BACKGROUND PAPER FOR
The Medical Board of California

Joint Sunset Review Oversight Hearing, March 16, 2023
Senate Committee on Business, Professions, and Economic Development
and Assembly Committee on Business and Professions

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS

BRIEF OVERVIEW OF THE MEDICAL BOARD OF CALIFORNIA

The Medical Board of California (MBC or Board) was subject to the Legislature's sunset review oversight throughout 2021. The Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions (Committees) held two hearings in 2021 to discuss a multitude of issues raised about every aspect of MBC functions. SB 806 (Roth, Chapter 649, Statutes of 2021) continued MBC operations for only two years, through January 1, 2024, to allow the Legislature additional time to evaluate MBC. SB 806 also required the Director of the Department of Consumer Affairs (DCA) to appoint an independent enforcement monitor to monitor the MBC's enforcement efforts, with specific concentration on the handling and processing of complaints and timely application of sanctions or discipline imposed on licensees and persons in order to protect the public.

Following the passage of SB 806 and prior to DCA appointing the enforcement monitor, MBC submitted a series of proposals to the Legislature on January 5, 2022 to further amend the Act beyond what was contained in SB 806, including requests for statutory changes related to Board administration, licensing processes, enforcement enhancements, and notably MBC's dire fiscal condition. On May 6, 2022, the Senate Committee on Business, Professions, and Economic Development held a hearing, *Medical Board of California: Enforcement Processes, Deficiencies, and Opportunities for Reform - Evaluating the Medical Board of California's 2022 Proposals for Statutory Updates* to discuss the enforcement-related proposals. While MBC's requests impacted many areas of MBC operations, the focus of the hearing was on specific proposals related to MBC enforcement.

DCA contracted with the independent enforcement monitor in July 2022. The initial enforcement monitor report (2023 Preliminary Monitor Report) was submitted to the Legislature on March 7, 2023, with expectations for a final report by July 5, 2023.

History and Function of MBC

For a detailed history of MBC, please refer to the staff-prepared background paper for the 2021 review of MBC available at the following link: 2021 MBC Background Paper.

Through the Medical Practice Act (Act), MBC has jurisdiction over physicians and surgeons, as well as special program registrants/organizations and special faculty permits, which allow those who are not MBC licensees, but meet licensure exemption criteria outlined in the Act, to practice medicine in

specified settings. MBC also has statutory and regulatory authority over licensed midwives, medical assistants, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, research psychoanalysts, and student research psychoanalysts. MBC also approves accreditation agencies that accredit outpatient surgery settings and issues Fictitious Name Permits to physicians practicing under a name other than their own.

The current MBC mission statement, as stated in its 2023-2027 Strategic Plan, is as follows:

> ***The mission of the Medical Board of California is to protect health care consumers and prevent harm through the proper licensing and regulation of physicians and surgeons and certain allied health care professionals and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing, policy, and regulatory functions.***

MBC has a large organization with various units to allow MBC to carry out its mission. Through its licensing program, MBC ensures that only qualified applicants, pursuant to the requirements in the Act and related regulations, receive a license or registration to practice. The licensing program has a Consumer Information Unit (CIU) that serves as a call center for all incoming calls to MBC. Via its enforcement program, allegations of wrongdoing are investigated and disciplinary or administrative action is taken as appropriate. MBC's Central Complaint Unit (CCU) receives and triages all complaints. If it appears that a violation may have occurred, the complaint is transferred either to the DCA's Division of Investigation, Health Quality Investigation Unit (HQIU), which includes sworn peace officers, or to MBC's own Complaint Investigation Office (CIO), which is comprised of non-sworn special investigators. Investigators investigate the complaint and, if warranted, refer the case for disciplinary action. MBC's Discipline Coordination Unit processes all disciplinary documents and monitors cases that have been referred for formal discipline to the Office of the Attorney General (OAG), which serves as MBC's prosecuting attorney. If a licensee or registrant is placed on probation, MBC's probation unit monitors the individual while they are on probation to ensure they are complying with the terms and conditions of probation. The Probation Unit is comprised of inspectors who are located throughout the state, housed within various field offices. Having inspectors throughout the state helps eliminate excess travel and enables probationers to have face-to-face meetings with the inspectors for monitoring purposes. MBC has its own Information Systems Branch (ISB) that performs information technology functions and assists in finding technological improvements to streamline MBC's enforcement and licensing processes. As MBC engages in a number of activities to educate physicians, applicants, and the public, the Office of Legislative and Public Affairs provides information to physicians, as well as applicants, regarding MBC functions, laws, and regulations.

MBC is comprised of 15 members: eight physicians and seven public members. All eight professional members and five of the public members are appointed by the Governor. One public member of the Board is appointed by the Senate Committee on Rules and one public member is appointed by the Speaker of the Assembly. Current law requires that four of the physician members hold faculty appointments in a clinical department of an approved medical school in the state, but no more than four members may hold full-time appointments to the faculties of such medical schools. The Board meets

about four times per year. MBC members receive a $100-a-day per diem. All meetings are subject to the Bagley-Keene Open Meetings Act.
The following is a listing of the current MBC members:

Board Member	Appointment Date	Term Expiration Date	Appointing Authority	Professional or Public
Kristina D. Lawson, J.D., President Kristina Daniel Lawson, of Walnut Creek, has served as a public member of the Medical Board of California since 2015. Lawson is a partner at Hanson Bridgett LLP in Walnut Creek and San Francisco, where she practices land use and environmental law. Lawson was a member of the Walnut Creek City Council from 2010 to 2014, and served as Walnut Creek's Mayor in 2014.	October 28, 2015 (reappointed June 8, 2022)	June 1, 2026	Governor	Public
Randy Hawkins, M.D., Vice President Dr. Randy W. Hawkins has been in private practice since 1985. His medical practice is composed of primary care, pulmonary and critical care medicine, and hospice care. He is board certified in internal medicine and pulmonary and critical care medicine. He is clinical assistant professor of medicine at the Charles Drew University of Medicine and Science. Dr. Hawkins represents the Medical Board on the Health Professions Education Foundation. He is a member of a Food and Drug Administration Advisory Committee.	March 4, 2015) (reappointed June 15, 2020)	June 1, 2024	Governor	Professional
Laurie Rose Lubiano, J.D., Secretary Laurie Rose Lubiano is an attorney licensed to practice law in the State of California and before the U.S. Patent & Trademark Office. She has been IP & Product Counsel for the Climate Corporation since 2017, where she handles a variety of matters including intellectual property, commercial agreements, international expansion and privacy compliance. Ms. Lubiano is a board member for the Mission Hiring Hall in San Francisco and a member of the National Asian Pacific American Bar Association and Asian American Bar Association of the Greater Bay Area. She is also the current President of the Filipino Bar Association of Northern California (FBANC) and founding member of the National Filipino American Lawyers Association. Ms. Lubiano also served on the Planning Commission for the City of Daly	December 17, 2018 (reappointed June 1, 2020)	June 1, 2024	Governor	Public

City for over 4 years.				
Michelle Bholat, MD, MPH Dr. Michelle Anne Bholat served as a member of the Medical Board from 2015 to 2019, appointed by former Governor, Edmund G. Brown Jr. Later, in 2022, Governor Gavin Newsom appointed her to the Medical Board. She is an editor for the Journal of Medical Regulation of the Federation of State Medical Boards. She also served as an expert reviewer to the Medical Board for many years. Her public service has been long-standing and she has been a member of many boards concerned with vulnerable populations including the Los Angeles County Public Health Commission, Health Care Los Angeles, IPA Chief Medical Officers and the Association of California Health Districts. Currently, she is a board member of the Beach Cities Health District. Dr. Bholat earned a Doctor of Medicine degree from the University of California at Irvine and completed residency training at Harbor-UCLA Medical Center. Post-residency, she earned a Master's in Public Health Policy and Management from UCLA School of Public Health. She is board eligible in Addition Medicine. She is Professor of Family Medicine at the David Geffen School of Medicine and Executive Director of the UCLA International Medical Graduate Program in the Department of Family Medicine at UCLA.	June 8, 2022	June 1, 2025	Governor	Professional
Ryan Brooks Mr. Brooks is the Executive Vice President of Government Affairs for Outfront Media, Mr. Brooks' many appointments include Industry Trade Advisory Committee on Services and Financial Industries under the Obama Administration and reappointed under the Trump Administration. In 2003, Mr. Brooks was appointed by San Francisco Mayor Willie Brown, Jr. to the San Francisco Public Utilities Commission and reappointed by Mayor Gavin Newsom in 2004, serving as the Vice President in 2006 and President in 2007. Mr. Brooks served as the Director of Administrative Services for the City and County of San Francisco. He previously served on the Board of Pharmacy, New	February 2, 2021	June 1, 2024	Governor	Public

Motor Vehicle Board, and Little Hoover Commission. Since 2003, Mr. Brooks has been a member of the California International Relations Foundation.				
James Healzer, M.D. Dr. James Healzer was appointed to the Medical Board in 2021 by Governor Gavin Newsom. Dr. Healzer is Chair of the Chiefs of Quality for The Permanente Medical Group and Staff Anesthesiologist at the Kaiser Permanente Santa Clara Medical Center. He is also Chair of the Permanente Federation's Peer Review Advisory Committee. He completed residency training in Anesthesiology at Stanford University and Internal Medicine at the University of California, San Francisco; and he is certified by the American Board of Anesthesiology and the American Board of Internal Medicine. Dr. Healzer earned a Doctor of Medicine degree from the University of California, Los Angeles School of Medicine and a Master of Science degree in biological sciences from Stanford University.	June 25, 2021	June 1, 2025	Governor	Professional
Nicole Jeong, J.D. Ms. Jeong has been the Southern California Regional Director of Advocacy at Root & Rebound since 2021, where she's been an Attorney since 2018. She was a Pro Bono Coordinating Attorney at Legal Services NYC from 2016 to 2018 and a Litigation Associate at Paul, Weiss, Rifkind, Wharton & Garrison LLP from 2014 to 2016. Ms. Jeong earned a Juris Doctor degree from Yale Law School.	April14, 2022 (reappointed June 24, 2022)	June 1, 2026	Governor	Public
Asif Mahmood, M.D. Dr. Asif Mahmood comes from humble beginnings, growing up in the remote Pakistani village called Kharian. He received his medical degree from Sind Medical College, did his Internal Medicine residency at the University of Kentucky Medical Center followed a Pulmonary fellowship at the University of Virginia and Harlem Hospital at Columbia University. Dr. Mahmood has been a practicing physician at Huntington Memorial Hospital in Pasadena since 2000 and has served in different capacities from medical executive committee member to chief of staff in different hospitals. He is also on the board of the East Los Angeles College	June 3, 2019	June 1, 2023	Governor	Professional

