estimates	**High**
Finding 10	Federation of State Medical Boards comparative analysis and commissioned audit	**High**
Finding 11	Board's own report and legislative fiscal notes, specific dollar figures	**High**
Finding 12	Board's own strategic plan and legislative request, including its written admission of being outmatched	**High**
Finding 13	Board's own operating budget testimony to the state legislature. Job posting corroboration is procedural, not testimonial	**High**
Finding 14	Eight separate public board notices. Pattern inference across states is this report's own analysis	**High**
Finding 15	Legislative Audit Bureau report. Attribution of the improvement to the new system reflects the auditors' judgment, not an isolated variable	**Moderate**
Finding 16	Oklahoma audit is dated 2017 and read as pattern, not current condition. Colorado's 2025 sunset review confirms the mechanism in the present	**Moderate**
Finding 17	Three state audits. Massachusetts 2020, Utah, Montana 2025. Dates vary and are disclosed in text	**High**
Finding 18	State statutory requirements and Joint Commission standard are documented. Onboarding accounts come from a physician transition guide, not from named institutions	**Moderate**
Finding 19	Comptroller investigation quoting the Board president directly. Report is dated 2020	**High**
Finding 20	State sunset review, 2025, quoting the statutory conflict and reporting actual quorum difficulty	**High**

Fifteen findings carry high confidence. Five carry moderate, and in each of those five the specific limitation is stated in the finding's own text as well as in the table above. A reader working through Part One should weight accordingly, and a reader building an operating decision on any single finding should read the source rather than the summary.

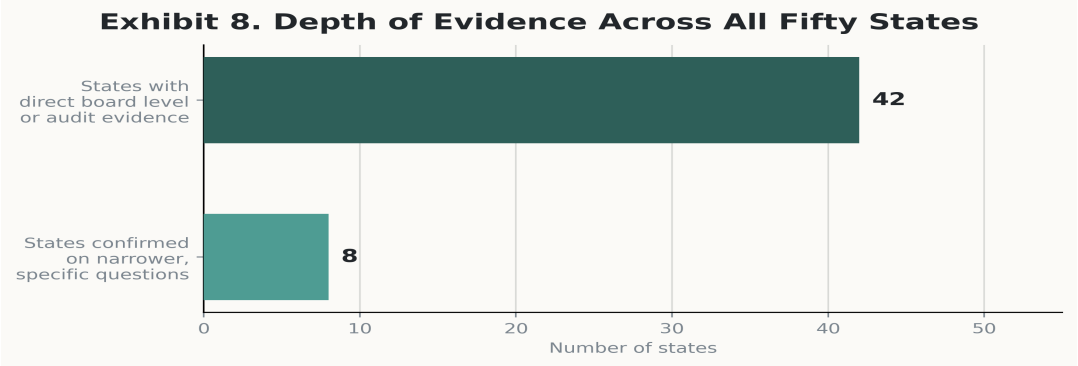

Exhibit 8. Depth of evidence located for each of the fifty states across this research effort. Every state examined reached at least the second tier of confirmed evidence, none remain at compact status alone.

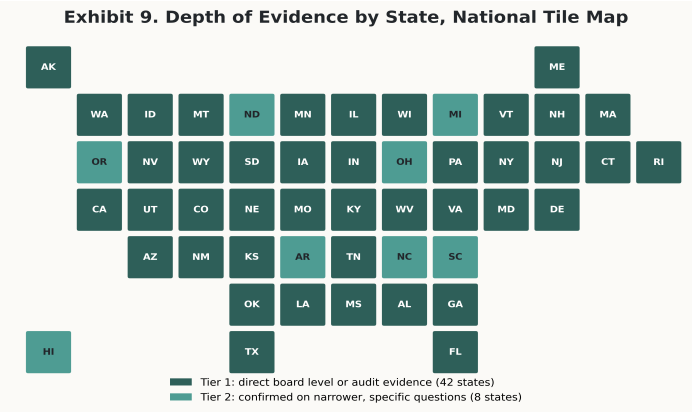

Exhibit 9. Evidence depth by state, arranged in approximate geographic position.

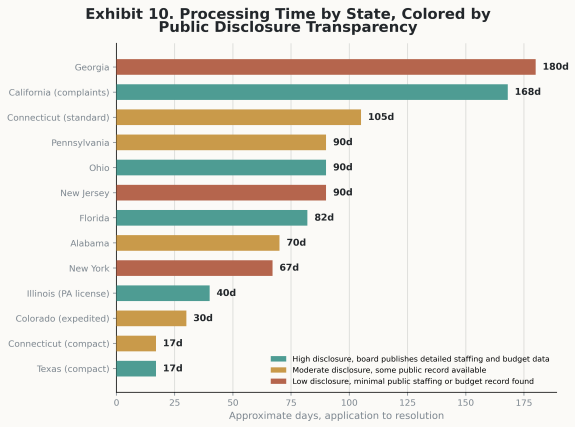

Exhibit 10. Reported or estimated processing time across thirteen states with confirmed public data, colored by depth of public disclosure. Mixes measurement types; read as illustrative of national variation, not a uniform dataset.