Foundation and the United Nations International Children's Fund, Western Region.				
David Ryu David E. Ryu was appointed to the Medical Board of California by Speaker of the Assembly Anthony Rendon in 2021. He is a former Los Angeles City Councilmember where he authored campaign finance reform efforts and legislation to expand oversight in City Hall and to create stronger checks on pay-to-play corruption. Mr. Ryu also advocated and secured COVID19 testing early on; championed Grave Disability Reform, Paid Parental Leave, and Autonomous Vehicles; established the Hillside Construction Regulation Zone, Concrete Streets Program, Utility Box Art Program and COVID Arts Relief Fund; secured $50M from State for After School Programs; and passed into law the Exotic Animals Ban, House Party Ordinance, and Tour Bus Ordinance. He previously served as Director of Development & Public Affairs at Kedren Community Health Center, dispute resolution mediator, and Senior Deputy to LA County Supervisor Yvonne Burke.	April 19, 2021	June 1, 2023	Speaker of the Assembly	Public
Richard E. Thorp, M.D. Dr. Thorp has been president and chief executive officer at Paradise Medical Group since 2001. He was an internal medicine physician and medical director for Butte County for the California Medical Foundation from 1994 to 2000 and internal medicine physician at Richard E. Thorp MD Inc. from 1981 to 1994. Dr. Thorp is a member of the American Medical Association, American College of Physicians, California Medical Association and the Butte-Glenn County Medical Association.	July 26, 2019	June 1, 2023	Governor	Professional
Veling Tsai, M.D., J.D., FCLM Dr. Tsai is a clinical assistant professor in the Department of Head and Neck Surgery at the University of California at Los Angeles – David Geffen School of Medicine. Dr. Tsai is also an attending physician in the Department of Surgery, Division of Head and Neck Surgery at Olive View – UCLA Medical Center in Sylmar, California. Additionally, Dr. Tsai is in private practice in Alhambra, California. He attended UCLA and received a	April 14, 2022	June 1, 2025	Governor	Professional

Bachelor of Arts degree in Geography/Environmental Science, graduating with Latin honors. Dr. Tsai then received his dual law and medicine degrees from Southern Illinois University - School of Medicine and School of Law. Dr. Tsai completed his Head and Neck Surgery residency training at UCLA, and is a board certified otolaryngologist by the American Board of Otolaryngology. He is licensed to practice both law and medicine in the State of California. Dr. Tsai previously served as the President of American College of Legal Medicine, and is currently on the Board of Directors of the American Academy of Legal Medicine.				
Eserick "TJ" Watkins Eserick "TJ" Watkins previously served as a Board member on the Physical Therapy Board of California and held the vice president position. Mr. Watkins is the owner of The Next Level Coaching, a hybrid strength training and life coaching company. He also serves on the board of South Coast Foundation, a US-based private foundation that funds children infected and affected by HIV/AIDS in South Africa. Mr. Watkins is a published author, speaker and coach.	June 1, 2019	June 1, 2023	Senate Rules Committee	Public
Vacant			Governor	Public
Vacant			Governor	Professional
Vacant			Governor	Professional

MBC has seven standing committees, seven two-member task forces or issue specific committees, two panels and one council that assist with MBC's work. MBC committees may meet on an as-needed basis and may meet outside of the cycle of when quarterly MBC meetings are held, offering an easier pathway for interested parties to weigh in on a particular issue. The committee structure also allows committee members to have an expanded discussion on a noteworthy topic and potentially make a decision that moves forward as a formal recommendation to MBC for consideration at a MBC meeting. Pursuant to MBC's strategic plan, MBC must convene every other year to discuss the purpose of each committee and reevaluate the need for the various committees/subcommittees/task forces.

For a detailed listing of MBC committees and task forces, please refer to the staff-prepared background paper for the 2021 review of MBC available at the following link: 2021 MBC Background Paper.

Fiscal, Fund and Fee Analysis

MBC is a special fund agency whose activities are entirely funded through regulatory fees and license fees. For years, the Board's expenditures have exceeded revenues. While SB 806 increased various MBC fees, the MBC's primary source of revenue, physician license renewal fees, accounting for over 80 percent of the money MBC brings in, were set below what MBC requested and below what was necessary, pursuant to a third-party fee study, to maintain MBC fund solvency.

MBC ended fiscal year (FY) 21/22 with 1 month in reserves. MBC began fiscal year (FY) 22/23 with a $6.606 million fund balance. The balance includes revenue from a Control Section 14.00 loan (a loan between Department special funds) of $10 million from the Bureau of Automotive Repair to the Medical Board Contingent Fund to ensure the Board has enough cash flow to continue operations until a fee increase can be secured. If MBC is not statutorily provided additional revenue through increased fees beginning in 2024, the fund will be insolvent and MBC will have a negative -4.8 months balance by the end of the next fiscal year.

The following is the past, current and projected fund condition for MBC, as indicated in the MBC sunset report submitted to the Committees in January 2023:

Fund Condition						
(Dollars in Thousands)	FY 22-23	FY 23-24	FY 24-25	FY 25-26	FY 26-27	FY 27-28
Beginning Balance*	$6,605	$15,612	$17,191	$4,200	$2,621	$10,773
Total Revenue**	$66,968	$84,466	$101,719	$101,499	$101,437	$101,521
Loans from DCA funds per Control Section 14.00	$25,000	$12,000	$0	$0	$0	$0
Loans repaid to DCA Funds per Control Section 14.00***	$0	-$10,149	-$25,650	-$12,312	$0	$0
Loans to General Fund	$0	$0	$0	$0	$0	$0
Loans Repaid to General Fund	$0	$0	$0	$0	$0	$0
Transfers to General Fund	$0	$0	$0	$0	$0	$0
Total Revenue and Transfers	$91,968	$86,317	$76,069	$89,187	$101,437	$101,565
Budget Authority****	$77,347	$79,621	$83,943	$86,334	$88,583	$91,448
Program Expenditures	$77,347	$79,621	$83,943	$86,334	$88,853	$91,448
Supplemental Pension Payments	$685	$685	$685	$0	$0	$0
Fi$Cal Assessments	$0	$0	$0	$0	$0	$0
Statewide General Administrative Expenditures	$4,929	$4,432	$4,432	$4,432	$4,432	$4,432
Fund Balance	$15,612	$17,191	$4,200	$2,621	$10,773	$16,414

Months in Reserve	2.2	2.3	0.6	0.3	1.4	2.1

**After prior year adjustments*

***Includes amended revenue projections for 2022-23 and proposed fee increase effective January 1, 2024*

****Operating Transfers from Vehicle Inspection & Repair Fund 0421 per EO E 21/22-313 (includes estimated interest repaid in 2023-24)*

*****Includes estimated growth in expenditure authority for employee compensation, retirement, other budget adjustments, and unscheduled cost recovery*

Most of MBC's rising costs remain out of the Board's control, for example: increased OAG costs to prosecute MBC enforcement cases; increased salaries and benefits costs for certain Peace Officer classifications within the HQIU which investigates MBC enforcement cases; ongoing increases in pro rata paid to DCA (pro rata is a percentage of licensing fees apportioned for every program at DCA based on the number of approved staff positions for each regulatory program within the DCA and funds various centralized DCA services); increased salaries and benefit costs for MBC staff and; numerous loan repayments.

MBC's Enforcement Program accounts for 75 percent of overall expenditures. The Licensing Program accounts for 14 percent, while the Executive and Administrative Services account for six percent. The Information Systems Branch accounts for the remaining five percent of overall expenditures.

MBC expenditures are noted below:

Expenditures by Program Component								**(list dollars in thousands)**
	FY 18-19		FY 19-20		FY 20-21		FY 21-22	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	$5,373	$41,461	$5,739	$39,704	$5,445	$43,683	$6,286	$44,522
Examination	$0	$0	$0	$0	$0	$0	$0	$0
Licensing	$4,348	$3,365	$4,510	$3,471	$4,435	$2,480	$4,836	$3,726
Admin *	$1,632	$508	$1,508	$628	$1,520	$445	$1,640	$597

MBC application, initial licensure, and renewal fees for all categories, physician and surgeon licensure and allied health programs regulated by MBC, were all increased through SB 806. MBC was also granted authority to recover enforcement costs from licensees facing disciplinary action through that measure.

MBC fees and the percentage of revenue from each fee type are noted below:

Fee Type by Name	**Pre SB 806 Amount**	**Current Amount**
Penalty Fee - Physician & Surgeon	$ 391.50	$ 431.50
Penalty Fee - Special Faculty Permit	$ 391.50	$ 431.50

Registration - Research Psychoanalyst	$ 100.00	$ 150.00
Fictitious Name Permit	$ 50.00	$ 70.00
Application Processing Fee	$ 442.00	$ 625.00
Postgraduate Training License Application Fee	$ 442.00	$ 625.00
Initial License Fee - Physicians & Surgeons	$ 783.00	$ 863.00
Initial License Fee - Special Faculty Permit	$ 783.00	$ 863.00
1/2 Initial License Fee - Physicians & Surgeons	$ 391.50	$ 431.50
Special Faculty Permit - Application Fee	$ 442.00	$ 625.00
Duplicate Fictitious Name Permit	$ 30.00	$ 40.00
Biennial Renewal - Research Psychoanalyst	$ 50.00	$ 75.00
Fictitious Name Renewal	Variable	$ 50.00
Biennial Renewal - Physicians & Surgeons	$ 783.00	$ 863.00
Biennial Renewal - Special Faculty Permit	$ 783.00	$ 863.00
Delinquent Fee - Physician & Surgeon	$ 78.00	$ 86.30
Delinquent Fee - Special Faculty Permit	$ 78.00	$ 86.30

Fee Schedule and Revenue							**(list revenue dollars in thousands)**
Fee	Current Fee Amount	Statutory Limit	FY 18/19 Revenue	FY 19/20 Revenue	FY 20/21 Revenue	FY 21/22 Revenue	% of Total Revenue
Application Fee (BPC 2435) (PS & PTL)	$625.00	$625.00	$3,342	$3,902	$3,258	$4,010	6.2%
Initial License Fee (BPC 2435) (16 CCR 1351.5)	$863.00	$863.00	$2,000	$2,159	$1,072	$2,380	3.2%
Initial License Fee (Reduced) (BPC 2435)	$431.50	$431.50	$1,680	$1,255	$785	$2,148	2.5%
Biennial Renewal Fee (BPC 2435) (16CCR 1352)	$863.00	$863.00	$50,602	$50,612	$52,759	$53,208	88.1%

Licensing

MBC's licensing program ensures licenses or registrations are only issued to applicants who meet legal and regulatory requirements and who are not precluded from licensure based on past incidents or activities. The Board issued almost 7,000 physician and surgeon licenses in FY 21/22. In addition to physicians, MBC licenses and/or issues registrations or permits for special faculty at medical schools, special programs, licensed midwives, research psychoanalysts and student research psychoanalysts, and polysomnographic trainees, technicians and technologists. MBC also has responsibility for other approvals and permits. MBC approves outpatient setting accreditation agencies that accredit specific types of outpatient surgery centers that many licensed physicians use when performing surgical procedures. MBC also issues Fictitious Name Permits that allow physicians to practice medicine under a name other than their own.