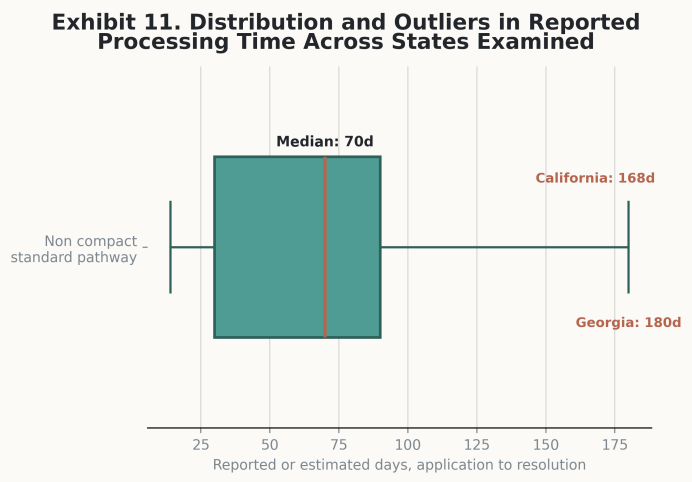

Exhibit 11. Distribution of the same reported processing time figures, showing the median, interquartile range, and the two genuine outliers, Georgia and California, that pull the national range far past what a typical state actually reports.

The Counterintelligence Question

Every finding in this report was built from public record, and that method has an assumption buried inside it that deserves the same scrutiny this report has applied to everyone else. The assumption is that the public record is a reasonably neutral sample of what is happening. It is not.

Consider what actually generated the strongest findings above. Nevada's discipline rate could be corrected because the Federation of State Medical Boards conducted an audit. Arizona's turnover ratio is known because Arizona publishes it. Louisiana's fifty four employee roster exists because Louisiana operates a standing transparency database. Colorado's quorum defect surfaced in a 2025 sunset review. Montana's monitoring gap came from its Legislative Audit Division. Alabama's fee diversion dispute is documented because a sunset report asked sitting board members a direct question and printed their answers.

In every one of those cases, the finding exists because an institution was willing, or legally obligated, to look at itself and publish what it found. The finding is downstream of the disclosure, not of the dysfunction.

Now invert it. Indiana produced almost nothing for this report, and the reason is documented: its State Auditor does not conduct performance audits of state agencies, and its State Board of Accounts directs its authority at local government. Tennessee produced nothing through two separate search approaches until a third attempt located a specific legislative mandate. Arkansas, Oregon, New Jersey, North Dakota, and Hawaii all have real, functioning audit bodies, and this research located no completed examination of their medical boards at all.

That is the uncomfortable inference, and it runs against the grain of how this report reads on first pass. The states that look worst in this document are, with few exceptions, the states that examined themselves most rigorously. The states that look cleanest are frequently the states where nobody has been assigned to look. A reader who finishes Part One believing California, Louisiana, and Nevada are the most troubled boards

in America has drawn precisely the wrong conclusion. They are the most transparent.

This does not weaken any individual finding. Every number in this report is real, sourced, and attributed. What it does is invert the reading of the silence. Twenty findings describe what forty six states were willing or required to disclose. Nothing in this report describes what the remaining institutions have never been asked.

For an operator, the practical translation is direct. A state with a thin public record is not a low risk state. It is an unmeasured one, and unmeasured is a different category than safe. The absence of a damaging finding should raise the question of who was responsible for looking, and whether anyone was.

Who Benefits From the Current State

Intelligence assessments end with a question that operational reports often skip. Not what is broken, but who has an interest in it staying that way. The question is not conspiratorial. Most systems persist in a bad configuration because the people positioned to change it have no incentive to, and because the people harmed by it lack the information to object. This system is no exception, and Finding 14 already demonstrates that someone found the vulnerability before this report did.

Eight state boards have issued public warnings about people impersonating them, calling licensed physicians, and demanding payment against a threatened license. That fraud works for a precise reason. A physician who has already waited six weeks in silence, or watched a colleague's file sit unresolved with no way to check status, has learned that unexplained regulatory trouble is plausible. The opacity documented across twenty findings is the operating environment those callers exploit. Adversaries priced this vulnerability before the industry did.

The Expediter Economy

A real industry exists to navigate this complexity on a physician's behalf. Licensing services, credentialing consultants, and expediters were among the most useful sources in this research, and several findings in this report exist because those firms described operational realities boards do not publish. Their observations were candid and, where testable against board documents, accurate.

That does not change the structural fact. An industry whose value proposition is navigating confusion has no commercial reason to want the confusion resolved. If every state published a reliable timeline, a reachable analyst, and a verifiable status page, a meaningful portion of that market would have nothing left to sell. This is not an accusation of bad faith. It is an observation about incentive alignment, and it is the kind of observation an operator should make before treating any single vendor's account of the landscape as disinterested.

The Vendor Incentive

The same logic runs through credentialing technology. This report's central finding is that the larger share of the timeline sits inside a state institution no software can reach. A vendor selling internal automation has

no incentive to make that distinction prominent, because the honest version of the sales conversation ends with a caveat about the half of the problem the product cannot touch.

The result is a market where speed is marketed as a product attribute rather than a jurisdictional condition. Report 005 tested that claim and found it overstated. This report explains why it was always going to be overstated, and the explanation implicates no individual vendor. The incentive is structural.

The Institutional Interest

Boards themselves are not neutral parties to their own reform. A professional telehealth source states directly that boards rely on licensure fees as a significant source of funding and are reluctant to cede disciplinary authority to a multistate body as a result. That is the same financial self interest documented in Texas, Georgia, and Alabama, where fee revenue was targeted for diversion, applied here to explain why comprehensive national reform has stalled while physician advocacy has retreated toward narrower fixes.

None of that requires anyone to act in bad faith. A board protecting its funding base is behaving rationally. So is a vendor emphasizing what its product does well. So is an expediter whose expertise has value precisely because the terrain is difficult. The problem is that every actor with the standing to simplify this system has a defensible reason not to, and the party carrying the cost of that equilibrium, the organization whose expansion timeline depends on it, is the only one with no seat at the table.

What This Means for the Reader

Two practical consequences follow. First, treat any account of licensing timelines as coming from a position, including this one. This institute's position is stated in the closing section, and every source in this report is named so a reader can weigh it. Second, and more importantly, recognize that no external party is going to solve this. The incentives point the other way. The only actor with an unambiguous interest in understanding a state board accurately is the organization that has to live with its output, which is precisely why that organization cannot outsource the question.

Where the AI Investment Conversation Points the Wrong Way

Healthcare is spending real money to solve the half of this problem it already controls. Every one of the twenty findings in this report lives inside a state institution, a board's own staffing, funding, disciplinary authority, or quorum requirements, and none of it is reachable by software an organization buys for its own internal use. AI applied to credentialing today is aimed almost entirely at document collection, internal routing, and initial verification, the portion of the timeline an organization was never the bottleneck on. The larger share, sitting inside the institutions this report has spent nineteen findings documenting, remains untouched by any of it.

That mismatch creates a real risk beyond simple inefficiency. A tool that compresses the portion of a timeline an organization controls can manufacture a false sense of completion, an application processed and submitted within hours reads as progress, even while the state board holding the remaining months of the actual timeline has not moved at all. Organizations that schedule start dates, staffing plans, and patient

volume against the fast, visible number rather than the slow, structural one are planning against an illusion the tool itself created.

A related risk compounds it further. If AI genuinely removes the administrative friction of operating across many states, it can make multi state expansion feel easier precisely at the moment an organization should be checking harder, not less. The friction AI removes was never the real signal of institutional risk in a given state. This report's twenty findings are. An organization that expands faster because the paperwork got easier, without expanding its due diligence into the specific board it now depends on, has solved the wrong problem.

The more constructive reframing is that this report has already documented, in Finding 15, exactly what a correctly targeted technology investment looks like. Wisconsin did not improve a hospital's internal onboarding software. The state itself invested in a new licensing system, and cut average processing time from over one hundred twenty days to fifty nine. That is technology actually reaching the larger, structural share of the timeline this report has spent nineteen other findings proving no hospital side tool can touch. The more useful question for this industry is not whether AI can make credentialing faster. It is why so much of the investment is aimed at the smaller half of the problem while the larger half sits almost entirely unaddressed.

The tools being adopted to work on that smaller half also carry a real, quantified, and growing risk of their own. Healthcare vendor security incidents have risen sharply, with 68 percent of healthcare organizations reporting a supply chain attack in 2024, and 82 percent of those reporting a direct disruption to patient care as a result. Every AI powered credentialing platform an organization adopts is itself a vendor, and inherits this same exposure. Federal regulators have taken notice directly, the Department of Health and Human Services Office for Civil Rights collected over 8.3 million dollars in HIPAA penalties across 21 resolved cases in 2025, the second highest annual enforcement total on record, with AI specific incidents now explicitly on the agency's regulatory radar heading into 2026. An organization adopting an AI credentialing tool to solve the smaller, controllable half of its timeline problem should weigh that against a real, separate, and growing liability the tool itself introduces.

One further limitation is worth stating plainly. Any tool that verifies a physician's license status is only as reliable as the data it reads, and that data originates directly from the same state systems this report has documented as inconsistently disclosed, technologically dated, and unevenly maintained. A verification tool built on top of a state that does not reliably publish current information inherits that unreliability completely. No algorithm improves on a data source that was never dependable to begin with.

Telehealth Multiplies Every Finding in This Report at Once

Everything in this report so far assumes a physician moves. One state, one board, one timeline, resolved once. Telehealth breaks that assumption at its foundation, because the license must follow the patient, not the physician. A doctor sitting in one state treating a patient sitting in another must be licensed where the patient is, at the moment of the visit, every time. Which means a telehealth practice serving patients nationally is not exposed to one state's version of this report's findings. It is exposed to all twenty of them,

in every state a patient happens to be sitting in, continuously, for as long as that relationship lasts.