MBC identifies applicants who indicate they are military service veterans or spouses through submission of documentation proving military status. Between FY 20/21 and 21/22, MBC approved 212 physician applications for waivers from professional license renewal fees and continuing education requirements for physicians requesting Military status, pursuant to BPC Section 2440. MBC also received 38 applications that qualified for the expedited license available to military spouses and domestic partners of a military member who is on active duty in California pursuant to BPC Section 115.5.

MBC notes that it does not have a mechanism to quantify the number of applicants who offered military education, training, and experience toward meeting licensing requirements, since the Board accepts applicants who have graduated from all medical schools approved by the Liaison Committee on Medical Education (LCME, the nationally-recognized accrediting authority for allopathic medical education programs leading to the issuance of Medical Doctor (M.D.) degrees in the U.S. and Canada) and all postgraduate training approved by the Accreditation Council for Graduate Medical Education (ACGME), and does not differentiate between military and non-military education, training, and experience, as there are overlapping requirements.

Physician applicants for licensure by MBC must pass nationally recognized examinations, the United States Medical Licensing Examination (USMLE) Step 1, Step 2 Clinical Knowledge (CK) and Step 3. MBC requires documents to be sent directly from medical schools, postgraduate training programs, other state medical boards and other sources to MBC as means of verifying proof of attendance, completion, licensure in another state and other evidence that is necessary to consider for licensure.

All applicants must obtain fingerprint criminal record checks from both the Department of Justice (DOJ) and the Federal Bureau of Investigation prior to the issuance of a license in California. MBC queries the National Practitioner Databank, a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S., for certain applicants with issues of concern disclosed on the application or during the application process as well as applicants who disclose that he or she holds a license in another state,

territory or province. MBC also queries all applicants in the Federation of State Medical Boards (FSMB) database, which contains a record of disciplinary actions taken by other states and jurisdictions, as well as any inappropriate behavior in another state or jurisdiction during an examination.

For more information about education and examination requirements and for physician applicants for licensure and how that information is submitted and verified, please refer to the staff-prepared background paper for the 2021 review of MBC available at the following link: 2021 MBC Background Paper.

Continuing Medical Education (CME)

Physicians are required to complete no less than 50 hours of approved CME during each two-year period immediately preceding the expiration date of his or her license. The only exception to this requirement is for a physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board, the individual can be granted credit for four consecutive years of CME credit for purposes of licensure renewal. Upon renewal, physicians are required to self-certify under penalty of perjury that they have met each of the CME requirements, that they have met the conditions exempting them from all or part of the requirements, or that they hold a permanent CME waiver. MBC requires that each physician retain records of all CME programs they completed for a minimum of four years in the event of a CME audit. MBC verifies completion of CME by auditing a random sample of physicians who reported their compliance. CME audits were suspended due to COVID-19; MBC reports it conducts 6,074 CME audits from FY 2020/21 through FY 2021/22. Of the 6,074 audits, there were 81 failures, a 1.3 percent failure rate.

Enforcement

MBC's enforcement activities are the core of its program, with the majority of its staff and resources dedicated to enforcement functions. MBC reports the following enforcement actions in FY 20/21 and 21/22:

Administrative Actions

	FY 20-21	FY 21-22
Administrative Actions		
Accusation	383	283
Petition to Revoke Probation/Accusation and Petition to Revoke	36	31
Amended Accusation/Petition to Revoke	66	217
Completed Investigations Referred to the AG and Awaiting the Filing of Accusation as of June 30, 2021	101	82
Cases Over 6 Months Old that Resulted in the Filing of Accusation	362	260
Administrative Outcomes		
License Revoked	36	29
License Surrendered (in Lieu of Accusation or with Accusation Pending)	118	96
License Placed on Probation with Suspension	4	5
License Placed on Probation	122	142
Probationary License Issued	19	14
Public Reprimand	152	118
Other Actions (e.g., Exam Required, Educational Course, etc.)	2	1
Accusation Withdrawn	20	11
Accusation Dismissed	9	13
Probation Violation Outcomes		
License Revoked	13	7
License Surrendered	7	10
Additional Suspension and Probation	0	2
Additional Probation	10	14
Public Reprimand	2	0
Other Actions (e.g., Exam Required, Educational Course, etc.)	0	0
Petition Withdrawn	3	0
Petition Dismissed	0	0
Referral and Compliance Actions		
Citation and Administrative Fines Issued	51	122

Petition Activity

	FY 20-21	FY 21-22
Petitions for Reinstatement of License		
Filed	22	16
Granted	5	5
Denied	9	8
Petitions for Penalty Relief[1]		
Granted	33	25
Denied	14	4
Petitions to Compel Exam		
Filed	20	33
Granted	15	29
Denied	0	0

[1]Penalty Relief includes: Petitions for Modifcation of Penalty and Petitions for Termination of Probation.

License Restrictions/Suspensions and Temporary Restraining Orders

Imposed while Administrative Action Pending	FY 20-21	FY 21-22
Interim Suspension Order (ISO)	23	21[1]
Temporary Restraining Order (TRO)	0	0
Other Suspension Orders	44	36[2]
Sought and Granted by Case Type for FY 21-22	**Sought**	**Granted[3]**
Gross Negligence/Incompetence	8	4
Inappropriate Prescribing	9	1
Unlicensed Activity	0	0
Sexual Misconduct	9	8
Mental/Physical Illness	15	7
Self-Abuse of Drugs/Alcohol	15	14
Fraud	6	1
Criminal Charges/Conviction	13	9
Unprofessional Conduct	14	13
Total	89	57

[1] Pursuant to BPC §2220.05(c), ISOs and TROs were granted in the following priority categories: 1 - gross negligence/incompetence

The enforcement process begins with a complaint. Complaints are received from various sources, including the public, generated internally by MBC, or based on information MBC receives from various entities that are required to report information to MBC, including:

- Reports of malpractice settlements, judgements, or arbitration awards from professional liability insurers, self-insured governmental agencies, physicians and/or their attorneys, and employers.

- Reports of indictments charging a felony and/or any convictions of any felony or misdemeanor, including a guilty verdict or plea of no contest from licensees and notifications of arrests and convictions from DOJ.

- Reports from a coroner if a death may have been the result of a physician's gross negligence.

- Reports from a licensed health care facility when the physician's application for staff privileges or membership is denied, the physician's staff privileges, or employment is terminated or revoked for a medical disciplinary cause.

- Reports from a licensed health care facility when restrictions are imposed or voluntarily accepted on the physician's staff privileges.

- Reports from a health care facility of any allegation of sexual abuse or sexual misconduct, if the patient or the patient's representative makes the allegation in writing.

MBC's complaint priorities are outlined in BPC section 2220.05 in order to ensure that physicians representing the greatest threat of harm are identified and disciplined expeditiously. MBC must ensure that it is following this section of law when investigating complaints, including complaints alleging the following as being the highest priority:

- Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public

- Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient

- Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor

- Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation

- Sexual misconduct with one or more patients during a course of treatment or an examination,

- Practicing medicine while under the influence of drugs or alcohol; and

- Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

The following identifies the types of complaints received by MBC during FY 21/22 and the source of those complaints. Of the 9,943 complaints received, 6,409 were received from the public, 3,649 of those involving gross negligence or incompetence, including quality of care.

Physician and Surgeon Complaints Received by Complaint Type and Source

	Public	Business and Professions Code[1]	Licensee/ Professional Group[2]	Government Agency[3]	Miscellaneous/ Anonymous	Total Type Complaints Received
Fraud	13	0	3	17	7	40
Health and Safety[4]	119	4	8	31	56	218
Non-Jurisdictional[5]	1,176	1	116	22	294	1,609
Gross Negligence/Incompetence[6]	3,649	553	45	315	278	4,840
Personal Conduct[7]	48	40	11	169	37	305
Unprofessional Conduct[8]	1,299	162	59	669	474	2,663
Unlicensed/Unregistered	105	0	8	71	84	268
Total Source Complaints Received	6,409	760	250	1,294	1,230	9,943

[1] Includes complaints received pursuant to BPC §§800 and 2240(a), and includes complaints initiated based upon reports submitted to the Board by hospitals, insurance companies and others, as required by law, regarding instances of health facility discipline, malpractice judgments/settlements, or other reportable activities.

[2] Includes the following complaint sources: other Licensee, Professional Society or Association.

[3] Includes the following complaint sources: Internal, Law Enforcement Agency, other California State Agency, other State Agency, other boards within the Department of Consumer Affairs, and Federal or other Government Agency.

[4] Includes excessive prescribing, sale of dangerous drugs, etc.

[5] Includes complaints not under the authority of the Board and are referred to other agencies such as the Department of Health Care Services, Department of Managed Health Care, etc.

[6] Includes complaints related to the quality of care provided by licensees.

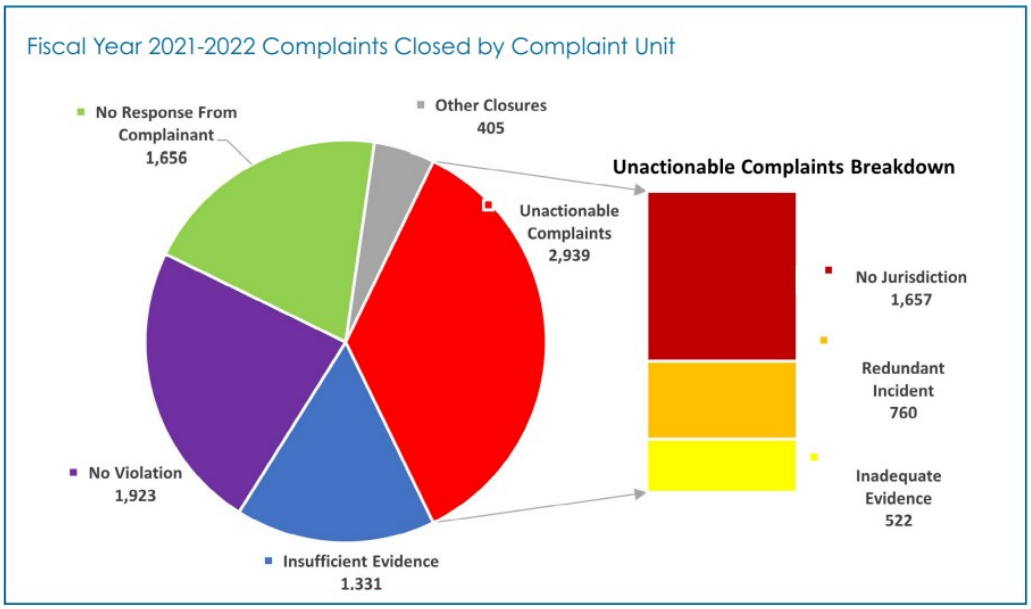
[7] Includes licensee self-abuse of drugs/alcohol, conviction of a crime, etc.

[8] Includes sexual misconduct with patients, failure to release medical records, violation of BPC §805 reporting, etc.

Complaints are received by CCU, which conducts an initial complaint assessment, starting the process of determining next steps for a complaint. Complaints that pertain to treatment provided by a physician require that patient medical records be obtained. Pursuant to BPC Section 2220.08, before a quality of care complaint is referred for further investigation, it must be reviewed by one or more

medical experts with the pertinent education, training, and expertise to evaluate the specific standards of care issues raised by the complaint to determine if further field investigation is required. When a medical reviewer determines a complaint warrants referral for further investigation, CCU transfers the complaint to the HQIU to be investigated by a sworn investigator, a peace officer. MBC notes there are 12 HQIU field offices located throughout California that handle these investigations. Complaints may also be forwarded to the Complaint Investigation Office (CIO) an internal unit at MBC comprised of non-sworn investigators. The CIO investigators handle complaints throughout the state from the Sacramento office.

MBC is required by law, BPC Section 129, to open a complaint within ten days of receipt and further required by law, BPC Section 2319, to set a goal of no more than 180 days between the time a complaint is received and the time a complaint is investigated.



For complaints that are subsequently investigated and meet the necessary legal prerequisites, a Deputy Attorney General (DAG) in the OAG drafts formal charges, known as an "Accusation". An accusation is filed upon signature of the MBC Executive Director. A hearing before an Administrative Law Judge (ALJ) is subsequently scheduled, at which point settlement negotiations take place between the DAG, the physician and their attorney and MBC staff.

Licensing boards often resolve a disciplinary matter through negotiated settlement, typically referred to as a "stipulated settlement." This may be done, rather than going to the expense of lengthy administrative hearing on a disciplinary matter. According to information from the Citizen Advocacy Center, (a national organization focusing on licensing regulatory issues nationwide) "It is not uncommon for licensing boards to negotiate consent orders [stipulated settlements] 80% of the time or more." Similar to a plea bargain in criminal court, a licensee

admits to have violated charges set forth in the accusation and accepts penalties for those violations. A stipulated settlement is not necessarily good or bad from a public protection standpoint. However, it is important for a licensing board to look critically at its practices to make sure that it is acting in the public's interest when it enters into a stipulated settlement and that it is acting in the best way to protect the public in each of these stipulated decisions.

The DAG assigned to a case reviews it, along with any mitigation provided, the strengths and weaknesses of the case, MBC's Disciplinary Guidelines, and, when applicable, any prior disciplinary action against the respondent physician to assist in drafting a settlement recommendation that frames the recommended penalty. MBC uses its Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines, 16 CCR section 1361) and the Uniform Standards for Substance-Abusing Licensees (Uniform Standards, 16 CCR section 1361.5) as the framework for determining the appropriate penalty for charges filed against a physician. Boards rely on disciplinary guidelines adopted through the regulatory process to guide disciplinary actions. Disciplinary guidelines are established with the expectation that ALJs hearing a disciplinary case, or proposed settlements submitted to a program for adoption, will conform to the guidelines. If there are mitigating factors, such as a clear admission of responsibility by the licensee early on in the process, or clear willingness to conform to board-ordered discipline, or other legal factors, a decision or settlement might vary from the guidelines. At other times in a disciplinary case, there can be problems with the evidence, but the licensee admits to wrongdoing in a matter and may be willing to settle a case without going to a formal hearing.

MBC states that this settlement recommendation takes into account consumer protection but also BPC Section 2229(b) requirements for MBC to "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of CME or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." The DAG's recommendation is reviewed and either approved or edited by the supervising DAG. Once that approval is received, the DAG submits the settlement recommendation to MBC staff for review and consideration. The Chief of Enforcement holds regular meetings with the MBC's Executive Director, Deputy Director and Chief Medical Consultant to review the settlement recommendations using the same criteria as the DAG – the recommendation at this level can either be approved or it can be changed. Both the prehearing settlement conference and the mandatory settlement conference are assisted by an ALJ who reviews the case and hears information from the DAG and the respondent physician and/or their counsel while helping to negotiate the settlement. During the settlement conference, the appropriate MBC representative must be available to authorize any change to the previously agreed-upon settlement recommendation.

Most formal disciplinary actions result in a stipulated settlement. If a settlement agreement is reached, the stipulated settlement document must be approved by Panel A or Panel B (panels created under MBC's statutory authority in BPC 2008 to appoint panels from its members to evaluate appropriate disciplinary actions. Panel A considers actions related to physicians with a last name starting with A-L and Panel B considers actions related to physicians with a last name

starting with M-Z) unless the settlement is for a stipulated surrender. The MBC Panel may adopt the settlement as written, request changes to the settlement, or reject the settlement and request the matter go to hearing.

MBC reports that throughout the process, public protection is the priority. Settling cases by stipulations that are agreed to by both sides facilitates consumer protection by imposing discipline more quickly. Entering into a stipulation places the individual on probation or other restriction sooner without the risk and delay of going to hearing, and it eliminates the ability of the licensee to appeal the decision in Superior Court. It also puts the public on notice of practice limitations and restrictions earlier than if the matter went to hearing. In addition, MBC may ultimately achieve more terms and conditions on a license through the settlement process than would have been achieved if the matter went to hearing. MBC advises that when deciding on a stipulation, Panel A and B members are provided the strengths and weaknesses of the case and notes that settlement recommendations stipulated to by MBC must provide for public protection and, when not inconsistent with public protection, rehabilitation of the licensee.

If a licensee contests charges, the case is heard before an ALJ who subsequently drafts a proposed decision. This decision is reviewed by Panel A or Panel B who either adopt the decision as proposed, adopt the decision with a reduced penalty, or adopt the decision with an increased penalty. If probation is ordered, a copy of the final decision is referred to MBC's Probation Unit for assignment to an inspector who monitors the licensees for compliance with the terms of probation.

MBC's probation unit works to ensure that physicians who are not compliant with probationary orders have swift action taken against their license by either issuing a citation and fine, issuing an order for the individual to cease practicing or referring the matter to OAG for subsequent discipline. MBC's Disciplinary Guidelines were updated to include language allowing MBC to issue a cease practice order for probationers not in compliance with certain terms of their probation.

MBC issues citations to licensees for technical violations of the Act. MBC reports common reasons for a citation include failing to maintain adequate and accurate medical records, failing to report criminal convictions, failing to report a change of address and aiding and abetting the unlicensed practice of medicine. MBC may also utilize the cite and fine process for dealing with unlicensed practitioners for practicing medicine without a license. MBC reports that it increasingly issues citations for violations identified during the course of an investigation that do not rise to the level to support disciplinary action. In these situations, MBC may require a licensee to complete some education related to a citation, like additional courses in medical record keeping if improper records were the reason a licensee was cited.

For detailed information about MBC regulated allied health professions and facilities, please refer to the staff-prepared background paper for the 2021 review of MBC available at the following link: 2021 MBC Background Paper.

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

MBC was last reviewed by the Legislature through sunset review in 2020-2021. During the previous sunset review, 26 issues were raised. In January 2023, MBC submitted its required sunset report to the Committees. In this report, MBC described actions it has taken since its prior review to address the recommendations made. The following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made. For those which were not addressed and which may still be of concern to the Committees, they are addressed and more fully discussed under "Current Sunset Review Issues."

- **A paperless licensing process is in the works.** MBC reports it has eliminated some of the documents previously required for licensure that were the source of applications being deficient. For example, MBC eliminated the requirement for the application to be notarized, which was previously required of online and paper applicants. MBC also eliminated a photo requirement and has tapped into its ability to verify licensure in another state directly by utilizing information from the FSMB and the American Medical Association (AMA). MBC continues to register medical schools and postgraduate training programs in its Direct Online Certification Submission (DOCS) portal, which allows these entities to submit documents required for license applications directly to MBC and eliminates the time and cost of mailing documents. As of September 30, 2022, 381 medical schools and 1,334 postgraduate training programs are registered in DOCS, a 39 percent increase since October 2020. MBC made significant changes to some of its online license applications in October 2022 that will allow for the elimination of a paper application and reduce the number of paper documents even mailed to MBC in support of applications. MBC advised that these changes, coupled with application volumes expected to normalize in 2023, application-processing times will return to no more than 45 days.

- **MBC's website was redesigned.** In July 2021, MBC launched a redesign of its public-facing website to conform to the latest standards established by the California Department of Technology to achieve a more user-centric, accessible, and mobile-friendly site. MBC's homepage now features faster load times and retained some of the previous website's most popular features like a quick physician name search, a news section that features the top three latest MBC news items, and an alert bar informing users of important developments.

- **Electronic wallet cards are available.** To reduce the Board's printing and mail expenses, the Board rolled out a service that allows licensees to generate and print their own Pocket License Cards. Licensees will be able to generate a PDF file for their own use or to forward to employers and others, as needed. In addition to saving MBC resources, licensees have instant access to these electronic cards and not have to wait 4-6 weeks to wait for a plastic card to be printed and mailed to them. MBC is working to determine the viability of producing digital cards (for use on Apple Wallet and Google Pay) that will automatically update on a licensee's

device with license information changes.

- **Interested parties meetings about complaints have taken place and an online complaint tracking system is in the works.** MBC has held numerous meetings with interested parties concerned about what happens when members of the public file a complaint with MBC. These meetings bring MBC members, staff, patients, and consumer advocates together to discuss MBC and its enforcement process, share concerns, and look for ways to collaborate on fulfilling MBC's consumer protection mission. MBC reports that is has gained helpful information during interactions through these forums and has worked to implement certain changes, including the posting of information suggested by patient advocates on the MBC's website and revising MBC's complaint form. Additionally, staff are developing an online system to allow complainants to check on the status of submitted complaints.

- **MBC redesigned the physician survey in order to receive up to date workforce data.** Each licensee is provided an extensive survey that may be voluntarily completed at the time of initial licensure and updated during each renewal period as part of the renewal process. The information requested from physicians includes data on years of postgraduate training; time spent in teaching, research, patient care, telemedicine, and administration; practice locations; areas of practice; and board certification. In addition, the survey requests information on race/ethnicity, foreign language, and gender. Even though these questions are optional, they are an important part of the efforts to examine physician demographics. AB 133 (Committee on Budget, Chapter 143, Statutes of 2021) renamed the former Office of Statewide Health Planning and Development to the Department of Health Care Access and Information (HCAI) and requires MBC to request certain workforce data from licensees and registrants on at least a biennial basis. MBC launched a new survey in 2022 that collects additional information including anticipated year of retirement, physical address of primary and secondary practice locations and types, date of birth, gender identify, National Provider Identifier (NPI), work hours, sexual orientation, and disability status. This information is submitted to HCAI.

- **MBC continues to take efforts to combat the opioid crisis.** MBC reports that it updated its approach to proactively investigating possible inappropriate prescribing of opioids so that deaths attributed to opioid overdose are examined to initially assess the case for possible inappropriate prescribing prior to reviewing a prescribing report on the related physician and conducting a full field investigation. Physicians who are not considered to present a risk to the public during the initial assessment are not subject to further review. In the first iteration of its efforts to review prescribing data, MBC initiated 520 cases against 471 licenses from data received for nearly 2,700 deaths in 2012 and 2013. Following those investigations, the Board took disciplinary action in dozens of cases. The Board imposed 10 probations, 24 public letters of reprimand/public reprimands, and accepted 11 license surrenders. MBC is also in the process of updating it's Guidelines for Prescribing Controlled Substances and has consulted with medical experts and held an interested parties meeting.