A real, documented explanation exists for why comprehensive reform of this problem has stalled, and it is not simple bureaucratic inertia. A professional telehealth industry source states directly that state medical boards rely on licensure fees as a significant source of their own funding, and are reluctant to cede disciplinary authority to a multistate body as a direct consequence. This is the identical financial self interest already documented in this report's own fee diversion findings in Texas, Georgia, and Alabama, applied here to explain resistance to structural reform rather than resistance to funding a board's own operations. The same incentive that keeps a board's fee revenue from reaching its own staff is a plausible part of what keeps national telehealth licensing reform from happening at all.

A second risk is sharper than anything documented elsewhere in this report, because it is live and ongoing rather than a one time delay. The APRN Compact had only four fully active member states as of early 2025. Compact eligibility does not mean national coverage. It means coverage exists only where both a provider's home state and the specific patient's state are active members. A provider who assumes broader coverage than that is not facing a slow license. They are practicing without a valid one, on every affected patient encounter, with real, documented consequences, license suspension or revocation, fines exceeding ten thousand dollars, criminal exposure in some states, and malpractice liability layered on top of all of it.

The pattern this report has already documented in Finding 6 repeats independently in a completely different compact system. The Psychiatric Mental Health Nurse Practitioner Compact has seventeen member states and explicitly excludes California, New York, Texas, Florida, Illinois, and Pennsylvania, the identical largest population states already documented sitting outside the physician compact. This is not one compact's design flaw. It is the same structural pattern recurring on its own, in an entirely separate profession's licensing system, suggesting the underlying cause sits deeper than any single compact's specific terms.

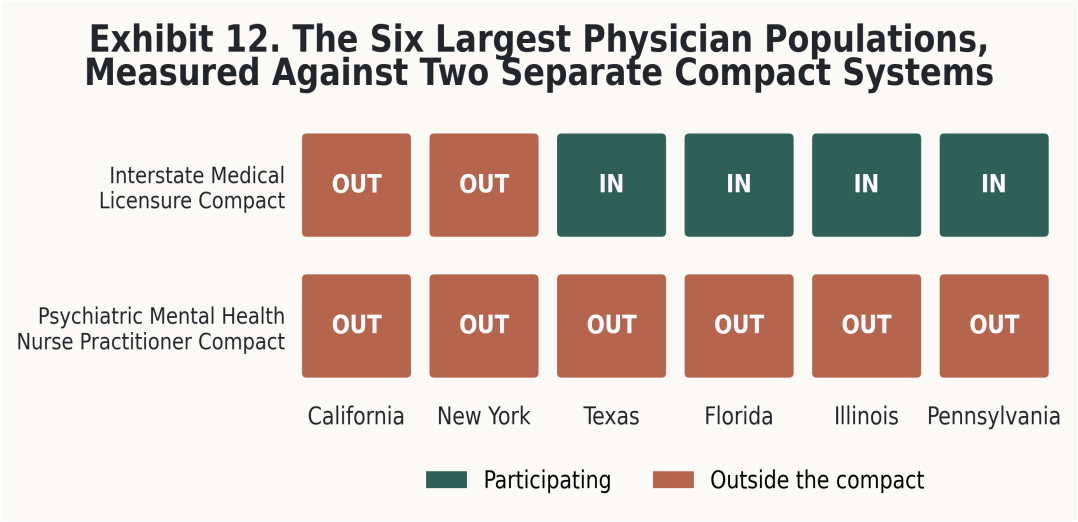

Exhibit 12. The six largest physician populations in the country, measured against two separate and independently governed compact systems. The bottom row is the finding: not one of the six participates in the psychiatric compact, in the specialty this report has documented as carrying the heaviest telehealth volume nationally.

One further signal is worth including for what it reveals about how this problem is perceived from inside the industry. Physician advocacy has reportedly shifted away from pursuing a comprehensive national telehealth license entirely, moving instead toward narrower fixes, federal continuity of care protections for existing patients, or a limited registry for high value consultations. That is the industry's own advocates signaling they no longer expect the comprehensive version of this problem to be solved, and are pursuing smaller wins instead. An organization building a telehealth strategy around the assumption that broad reform is coming should know that the people closest to this fight have largely stopped expecting it.

The volume of exposure carried by every risk in this section is also actively growing, and it is growing fastest among the generation least likely to see it as a risk at all. A 2025 survey of over two thousand consumers found 30 percent of Gen Z and Millennials use telehealth for care, against just 6 percent of Baby Boomers, and for mental health specifically, Gen Z reports the highest usage of any generation at 22 percent, more than four times the boomer rate. Separately, 62.3 percent of all telehealth claims nationally in February 2025 carried a mental health diagnosis, meaning mental health data is not incidental to telehealth. It is the dominant category moving through it.