- **Regulations are being adopted.** MBC has undertaken a number of regulatory packages in the past two years, including: updating regulations to evaluate how criminal history is substantially related to the practice of medicine when reviewing applications for licensure; implementing postgraduate licensing requirements; updating requirements for medical and midwife assistant certifying organizations; implementing the requirements that licensees notify patients or clients that the provider is licensed or registered by MBC and how to check that license; authorizing a MBC official to issue citations, including those containing orders of abatement and/or fines, to any licensee for a violation of any statute or regulation which would be grounds for discipline and; implementing the Physician and Surgeon Health and Wellness Program.

- **A Chief Medical Consultant (CMC) is assisting with enforcement efforts.** In FY 19/20, MBC hired a new CMC who provides an immediate and direct source for medical expertise. The CMC also reviews reports from medical experts where appropriate in order to improve the quality of reports. MBC believes that this emphasis on the medical review of the cases and evaluation of expert opinions can create financial and time savings and allow MBC to target its prosecution costs more efficiently and effectively. It will also allow MBC to shorten timeframes by having a medical evaluation of the case at hand on a timely basis.

- **Cost recovery has been reestablished.** Prior to SB 806, MBC was prohibited from seeking reimbursement from physicians for costs related to disciplinary action. SB 806 restored this authority and between January 1, 2022, and June 30, 2022, MBC imposed cost recovery on 40 physician and surgeon cases for a total amount of $239,520.51 (an average of $5,988.01 per case). As of September 29, 2022, $26,286.26 was recovered. MBC reports that investigations that commence after January 1, 2022 may see larger cost recovery awards and notes that, anecdotally, the reinstatement of cost recovery appears to be encouraging earlier settlement of certain cases and reinforces the importance of licensees promptly responding to MBC investigation and prosecution efforts, given that the timely resolution of cases benefits consumers, licensees, and MBC.

- **Policies aimed at decreasing bias and disparity in enforcement are in place.** Stemming from questions about MBC efforts to ensure that bias and disparities do not exist in any of its programs, MBC requires all staff and every MBC member to attend mandatory training on implicit bias

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to MBC or areas of concern that should be considered, along with background information for each issue. There are also recommendations Committee staff have made regarding particular issues or problem areas MBC needs to address. MBC and other interested parties have been provided with this Background Paper and MBC will respond to the issues presented and the recommendations of staff.

MBC ADMINISTRATION ISSUES

ISSUE #1: (BOARD COMPOSITION.) Does MBC's composition need to be updated to include additional members of the public? What is the actual role of Medical Board of California board members in the disciplinary process? What benefit would be achieved by adding additional members of the public to the Medical Board of California, specifically in regards to the disciplinary process?

Background: In 2010, the Federal Trade Commission (FTC) brought an administrative complaint against the North Carolina State Board of Dental Examiners (Board) for exclusion of non-dentists from the practice of teeth whitening. The FTC alleged that the Board's decision was an uncompetitive and unfair method of competition under the Federal Trade Commission Act. This opened the Board to lawsuits and substantial damages from affected parties.

The Board was composed of six licensed, practicing dentists and two public members. The practice of teeth whitening was not addressed in the statutes comprising the Dental Practice Act. Instead of initiating a rulemaking effort to clarify the appropriate practice of teeth whitening, the Board sent cease-and-desist letters to non-dentists in the state offering teeth whitening services. The Board argued that the FTC's complaint was invalid because the Board was acting as an agent of North Carolina, and according to state-action immunity, one cannot sue the state acting in its sovereign capacity for anticompetitive conduct. A federal appeals court sided with the FTC, and the Board appealed to the United States Supreme Court (Court).

In February 2015, the Court agreed with the FTC and determined that the Board was not acting as a state agent and could be sued for its actions. The Court ruled, "Because a controlling number of the Board's decision-makers are active participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met."

The Court was not specific about what may constitute "active participants" or "active supervision." However, the Court did say that "active supervision" requires "that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy," and that "the supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it."

In October 2015, the FTC released a staff guidance, *Active Supervision of State Regulatory Boards Controlled by Market Participants* in order to better explain when active supervision of a state regulatory board would be required, in order for a board to invoke the state action defense. The guidance also aimed to highlight what factors are relevant when determining if the active supervision requirement has been satisfied. The FTC states that active supervision includes the ability of a state supervisor to review the substance of the anticompetitive decision and have the power to veto or modify a decision. The state supervisor may not be an active market participant. In addition, the FTC states that active supervision must precede the implementation of the alleged anticompetitive restraint.

The FTC states that the guidance addresses only the active supervision requirement of the state action defense, and antitrust analysis is fact-specific and context-dependent. This means that although a state action defense might not be applicable in a certain case, this does not mean that the conduct of a regulatory board necessarily violates federal antitrust laws.

On October 22, 2015, the Committees held a joint informational hearing to explore the implications of the Court decision on the DCA's professional regulatory boards and consider recommendations.

In response to the Court's decision, State Senator Jerry Hill requested an opinion from the Office of Attorney General Kamala Harris (AG). The AG released the following:

> "North Carolina Dental has brought both the composition of licensing boards and the concept of active state supervision into the public spotlight, but the standard it imposes is flexible and context-specific. This leaves the state with many variables to consider in deciding how to responds.
>
> "Whatever the chosen response may be, the state can be assured that North Carolina Dental's 'active state supervision' requirement is satisfied when a non-market-participant state official has and exercises the power to substantively review a board's action and determines whether the action effectuates the state's regulatory policies."

Boards like MBC are semiautonomous bodies whose members are appointed by the Governor and the Legislature. Although most of the non-healing arts boards have statutory authority for a public majority allotment in their makeup, most healing arts and non-healing arts boards are comprised of a majority of members representing the profession.

North Carolina State Board of Dental Examiners v. FTC placed limitations on the immunity of regulatory boards controlled by active market participants. This is because individuals who are directly affected by their own rulemaking may not be able to detect their biases, purposefully or inadvertently placing their benefit over those of the public. Or, as the Supreme Court stated, "Dual allegiances are not always apparent to an actor." Although the boards are tied to the state through various structural and statutory oversights, it is presently unclear whether current laws and practices are sufficient to ensure that the boards are state actors and, thus, immune from legal action. Changing

MBC's composition to a public member majority may decrease MBC's risk of exposure to lawsuits. Currently, MBC is comprised of 8 licensees and 7 members of the public.

Questions have arisen about the role of MBC members in the enforcement process and if there are benefits to patients and the public in the composition of MBC reflecting a majority of public rather than professional members. MBC advised in its January 2022 letter to the Legislature that "The Board believes that changing the composition to a public member majority would help to restore the public's trust in the Board's operations and priorities", however, as MBC members play a limited role in directing day-to-day functions as well as disciplinary proceedings, additional information is necessary in order to better understand any value from additional public MBC members.

MBC requested this change again in its 2023 Sunset Report. It is not clear what practical impact that would have on MBC operations, if any, or MBC enforcement outcomes. It may be helpful for the Committees to understand what impacts a change in composition could have.

Staff Recommendation: ***MBC should provide information about how this change would make MBC more effective and successful.***

ISSUE #2: (RESEARCH PSYCHOANALYST REGISTRATION.) MBC registers Research Psychoanalysts (RPs), individuals who practice psychoanalysis for fees for no more than one third of the individual's total professional time (which includes time spent in practice, teaching, training or research). Why does MBC administer the RP registration program rather than the Board of Psychology, which oversees those practicing in psychology and has experience administering registration programs?

Background: According to the American Psychological Association (APA), psychoanalysis is a specialty in psychology that is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitually recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing and creative expression. The APA states that psychoanalytic training typically requires four to eight years of advanced study after completion of a doctoral degree in psychology acceptable to the American Board of Professional Psychology and further requires specialized training at free-standing psychoanalytic institutes, postdoctoral university programs, or an equivalent training secured independently that is acceptable to the American Board and Academy of Psychoanalysis.

A registered RP is an individual who has graduated from an approved psychoanalytic institution and is registered with MBC pursuant to BPC 2529. Students currently enrolled in an approved psychoanalytic institution register with MBC as a Student RP, and as such, are authorized to engage in psychoanalysis under supervision. Existing law authorizes individuals who have graduated from an approved psychoanalytic institute to engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts. "Adjunct" means that the RP may not render

psychoanalytic services on a fee-for-service basis for more than an average of one-third of his or her total professional time, including time spent in practice, teaching, training or research. Students and graduates are not entitled to state or imply that they are licensed to practice psychology, nor may they hold themselves out by any title or description of services incorporating the words: psychological, psychologist, psychology, psychometrists, psychometrics, or psychometry. MBC follows a process to determine the appropriate education and training qualification (as reflected through materials received directly from entities verifying this information) and the proper background checks for applicants for RP registration.

In 1977, when RPs were first recognized statutorily, MBC—then the Board of Medical Quality Assurance—was comprised of three sections: the Division of Medical Quality, the Division of Licensing, and the Division of Allied Health Professions. Several allied health professions were within the jurisdiction of the Division of Allied Health Professions, including audiologists, acupuncturists, hearing aid dispensers, physical therapists, medical assistants, physician assistants, podiatrists, registered dispensing opticians, speech pathologists, and psychologists. In 1990, when the Board of Psychology came into existence, RPs remained under the MBC's oversight.

The Board of Psychology previously had a member who served as president of the Northern California Society for the Psychoanalytic Psychology Board of Directors and who was an assistant editor for a psychoanalytic publication. It appears that the Board of Psychology may have more expertise in this discipline and may be a more appropriate entity to register RPs who engage in the practice. In its January 2022 letter to the Legislature and again in its 2023 Sunset Report, MBC requested that RP registration be transferred to the Board of Psychology, citing that regulatory body as having appropriate resources and expertise to regulate this category of individuals.

Staff Recommendation: ***The Committees should evaluate the implications of this transfer, including potential cost savings or other fiscal impacts and workload. MBC and the Board of Psychology should provide an update on any efforts to coordinate their work and oversight of those providing these services, including assurances that BPC Section 2529 limitations on practice are complied with. The Committees may wish to transfer registration of RPs to the Board of Psychology, which already successfully administers registration programs for individuals practicing psychology.***

ISSUE #3: (LICENSED MIDWIVES.) MBC regulates licensed midwives but regulations to allow LMs to practice independently have stalled. What is the status of LM independent practice authority and what changes may be necessary to achieve the Legislature's intent?

Background: MBC received regulatory authority over licensed midwives in 1994 at a time that MBC also had oversight for a multitude of allied health professions. While many other health professions later developed their own regulatory boards, MBC continues to have jurisdiction over this category of professionals. A licensed midwife (LM) is an individual who has been issued a license to practice midwifery by MBC. LMs who have achieved the required educational and clinical experience in midwifery (including completing a three-year postsecondary education program in an accredited midwifery school approved by the MBC) or met the challenge requirements (obtaining credit by

examination for previous education and clinical experience – as of January 1, 2015, new LMs may not substitute clinical experience for formal didactic education), must pass the North American Registry of Midwives' comprehensive examination. After successful completion of this examination, prospective applicants are designated as a "certified professional midwife" and are eligible to submit an application for licensure as a LM.