A privacy focused industry source covering this exact convergence describes it plainly: a pandemic era boom in telehealth therapy collided with a pandemic era boom in generative AI, both running on top of a regulatory framework, HIPAA, written in 1996 for paper records and fax machines. The same source documents real, current consequences already unfolding, breaches, subpoenas, lawsuits, and regulatory actions tied specifically to digital mental health platforms. Every cross state licensing risk documented in this section is compounding against a rapidly growing base of exactly this kind of data, carried by the generation most comfortable generating it and least likely to question where it goes.

Part Two: The Five States That Matter Most

The remainder of this report goes deep on five states specifically, New York, New Jersey, Connecticut, Florida, and Texas. These states were selected because together they describe the exact corridor most relevant to organizations expanding across the northeast and into the fastest growing retirement destinations in the country, and because the contrast between them is itself a finding. Two of these states, Florida and Texas, are Interstate Medical Licensure Compact members with materially faster compact specific pathways. Three, New York, New Jersey, and Connecticut, are not full compact states, and an organization licensing across all five is, in practical terms, operating five entirely different regulatory relationships at once.

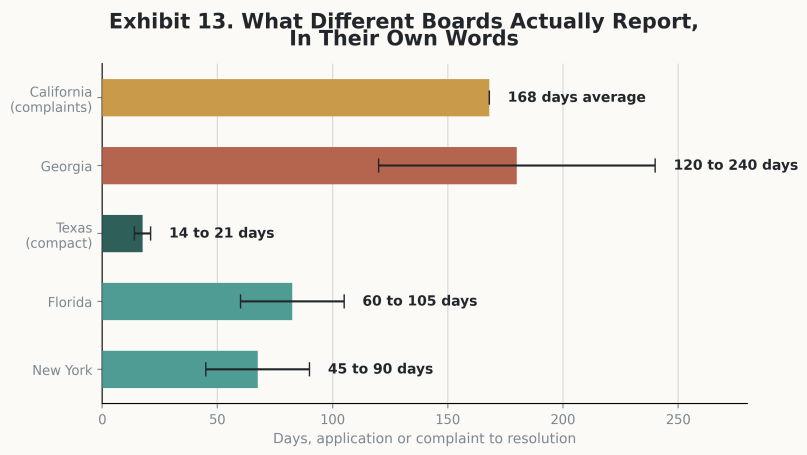

Exhibit 13. Reported processing timelines by state, from each board's own disclosure or from licensing services. Not directly equivalent measurements.

New York

New York still licenses its physicians through a decision made in 1891. Not a law from 1891 that has since been modernized, the original architectural choice itself, to license medicine through the Board of Regents rather than a standalone health authority. Today that means physician licensing does not run through a dedicated medical board at all. It sits inside the State Education Department's Office of the Professions, alongside licensing for dozens of unrelated professions. This is the most structurally distinct state examined in this report, and the one where this institute found the least public visibility into how it actually operates.

That structure has real, practical consequences. Where California's Medical Board publishes detailed, board meeting level staffing and budget disclosures as a matter of routine practice, this institute could not locate an equivalent standalone staffing or vacancy disclosure specific to physician licensing within the Office of the Professions. The Office's own applicant facing guidance states plainly that a status update cannot be requested until six weeks after full documentation is submitted, and that status cannot be provided by phone under any circumstance. Reported total processing time for domestic graduates runs 45 to 90 days, but that range describes the outcome, not the process producing it, since the process itself is largely opaque to anyone outside the Office.

New York is also, notably, among the states with compact legislation passed but not yet fully operational, meaning the faster pathway available in Texas and Florida does not yet exist for New York applicants in practice, regardless of what the legislation on paper allows.

New Jersey

A physician licensed in twenty states does not enter New Jersey any faster than a physician licensed in none. New Jersey is not an Interstate Medical Licensure Compact member, so every applicant runs the same standard track regardless of what they already hold, an average issuance timeline of 2.5 to 3.5 months, 75 to 105 days, through the Board of Medical Examiners under the state's Division of Consumer

Affairs. Prior verification, in New Jersey, buys nothing.

The public record on New Jersey's board level staffing and funding is thinner than California's, itself a finding consistent with Finding 3. Several state boards simply do not publish the disclosure that would let anyone evaluate their actual capacity before relying on it.

Connecticut

Two physicians can apply to Connecticut on the same morning with identical credentials. One is licensed in two to three weeks. The other waits three to five months. The only difference between them is which pathway they qualified for. Through the Interstate Medical Licensure Compact, an eligible physician obtains a Connecticut license in 2 to 3 weeks. Outside it, the standard pathway runs 8 to 14 weeks by the Board's own typical range, with licensing services separately reporting a wider 75 to 135 day range depending on whether the applicant graduated from a domestic or foreign medical school. That is the sharpest internal contrast in any state examined for this report.

Connecticut is also a state where this report found a specific, named, and repeatedly reported operational failure point. Licensing professionals working directly with the Connecticut Medical Examining Board describe the availability of licensure analysts as the central obstacle in the entire process, not the rules themselves, not the documentation requirements, but the practical difficulty of reaching a person who can confirm what is actually missing from a file. Emails go unanswered for extended periods. Calls default to voicemail. Callbacks are inconsistent. For an organization trying to plan a hiring timeline around Connecticut licensure, this means the real variable is not the published range at all. It is whether a specific application happens to land with an analyst who is actually reachable.

Connecticut is also worth noting for a specific structural nuance. It participates in the compact as a state that can issue licenses through it, but cannot serve as a physician's State of Principal Licensure, the compact designation required to initiate an application into the compact in the first place. This means a Connecticut based physician cannot use their own Connecticut license as the entry point for compact licensure elsewhere, a limitation with direct relevance to any organization building a multi state hiring strategy anchored in Connecticut.

Florida

On paper, Florida is the strongest state in Part Two. Full Interstate Medical Licensure Compact member, State of Principal Licensure, a standard timeline of 2 to 3.5 months, 60 to 105 days, from submission to issuance through the Board of Medicine under the Department of Health's Division of Medical Quality Assurance. Genuine structural advantages Connecticut and New Jersey do not have. Then Florida changed a rule, and the published average stopped describing the same population it used to.

Florida is also, as of this report, the site of the single most consequential regulatory change identified across all forty six states examined. Effective January 1, 2025, Florida implemented rule changes that, in practice, denied licensure outside the compact system to any physician with a reported malpractice payment, board action, or hospital action on file, regardless of the circumstances or resolution of that

report, unless the application proceeded specifically through the compact pathway. The rule was narrowed in June 2025 under House Bill 1299, which allowed physicians with National Practitioner Data Bank reports to apply outside the compact if the underlying issue did not itself constitute a violation of Florida law prior to the rule's original implementation, with the physician informed they may still not qualify and could request Board level review instead.

For any organization treating Florida as a straightforward, fast, compact friendly state, this finding is a direct correction. For a meaningful population of physicians, specifically those carrying any reported claim history regardless of outcome, Florida's actual licensing pathway narrowed considerably during 2025, in a way that would not appear in any published average processing time, because those applicants are being filtered before they are ever counted in that average at all.

Texas

Texas presents the most favorable published numbers of the five states examined, and the most explicit public acknowledgment that those numbers depend on staffing the state does not yet have. The Texas Medical Board's own legislative budget submission for the 2026 through 2027 biennium requests

4,823,673 dollars in general revenue specifically to add 30.5 full time equivalent positions, alongside separate funding for salary increases and ongoing information technology costs that explicitly include document scanning, indicating a meaningful share of the Board's process remains paper based as of this request.

Texas is a full compact member and State of Principal Licensure state, and compact pathway applicants report timelines as fast as 14 to 21 days, among the fastest in the country. But that figure describes the compact pathway specifically. The Board's own budget request, asking the legislature directly for nearly a third more staff than it currently operates with, is the clearest public acknowledgment found anywhere in this research that even a well regarded, fast reporting state is not confident its current staffing can sustain that performance without direct legislative intervention.

A formal resolution from the Texas Medical Association, the state's own physician professional association, gives a sharper explanation for why that staffing request exists at all. The resolution states directly that Texas Medical Board licensing fees are diverted to the state's general fund, resulting in inadequate funding for the Board's own operations, while describing the Board as presently collecting a real financial windfall in new applicant fees. Read plainly, this is not a board that lacks sufficient revenue. It is a board whose own fee revenue is being redirected elsewhere by the state, a genuinely different and more direct mechanism than the simple underinvestment documented in Oklahoma in Finding 16. A licensing consultant who works directly with the Board separately notes that its published processing figures measure only the time after an application clears initial screening, and that four months is realistic for most applicants in practice, longer for anyone with multiple hospital affiliations, prior malpractice history, or any disciplinary record, regardless of age or resolution.

Georgia's own State Auditor confirms this is not a Texas specific mechanism. A formal audit of the Georgia Composite Medical Board recommends the legislature restrict the Board's own fee revenue to purposes related to board operations, a direct signal that, as of the audit, it is not restricted that way. Alabama confirms it a third time, with the most direct evidence of all three, the board members' own words. A 2024 sunset review surveyed sitting members, and two separately described an active dispute over exactly this mechanism, one stating the Governor's office was attempting to move the Board's license fees into the state's general fund. Three states, reached through three entirely different sources, a professional association's resolution in Texas, a state auditor's recommendation in Georgia, and sitting board members' testimony in Alabama, now confirm the same pattern, a board's own collected fee revenue targeted for diversion away from the operations it was meant to fund.

> *“The overreach by the governors office to obtain our funds, that is, to be held by the treasury.”*
>
> Source: Alabama Board of Medical Examiners board member, 2024 Sunset Report survey response

National Compact Status, All Fifty States

The following reflects confirmed Interstate Medical Licensure Compact membership status for all fifty states, drawn from the Compact Commission's own published member list and cross referenced across multiple current sources. This is Tier Three evidence under the methodology described above, confirmed status on a single binary question, not a claim of operational depth.