LMs are authorized to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. LMs can also directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice. LMs can practice in a home, birthing clinic or hospital environment. As of March 1, 2021, there are 471 actively licensed LMs in California.

When the Licensed Midwifery Practice Act of 1993 was first enacted, LMs were required to practice under the supervision of physicians. Since AB 1308 (Bonilla, Chapter 665, Statutes 2013) went into effect on January 1, 2014, LMs are authorized in statute to practice autonomously without any supervision requirements.

LMs do not have member representation on MBC, rather, BPC Section 2509 authorizes MBC to create a Midwifery Advisory Council (MAC) and appoint its members consisting of LMs and members of the public, specifically at least half of the MAC members are LMs, and it includes one physician and two public members. The MAC makes recommendations on matters specified by MBC and MBC holds all authority to take action regarding the licensure and regulation of midwives in California.

The fees collected by LMs to fund MBC's oversight of the profession are deposited into a LM Fund administered by MBC. When oversight of the profession began in 1994, MBC received a $70,000 loan from the General Fund, in order to ensure fund solvency. This loan was paid off over the course of ten years and paid in full in 2004. Beginning in FY 14/15, an appropriation was established to fund the personnel needed to administer MBC's Midwifery Program. Beginning in FY 17/18, MBC began requesting payment from the Midwifery Program for the staff resources necessary to perform the licensing and enforcement functions of this program within MBC.

LMs submit an application and initial license fee of $450 and have a biennial renewal fee of $300, fees that were adjusted in SB 806 in 2021. The renewal fee comprises about 78 percent of the fees received in the LM Fund.

LM Licensee Population					
		FY 18/19	FY 19/20	FY 20/21	FY 21/22
Licensed Midwife	Active[1]	412	435	453	477
	Delinquent	70	68	75	101
	Out-of-State	Unknown	Unknown	Unknown	36
	Out-of-Country	Unknown	Unknown	Unknown	1
	Retired Status *if applicable*	8	11	11	13
	Inactive	9	15	20	25
[1] Active status is defined as able to practice. This includes licensees that are renewed, current, and active.					

MBC states that the overall number of complaints involving LMs is down in comparison to the years prior to FY 20/21, in line with other complaints also being down due to impacts from the COVID-19 pandemic. MBC issued three public reprimands and one licensee was placed on probation, an increase in disciplinary actions when compared to the prior three-year period. MBC utilizes midwives for medical consultant and expert roles in cases involving midwives and utilizes its Disciplinary Guidelines as a model for disciplinary action imposed on midwives. Over the past two fiscal years, there were nine accusations filed against LMs.

MBC states that the majority of complaints received regarding LMs relate to the care provided during labor and delivery. These complaints are considered the highest priority. MBC reports that it also receives complaints regarding the unlicensed practice of midwifery, which are also considered urgent complaints. MBC received 29 complaints in FY 20/21 and 22 complaints in FY 21/22, the majority of which came from members of the public. MBC processed four cases that resulted in disciplinary actions in the past two-year period.
AB 1308 removed the statutory requirement for an LM to practice under the supervision of a M.D. and instead specified that a midwife may assist in "normal" pregnancy and birth, defined through regulations. Until MBC adopts regulations, LMs are not able to be a "comprehensive perinatal provider" for purposes of providing comprehensive perinatal services to Medi-Cal beneficiaries in the Comprehensive Perinatal Services Program (CPSP). SB 407 (Morrell, Chapter 313, Statutes of 2015) authorized a health care provider to employ or contract with LMs for providing comprehensive perinatal services in the CPSP.

MBC held several interested parties meetings on the regulations to implement AB 1308, including working with both the California Association of Midwives/California Association of Licensed Midwives (CAM/CALM) and the American College of Obstetricians and Gynecologists. A sticking point in the discussions on regulations was whether prior cesarean sections should be on the list of preexisting conditions, which would require a physician and surgeon examination prior to the LM continuing to provide care.

MBC established a Midwifery Task Force, comprised of two MBC members to assist with the development of regulations pursuant to AB 1308. The Midwifery Task Force discussed the challenges created by the current language under 2507(b)(2) requiring a LM to refer a client with a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy, to a physician for an examination and a determination by the physician that the risk factors presented by the individual's disease or condition are not likely to significantly affect the course of pregnancy and childbirth if the LM is allowed to continue care. The Task Force was informed that requiring physicians to make this determination puts physicians in a difficult position, causing reluctance and challenges for collaboration and access to care for midwifery clients. It was acknowledged that this issue could not be resolved through regulations.

The Midwifery Task Force determined that legislation was necessary. According to the proposal, it would be the LM making that determination within the midwifery standard of care, rather than the physician and surgeon, as to whether the individual should continue with midwifery care. If the individual does have a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy likely to significantly affect the course of pregnancy or childbirth, the LM would have to refer the individual to a physician and surgeon for care, with the LM providing collaborative care, as appropriate.

MBC approved pursuing the proposed statutory amendment to change the requirements of BPC Section 2507 so that if the client has a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy, the midwife will still be required to refer the client to a physician trained in obstetrics for an assessment of the risk factors that may adversely affect the outcome of the pregnancy or childbirth. The LM would have to include the physician's assessment in evaluating whether the client's disease or condition is likely to significantly affect the course of the pregnancy or childbirth. It would ultimately be the midwife making the determination within the midwifery standard of care, rather than the physician, as to whether the client should continue with midwifery care. The proposed language was not included in MBC's prior sunset bill in 2017 and there have been no statutory changes since then.

At its quarterly meeting on November 7, 2019, MBC considered and rejected a legislative proposal to prohibit LMs from attending home births if the mother has had a prior cesarean delivery.

Members of the MAC, individual LMs, and state midwifery professional associations have called for LMs to be regulated by a separate board within the DCA. In general, these stakeholders argue that LMs and the physician community have incompatible approaches to providing care, therefore, it is inappropriate for LMs to be regulated by MBC. MBC notes in its sunset report that it agrees and that with an appropriate scope of practice and related statutory protections for consumers, LMs could be effectively regulated through a separate entity within DCA. In support of this proposal, CALM writes that:

> "as physicians and surgeons, Board members are not trained or educated in midwifery practice, nor are they taught about the midwifery profession when they join the Board…Board members are often unaware that they are responsible for regulating LMs; that LM clinical practice takes

place in out-of-hospital, community-based settings; that LMs are not nurses or nurse-midwives; that LMs do not engage in the practice of medicine; and that the midwifery model and standards of maternity care are distinct from the obstetrical model of maternity care. The Board routinely assigns physicians with no background in midwifery education, training, or scope of practice to serve as expert reviewers of LM complaints and investigations and to determine the outcome of LM disciplinary cases. Physician expert reviewers assigned to LM cases rely on guidelines provided by the Board that have with no statutory authority and have not been promulgated…The Board refers all hospital transport reports, which are meant for data collection and represent adherence to appropriate standards of care, to the Enforcement Program for review as potential complaints…Board members' general lack of awareness of or interest in the licensed midwife profession is reflected in the notable absence of information or programs for or about LMs found in the outreach and communication initiatives of the Board's Office of Public Affairs. Board initiatives on professional development and quality improvement are likewise focused almost exclusively on physicians. The Board has not appropriately updated LM guidelines and regulations as standards of care evolve and new evidence and research becomes available. The Board has claimed that rules cannot be promulgated when stakeholders are in disagreement; however, its insistence that physician associations with interests in direct conflict with LMs be treated as stakeholders has resulted in regulatory capture. The Board's billing practices create inefficiencies that disproportionately impact LMs when it comes to shared costs…

[The] MAC cannot function effectively or efficiently because it must receive prior approval from the Board for topics or concerns, which may only be considered at subsequent meetings; Midwifery Task Force members, like other members of the Board, are not trained in midwifery and are not adequately familiar with LM standards of care and regulation…

While the Board's exercise of its statutory jurisdiction over LMs is a relatively minor aspect of its workload, for CALM and the families we serve, control over midwifery practice by another profession remains an ongoing challenge that is becoming increasingly unsustainable."

This issue was raised during the prior sunset review oversight of MBC. MBC was asked by the Committees to describe the impacts of creating a new, standalone board for a small licensing population, including costs that would be necessary to establish a LM board and to inform the Committees of the benefit to patients that this proposal would result in. MBC states that it has been "diligent in its licensing and disciplinary responsibilities and pursuing its mission with regard to consumers of LM services. A new LM board would also be able to handle these functions, thereby, at minimum, extending existing consumer protections. [MBC] has not studied what additional benefits there may be to patients if the Legislature approves the creation of an LM board."

In FY 2020/21, the LM Fund had a $120,000 budget and Shared Service expenses of $160,748 in FY 2020/21. In FY 2019/20, the LM Fund had a total revenue of $71,936. LM fees were increased through SB 806.

LM Fund Condition				
(Dollars in Thousands)	FY 18/19	FY 19/20	FY 20/21	FY 21/22
Beginning Balance	398	451	402	330
Total Revenue	60	60	61	63
Total Resources	458	511	463	393
Budget Authority	120	120	120	120
Expenditures	7	109	133	133
Loans to General Fund	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0
Loans Repaid From General Fund	0	0	0	0
Fund Balance	451	402	330	260

MBC states that it has not studied the impacts that a new LM board would have on consumers, nor projected the various associated costs.

In its January 2022 letter to the Legislature and again in its 2023 Sunset Report, MBC requested that a separate board be created to regulate LMs.

Staff Recommendation: ***MBC should describe the potential impacts of creating a new, standalone board for a small licensing population, including all costs that would be necessary to establish a LM board. MBC should inform the Committees of any potential benefit to patients that this proposal would result in.***

ISSUE #4: (COMPLAINANT LIAISON.) Complaints are the heart of MBC's enforcement program. Delays in complaint processing can have grave effects on patients and the public and compound MBC's efforts to protect consumers. In consumer satisfaction surveys, MBC consistently receives unfavorable feedback and response for its handling of complaints. Questions have arisen for many years about the potential benefit to patients and the public if complaint information is made available, and the value for MBC to establish a formal program with dedicated staff and resources to assist patients as they navigate the enforcement process. Should MBC establish a dedicated ombudsperson or liaison unit to ensure that complainants are able to participate in the enforcement process?

Background: Accepting, processing and acting on complaints from patients, the public, MBC staff, other agencies and other sources is a primary mechanism by which MBC can ensure that licensees are in compliance with the Act and that patients have options for action in the event that their physician violates the law. The timely processing of complaints provides MBC with critical information about their licensees and assists in prioritizing workloads.