Status	States
Full member, standard pathway	Alabama, Alaska, Arizona, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, Wyoming
Member, not a State of Principal Licensure	Connecticut, Hawaii, Vermont
Legislation passed, not yet fully operational	Arkansas, New Mexico, Rhode Island
Legislation pending, in committee	Massachusetts
Not a compact member	California, New York, Oregon
Status not confirmed in this research	South Carolina, Virginia

Thirty eight states hold full, standard compact membership. Three participate with a structural limitation. Four have passed legislation not yet operational or still pending. Three of the largest physician populations in the country remain entirely outside the system. Two states' current status could not be confirmed within this research and are stated as such rather than assumed.

What Compounds If This Stays Unexamined

None of the twenty findings in this report are hypothetical, and none of them stay contained to the specific board where they originated. A vacancy rate inside a state licensing authority does not just slow that authority's own internal work. It becomes every downstream organization's revenue projection, built on a thirty day assumption a specific board was never actually staffed to deliver. A structural accountability gap, a reference system nobody can prove was received, a phone line nobody answers, does not just frustrate one applicant. It becomes an unmeasured, unbudgeted variable sitting inside every hiring timeline built around that state, indistinguishable in a spreadsheet from ordinary processing time until the exact month it is not.

The organizations most exposed to this risk are not the ones operating in a single, familiar state. They are the ones expanding across exactly the kind of corridor this report examines in depth, multiple states, multiple institutional structures, multiple entirely different failure modes, treated by an internal growth plan as though they were one interchangeable variable called credentialing time.

None of this would matter much if the country had time. It does not. Two curves are converging on the same decade, and the credentialing system documented in this report sits directly between them. The National Center for Health Workforce Analysis projects a physician shortage of 57,259 as of this year, growing to 81,180 by 2035, driven primarily by an aging population that the Association of American Medical Colleges projects will grow 34.1 percent among those 65 and older, and 54.7 percent among those 75 and older, by 2036.

The industry itself has a name for the compounding half of this problem, the physician retirement cliff, coined by AMN Healthcare to describe a workforce where more than three in ten actively practicing physicians are 60 or older, two in ten are 65 or older, and in specialties like pulmonology, directly relevant to an aging population's respiratory disease burden, 73 percent of physicians are 55 or older. The Health Resources and Services Administration projects a shortfall of roughly 187,000 physicians by the mid 2030s, with nearly half of that deficit concentrated in primary care, the exact specialty an aging population depends on most for chronic disease management.

Every replacement physician needed to close that gap must pass through the identical credentialing infrastructure this report has spent twenty findings documenting as understaffed, underfunded, and unevenly disclosed. This institute's sixth report, One Curve, Fifty Clocks, documented the geographic half of this collision, that the states absorbing the heaviest senior population growth are disproportionately the same states already slowest to credential a physician. This report supplies the institutional half. The demographic pressure driving demand for more physicians and the structural fragility slowing down how fast new physicians can actually begin practicing are accelerating on the same timeline, not independently

of each other. An organization planning workforce growth against a shortage this severe cannot treat the speed of the system delivering that workforce as a fixed, background assumption.

Scenario: What the Intersection Looks Like

The preceding section establishes two curves moving toward each other. It stops short of saying what happens where they meet, and that restraint is deliberate, because projecting a system this fragmented invites exactly the false precision this report has refused elsewhere. What follows is not a forecast. It is a scenario, stated with its assumptions visible, so a reader can disagree with the assumptions rather than the arithmetic.

The Assumptions

Assume first that board capacity holds roughly flat. Nothing in this research suggests otherwise. Iowa's fees have not moved since 2007. Kansas budgets full staffing with no salary increases while its total budget climbs. Oklahoma's revenue grew twenty percent against three tenths of one percent in personnel spending. Colorado's expenditures rose across three fiscal years while dedicated staff stayed flat. Boards are not contracting. They are also not scaling, and the funding mechanisms that would let them scale are frozen, diverted, or contested in the states where this report could examine them.

Assume second that demand rises as projected. The National Center for Health Workforce Analysis puts the physician shortage at 57,259 now and 81,180 by 2035. The Health Resources and Services Administration projects roughly 187,000 by the mid 2030s, nearly half in primary care. More than three in ten practicing physicians are already 60 or older.

Assume third that nothing structural changes. No national licensure. No compact covering the three largest physician populations, all of which currently sit outside it. Physician advocacy has already retreated from comprehensive reform toward narrower fixes, which is the clearest available signal about what the people closest to this expect.

What Follows From Those Assumptions

Every physician replacing a retirement, and every physician added against the shortage, passes through the same fifty institutions. The queue does not lengthen because boards get worse. It lengthens because the same throughput is asked to absorb more volume, and throughput that has been flat for a decade does not respond to demand by expanding.

The compounding effect lands unevenly, and that is the part worth planning around. The states absorbing the heaviest senior population growth are disproportionately the states this institute's sixth report already identified as slowest to credential. A national average, if one existed, would conceal that entirely. The pressure concentrates precisely where the demographic curve is steepest, which means the organizations expanding into high growth retirement corridors are the ones most exposed, and they are expanding there because the demand signal is strongest.