Complaints are confidential until substantiated and the complaint and investigation result in some type of formal, public action. This is not the case for all DCA boards, notably the Contractors State License Board which is required (BPC Section 7124.6) to "make available to members of the public the date,

nature, and status of all complaints on file against a licensee that do either of the following: (1) Have been referred for accusation. (2) Have been referred for investigation after a determination by board enforcement staff that a probable violation has occurred, and have been reviewed by a supervisor, and regard allegations that if proven would present a risk of harm to the public and would be appropriate for suspension or revocation of the contractor's license or criminal prosecution." MBC, however, notes that this requirement for confidentiality is not unique to California or the MBC and that a number of professional boards in California and throughout the country keep complaints confidential until an accusation is filed or action is taken.

MBC states that individuals who file a complaint are notified at various stages of the enforcement process. Upon receipt and opening of a complaint, an acknowledgement letter is sent to the complainant. This letter informs the complainant that MBC received their complaint and that if they have additional information they may submit it to CCU for review. MBC also sends a letter to patients or plaintiffs in malpractice cases who may be unaware that MBC received a mandated report complaint. This letter informs them that MBC received this report, asks them to provide additional information they may have, and outlines MBC's statute of limitations.

When MBC sends a request to the complainant for their release of medical records, MBC also informs the complainant that they can provide additional information regarding their complaint. MBC states that during the complaint review process, if the complainant calls MBC, staff also informs them that they may provide additional information.

For quality of care cases, the complainant is notified that all the medical records have been received and that the complaint is going to be sent to a medical consult expert for review. For all cases, if it is determined that the complaint is moving to formal investigation, the complainant is sent a letter notifying them of this transition of the case. Once the complaint goes to formal investigation, MBC states the complainant will be contacted by the investigator. If the matter is referred to OAG, the complainant receives a letter notifying them the matter has been referred and also receives a letter and a copy of the accusation, if one is filed. If disciplinary action is taken, the complainant also receives a copy of the final decision in the matter. MBC says that complainants are informed that the complaint they filed with MBC has led to disciplinary action.

MBC reports it has made a number of enhancements and revisions to the complaint forms, online forms, and public information to provide more accessibility, efficiency and explanation of the process to the public. Complaint forms were revised to allow for more specific information from the complainant and the form now includes a release for the patient's records to allow for a quicker processing time of the complaint. The online forms were set up to mirror the paper forms and allow for the release(s) to be sent at the time of submission of the complaint. In 2019, MBC created a new brochure outlining the complaint process that is available to the public in print or on its website. MBC notes that it is currently working on IT options in order to move to a fully paperless complaint system.

MBC reports that in order to improve communication between MBC and complainants and to enhance the public's understanding of the enforcement program, MBC initiated conversations during its

February 2022 meeting about the creation of a Complainant Liaison Unit (Liaison Unit). MBC voted at its December 2022 meeting to pursue this endeavor and included funding for the Liaison Unit as a request in its 2023 Sunset Report.

MBC states that the Liaison Unit would have the following areas of responsibility:

- Consumer Communication Prior to Filing a Complaint
- Complainant Communication Support After Case Referred to Field
- Support Consumer Outreach Regarding the Board's Role and Procedures
- Evaluate Complaint Closure Review Requests Consumer Communication Prior to Filing a Complaint

The Liaison Unit would respond to all communications from the public about the complaint review and enforcement process prior to the filing of a complaint. This would include, but not be limited to, responding to emails and phone calls from those with questions about how to file a complaint and what information and documents should be included. After it is filed, the complaint, including all communication with the complainant, would be handled by CCU staff.

After a case is referred to HQIU for further investigation, complainants will be advised to contact the Liaison Unit if they have questions and the Liaison Unit would coordinate necessary communication between the investigator and complainant.

Once a case proceeds to OAG, the Liaison Unit would provide the complainant with additional requested details regarding the process, expected timeframes, and answer other general questions. The DAG assigned to the case could also be in contact with the complainant if they are needed at a hearing as a witness. The Liaison Unit would not interfere with a complainant's interaction with OAG, but would assist and facilitate communications, as needed.

If MBC's disciplinary decision is appealed by the licensee, the Liaison Unit would be a resource to assist the complainant through the various appeals steps and the timing involved. When a licensee asserts their due process rights and appeals a case through a writ to a superior court, and possibly to higher courts, the Liaison Unit could update the complainant on the general timeframes are for those steps to take place.

The Liaison Unit would partner with the MBC Public Information Unit to update website content (for example, narrative webpage content, podcasts, videos) that improves public understanding of the enforcement process, including related laws and policies. Liaison Unit staff would participate in appropriate online and in-person outreach events to educate attendees on the MBC's role and procedures.

In the event CCU closes a complaint, the closure letter would include a "request for review" form (and appropriate instructions) that the complainant could fill out and return to MBC, if they believe the case was closed in error or if they have additional information to support their allegations. If a request for

review is received, it would be routed to the Liaison Unit to review. The Liaison Unit would log the requests, review, and handle necessary correspondence with the complainant but would not be able to disclose confidential information.

MBC advises that the Liaison Unit would necessitate four new employees, including a lead or manager and three analysts.

Staff Recommendation: ***MBC should explain the steps necessary to effectively establish this program, including the role that any increased revenue would play in bringing this effort to fruition.***

MBC BUDGET ISSUES

ISSUE #5: (FUND CONDITION AND FEES.) MBC continues to face insolvency, having relied on loans from various other state agencies to fund its operations. Fees were raised in 2021 but physician and surgeon fees were set almost $300 below what MBC requested, and what a third-party fee study identified as appropriate levels. Since then, costs have increased and now MBC has to pay back loans with interest.

Background: MBC does not receive funding from the state's General Fund. Expenses are supported entirely by fees paid by MBC applicants and licensees. Close to 90 percent of MBC revenue stems from physician and surgeon licensing fees. MBC's revenue has not kept up with its growing expenditures, drawing MBC's reserves down to extremely low levels, an issue that has been brought to the Legislature's attention for multiple years.

MBC identified the need for additional revenue to support its operations and in November 2019, contracted with CPS HR Consulting to perform a fee study to determine the appropriate levels for licensing fees that would allow MBC conduct its business at a service level that is efficient for licensees and still ensures public protection, given that MBC's fee structure had been unchanged since 2009. The fees reviewed in the study included Physician and Surgeon, Special Faculty, LM, Polysomnographic Trainee/Technician/Technologist, RP, and Fictitious Name Permit fees. The final report, *Medical Board of California: Fee Study*, published January 2020 noted that MBC's revenue had remained relatively static in the past 13 fiscal years but expenditures significantly outpaced revenues. The report noted that if MBC incurred any additional unbudgeted cost increases or sought any additional resources beyond what was currently authorized, the fund reserve would drop even further.

According to the 2023 Preliminary Monitor's Report, "Of particular note, the medical program's OAG HQE expenses increased significantly in FY 2020/21. Effective July 1, 2019, the OAG increased its billing rates for services, as follows: Attorney services by 29%, from $170 to $220 per hour; Paralegal services by 71%, from $120 to $205 per hour and ; Auditor/research analyst services by 97%, from $99 to $195 per hour…given MBC's fund condition, the effective date was initially pushed back to

September 1, 2019. The effective date of such rate increases was again delayed until January 1, 2021, aligning with the anticipated MBC licensee fee increases."

SB 806 provided MBC with the necessary and requested fee increases in every categtory other than physician and surgeon licensing. While the physician and surgeon licensing fee was increased some through SB 806, the 2020 *Medical Board of California: Fee Study* suggested statutorily establishing a $1150 fee amount, an increase from language in the Act that established a physician and surgeon fee at an amount that "shall not exceed [$790]", in order to provide fund stability. SB 806 initially included this full $1150 amount MBC requested but due to significant opposition from physicians and surgeons, and the threat of the measure failing passage entirely on the Senate Floor, the bill was amended to decrease this amount to $863.

MBC reports that due to efforts to control spending through various cost savings measures, coupled with temporary spending reductions stemming from the COVID-19 pandemic (for example, staff salary reductions and travel limitations) and increased licensing fee revenue that SB 806 provided, MBC's fund balance is estimated to show marginal improvement over prior estimates provided throughout the last year since the sunset review oversight discussions. However, MBC confirms that these savings measures are not sufficient to avoid the need for a fee increase due to rising costs that MBC cannot control. MBC advises that staff continues to find ways to streamline and automate tasks, lessen the reliance on paper, and control certain MBC expenses but various external cost drivers are outside MBC's direct control. In addition to rising costs, in June 2022, MBC received a $10 million loan from the Vehicle Inspection and Repair Fund adminstered by the Bureau of Automotive Repair which must now be repaid with interest by June 2024, a reality that has factored into adjusted MBC projections. It is likely MBC would need additional loans in the current and next FY as well in order to remain solvent.

MBC requests the following adjustments in order to achieve fiscal stability and fund solvency:

- increase the initial physician and surgeon fee from $863 to $1,350
- increase the physician and surgeon license renewal fee from $863 to $1,350
- increase the reduced physician and surgeon license fee from $432 to $675
- increase the delinquent physician and surgeon fee from $86 to $135

MBC states that to help mitigate the need for further large fee increases in future years, it requests eliminating the statutory requirement that MBC maintain a reserve amount of between two and four months. Instead, MBC would like authority to have up to a 24 month reserve, in line with many other DCA boards, per BPC Section 128.5. MBC also requests authority for future revenue adjustments through the rulemaking process, including allowing a fee increase of up to an additional 10 percent.

In addition to these current fee adjustments, MBC has requested to establish a fee charged to disciplined licensees who seek to modify or terminate their probation, or reinstate their license. Pursuant to BPC Section 2307, a disciplined licensee may petition MBC to seek reinstatement of a revoked or surrendered license or to have their probation modified or terminated early. The process to

evaluate and consider each petition involves substantial legal costs. For example, in FY 20/21, MBC spent nearly $1 million in costs to OAG and the Office of Administrative Hearings for litigation and hearing expenses for these petitions. Currently, the individuals petitioning MBC do not have to bear any of these costs, thus MBC is not able to recover any of the significant costs this process incurs. MBC would like the Act to be amended to authorizes MBC to establish an application fee for petitioners, not to exceed MBC's reasonable costs to process and adjudicate petitions for reinstatement, early termination of probation, or modification of probation.

Staff Recommendation: ***MBC should be provided increased revenues to ensure its fiscal stability and fund solvency. MBC should provide an update on the status of discussions with licensees and the Department of Finance to assist the Legislature in charting a course forward that allows MBC to have resources to conduct its important work.***

MBC LICENSING ISSUES

ISSUE #6: (APPLICATION INQUIRIES.) Does asking applicants about physical or mental health conditions potentially prevent them from seeking important and necessary treatment?

Background: According to MBC, applicants for physician and surgeon licensure must respond to questions about whether they have a current physical or mental health condition(s) that impacts their ability to practice medicine safely. MBC states that any positive answer does not automatically disqualify the applicant from licensure and MBC will make an individualized assessment of the nature and severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, or conditions should be imposed on the license. If an affirmative response to any of the questions is provided, the applicant must provide a detailed narrative explaining the medical conditions. MBC states that it did not deny any licenses or issue any probationary licenses in FY 20/21 or FY 21/22 for reasons related to physical or mental health, except when the reason was related to alcohol or substance abuse.