Two specific failure modes follow directly from findings above. A board operating near seventeen percent vacancy absorbs rising volume by reassigning staff, which is exactly what California's own reports document, and the reassignment shows up as improvement in one metric and deterioration in another. A board dependent on a compact it does not fully control, or on a federal authorization queue, carries a risk that does not scale with volume at all but can remove access outright, as Michigan came within two days of demonstrating.

What Would Change the Scenario

This is not deterministic, and Findings 4 and 15 are the evidence. Illinois compressed processing by roughly a quarter in one year when a legislature applied pressure to one named function. Wisconsin halved it with a targeted system investment. Arizona built a recognition pathway that operates at scale. Each of those is a policy decision that was available to every other state and was not taken.

So the scenario turns on a single variable, and it is not demographic. It is whether states treat board capacity as infrastructure worth funding before the queue makes the question unavoidable, or afterward. What this report establishes is that the decision is being made right now, in fifty separate places, mostly by default, and almost entirely without anyone outside those buildings watching.

The Future State, What Winning Actually Looks Like

An organization that has actually absorbed the findings in this report does not build a single national credentialing timeline assumption. It builds fifty, each one specific to the real institutional structure, staffing reality, and accountability pattern of the state it describes.

It knows New York's process runs through an education bureaucracy, not a dedicated board, and plans communication accordingly. It knows Connecticut's real bottleneck is reaching a specific person, not meeting a specific requirement, and staffs its own outreach to account for that. It knows Florida's published average no longer describes every physician equally, and checks claim history before assuming a compact timeline applies. It knows a fee revenue dispute is quietly unfolding inside a board's own walls in at least three states, and asks about it directly, before it shows up as an unexplained delay six months later. That organization prices institutional risk into its workforce planning the same way it prices any other geographic risk, rather than discovering it after a hiring decision has already been made. It knows, before a buyer's diligence team ever asks, exactly which boards in its footprint are structurally fragile, and can explain why, with a named source, rather than being surprised by the question.

That organization is not lucky, and it is not working with better software. It is the one that audited the auditor before building a plan on an assumption nobody had tested.

Questions to Ask Before You Expand

Operators evaluating a new state for workforce expansion can apply this report's findings directly, without waiting for a comprehensive internal study.

- Ask whether the target board's fee revenue stays with the board, or whether any part of it is currently contested by the state's own general fund, the way it is in Texas, Georgia, and Alabama.
- Ask whether the board can actually convene a quorum to vote on the specific action your timeline depends on, not just whether it has enough staff, the way Colorado's own licensing panel cannot always do.
- Ask how recently the board's own staffing or budget was reviewed by an outside auditor, and whether that review is public, since a board nobody has checked is not necessarily a board performing well.
- Ask whether the state's compact status is full, partial, or dependent on a federal authorization queue outside the state's own control, the way Rhode Island's has been for years.
- Ask whether a physician's home state, not just the destination state, has the staffing capacity to issue a Letter of Qualification promptly, since the compact relocates the bottleneck rather than removing it.
- Ask whether the malpractice insurance requirement is enforced by the state board or left entirely to the hospital's own credentialing committee, since in forty three states it is the latter.

Limitations of This Report

This report is compiled from public record, board meeting minutes, legislative budget documents, state auditor reports, and boards' own annual disclosures, not from direct primary confirmation with every board examined, and individual figures are subject to change as staffing, application volume, and state legislation shift. Several sources cited in this report are dated, and are explicitly labeled as evidence of a historical pattern rather than current condition wherever that distinction matters.

The three tier evidence framework used throughout this report is this institute's own original classification, not a peer reviewed methodology, and readers should weight each finding according to the tier disclosed alongside it. The group comparison in Exhibit 11 reflects a small, confirmed sample of states with public processing time data, not a controlled statistical analysis, and this report does not claim a formal regression can responsibly be run on data this inconsistently measured across states.

Compact status reflects documented membership as this report was written and is among the more frequently changing data points here, since legislatures continue to pass compact legislation. South Carolina and Virginia's status could not be confirmed and are stated as unconfirmed rather than assumed. Two states' status was corrected during this research, a reminder that even careful research is not static.

Where Koru Enters

Koru Health is not a credentialing vendor, and does not compete with one. Every organization eventually learns what is in this report. The only variable is how. Some learn it the way this report was assembled, deliberately, in advance, from public record, before a single hiring decision depends on the answer. Most learn it the other way, one state, one missed timeline, one unanswered phone call at a time, usually at the exact moment the cost is highest. We build the market intelligence and operational discipline that determines which of those two an organization gets.

For an organization planning genuine multi state growth, that is the actual difference between a credible operating plan and an optimistic one, and it is the difference this report was built to demonstrate before the first real expansion decision is made.

The organizations that get hurt by this system are not the ones operating in a single, familiar state. They are the ones who assumed the fiftieth state would behave like the first.

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Koru Research Institute is the research and publishing arm of Koru Health, based in New York, NY. Its mission is to bring rigorously sourced, transparently cited analysis to questions that healthcare executives are otherwise left to answer with vendor marketing or internal anecdote.