Throughout the COVID-19 pandemic, frontline healthcare workers and first responders, such as physicians, nurses, respiratory care therapists, paramedics, and more, have been caring for COVID-19 patients through multiple deadly surges, including a record-shattering death toll surge in December of 2020. The Centers for Disease Control noted that "[p]roviding care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions…. Experiencing or witnessing life-threatening or traumatic events impacts everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, post-traumatic stress disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic."

While MBC notes that it has not made any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic, MBC would only

potentially be aware upfront of any mental or behavioral healthcare needs if applicants disclose this as a condition that impairs their ability to practice safely, or if this information is discovered through the course of an investigation.

It would be helpful for the Committees to understand if applicants believe they may receive support by answering questions about mental health or whether applicants may be worried about potential punitive and disciplinary action that could lead to them not seeking assistance for various issue.

Staff Recommendation: ***MBC should inform the Committees about the usefulness of inquiring at the time of application and the impact of applicants being asked about their behavioral health.***

ISSUE #7: (POSTGRADUATE LICENSE.) MBC issues a license to physicians enrolled in residency programs, an effort MBC began exploring and working on in 2016-17 in order to ensure that this category of physicians have met certain educational and training requirements, with the goal of simplifying licensing processing for these physicians as they progress through national examination requirements. The initial effort was delayed until 2020 and now, physicians must complete 3 years of postgraduate training in order to have their license renewed.

Background: Beginning January 1, 2020, all physician license applicants, regardless of whether they graduated school in the U.S./Canada or a foreign country, were required to satisfactorily complete a minimum of 36 months of Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC) accredited postgraduate training. Three years came from the industry-recognized standard of three years of training required for board certification by American Board of Medical Specialty boards in specialties like family medicine, internal medicine, pediatrics and others. This specification was designed to allow MBC's evaluation process to rely on programs setting the same criteria, requirements, and standards to ensure that all participants in these programs meet the same criteria, requirements, and standards. Previously, MBC authorized licensure after only one year of postgraduate training and did not require completion of a full residency program, and MBC had to approve foreign medical schools rather than being able to rely on approval from another organization. The goal was to create a more effective assessment of an applicant's eligibility for licensure based on criteria other than where they attended medical school and completed undergraduate clinical rotations.

Following the passage of SB 798 (Hill, Chapter 775, Statutes of 2017), all medical school graduates who matched into an accredited postgraduate training program in California were required to obtain a postgraduate training license (PTL) in order to practice medicine as part of their training program. If the medical school graduate failed to obtain the PTL within 180 days after enrollment in a MBC-approved training program, or MBC denied the PTL application, all privileges and exemptions would automatically cease. The PTL was valid for up to 39 months and could not be renewed; however, MBC had limited authority to grant an extension under certain conditions.

The initial PTL posed challenges for MBC and physicians alike. MBC experienced high numbers of PTL applications and the COVID-19 pandemic led to increased issues with the effective issuance with

these licenses. The PTL was also intended to be an unrestricted licenses and for purposes of the Act, specified that a resident possessing this category of recognition from MBC may engage in the practice of medicine in connection with their duties as an intern or resident physician in a MBC-approved program, including its affiliated sites, or under those conditions as are approved in writing and maintained in the postgraduate training licensee's file by the director of their program. These physicians are authorized to diagnose and treat patients; prescribe medications without a cosigner, including prescriptions for controlled substances, if individual has the appropriate Drug Enforcement Agency registration or permit and is registered with CURES; sign birth certificates without a cosigner; and sign death certificates without a cosigner. However, while the Act was clear on PTL authority, some agencies had policies or statutes that only authorized an unrestricted medical license holder to engage in certain activities, and advised that residents holding a PTL were not fully authorized the same as physician licensees who had completed their three-year residency. Concerns were raised that a PTL may not be deemed equivalent to an unrestricted medical license for purposes of Medi-Cal billing and could impact the ability for an individual to enroll as a Medi-Cal Fee-For-Service or Managed Care provider in order to work outside of a residency program, known as moonlighting. Residents with a PTL were not able to obtain Substance Abuse and Mental Health Services Administration DEA X-waivers in order to prescribe buprenorphine and practice medication-assisted treatment. Residents with a PTL reported that they might not be able to sign birth certificates, death certificates, and disability forms.

In response to these various issues and to resolve numerous issues while maintaining patient safety standards by ensuring that physicians complete postgraduate training, SB 806 adjusted MBC licensing again to clarify that a physician and surgeon can obtain a physician and surgeon certificate after receiving credit for 12 months of postgraduate training, but must receive credit for 36 months of postgraduate training in order for the certificate to be renewed at the time of initial renewal. Notably, SB 806 also granted broad discretion to MBC to make a determination of license renewal even if certain timeframes are not met in order to take into consideration leave or other factors that may affect completion of a program within exactly 36 months.

MBC continues to evaluate how to effectively issue licenses to qualified candidates. MBC reports that it has heard from some PTL holders who graduated from a U.S./Canadian medical school and are facing difficulty scheduling, taking, and receiving their exam scores for the United States Medical Licensing Examination (USMLE) Step 3, which is a requirement for a California physician and surgeon license. These delays can impact the individual continuing to practice since they could potentially have a PTL expire prior to their transition to a physician and surgeon license category for individuals who have completed all of the requisite exams that are taken during postgraduate training. In order to address this issue and assist a PTL holder from having an interruption in their postgraduate training (since residents must be licensed to practice and treat patients), MBC staff propose extending the term of the PTL which will allow the PTL holder to continue training in a MBC-approved program while taking the exam and waiting for the results.

MBC also proposes a number of additional changes to account for a number of scenarios residents may face, like clarifying that applicants for physician and surgeon licensure are not limited to attending

postgraduate training in California and ensuring that the requirement for completing 36 months of training does not apply to those who become licensed through various reciprocity pathways or a special licensing program, among other necessary updates to the Act.

Staff Recommendation: ***The Committees may wish to consider changes to the Act in order to create efficiencies in the PTL licensing process.***

ISSUE #8: (MEXICO PILOT PROGRAM.) Legislation passed in 2002 established a pilot program aimed at addressing primary care and dental practitioner shortages by authorizing MBC and the Dental Board of California to issue licenses for three years to physicians and dentists from Mexico who meet specified criteria. What steps has MBC taken since 2003 to put the program in place? What is the status of the effort to better serve limited English proficient Californians?

Background: The Licensed Physicians and Dentists Program (Mexico Pilot Program), established by AB 1045 (Firebaugh, Chapter 1157, Statutes of 2002), was designed to bring physicians and dentists from Mexico with rural experience, who speak the language, understand the culture, and know how to apply this knowledge in serving the large Latino communities in rural areas who have limited or no access to primary health care services. Proponents of the measure were concerned about addressing primary care physician and dentist shortages while maintaining a high quality of care.

The bill authorized up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for up to three years, and required the individuals to meet certain requirements related to training and education.

AB 1045 tasked MBC with oversight review of both the implementation of the program and an evaluation of the program once it is implemented. The bill specified that any funding necessary for the implementation of the program, including the evaluation and oversight functions, was to be secured from nonprofit philanthropic entities and further stated that implementation of the program could not move forward unless appropriate funding was secured from nonprofit philanthropic entities.

Program participants are required to undergo a six-month orientation program approved by MBC that addresses medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices and pharmacology differences.

MBC received the necessary philanthropic funding in 2018 to initiate the program and began taking the necessary steps for implementation. As of April 2019, MBC began accepting applications for the Mexico Pilot Program. MBC received the required funding commitments necessary for program implementation in December 2020. MBC reports that as of September 2022, MBC had issued 21 licenses to qualified Mexico Pilot Program applicants. One qualified applicant asked MBC to delay issuing their license pending submittal of their visa applications. The Board anticipates approving a

cohort of eight additional applicants (for a total of 30, the maximum under the law) in spring 2023. Mexico Pilot Program physicians are authorized to practice in the following MBC-approved community health clinics: Clinica de Salud del Valle de Salinas in Monterey County; San Benito Health Foundation in San Benito County; Altura Centers for Health in Tulare County and; AltaMed Health Services Corporation

In August 2022, the Center for Reducing Health Disparities (CRHD) at the University of California, Davis released its first annual progress report of the Mexico Pilot Program. The initial report covers the two FYs of the Mexico Pilot Program's operations, FY 20/21 and 21/21 and includes baseline data results in three of the requisite categories. Per BPC Section 853 (j), the evaluation must include, but not be limited to:

- Quality of care provided by doctors and dentists licensed under this pilot program.
- Adaptability of these licensed practitioners to California medical and dental standards.
- Impact on working and administrative environment in nonprofit community health centers and impact on interpersonal relations with medical licensed counterparts in health centers.
- Response and approval by patients.
- Impact on cultural and linguistic services.
- Increases in medical encounters provided by participating practitioners to limited-English-speaking patient populations and increases in the number of limited-English-speaking patients seeking health care services from nonprofit community health centers.
- Recommendations on whether the program should be continued, expanded, altered, or terminated.

Discussions continue between the original sponsors of AB 1045 who remain supportive of the Mexico Pilot Program's goals, MBC staff, and CRHD representatives about what context and factors for capturing baseline data should be take into consideration in order to provide an effective evaluation.

BPC Section 853 (l) specifies, "Program applicants shall be responsible for working with the governments of Mexico and the United States in order to obtain the necessary three-year visa required for program participation." Representatives of the Mexico Pilot Program participants report to MBC and the Committees that they continue to face challenges in obtaining visas. While California statute and MBC cannot control for decisions at the federal level, they have requested that the Act be amended to require MBC to issue a license to an applicant who would otherwise be eligible for the Mexico Pilot Program but are precluded from applying because they are not able to provide an individual taxpayer identification number or social security which MBC requires for all physician and surgeon

applications. While providing a license, the proposal would prohibit an applicant from engaging in the practice of medicine until they provide an individual taxpayer identification number or social security number to MBC once they have an approved visa and those have been issued.

Staff Recommendation: ***MBC should advise the Committees of any statutory changes necessary to the Act and comments about the proposal from Mexico Pilot Program participants and supporters.***

MBC ENFORCEMENT ISSUES

ISSUE #9: (MANDATORY REPORTING.) MBC receives reports related to physicians from a variety of sources. These reports are critical tools that ensure MBC maintains awareness about its licensees and provide important information about licensee activity that may warrant further MBC investigation. Is current law sufficient regarding mandatory reporting of physician practice and conduct by health facilities to the Medical Board of California?

Background: There are a significant number of reporting requirements outlined in BPC designed to inform MBC about possible matters for investigation. MBC includes information in its Newsletter regarding mandatory reporting, conducts presentations regarding requirements for reporting and posts information on its website regarding the submission of required reports. For a detailed listing of these requirements, please refer to the staff-prepared background paper for the 2021 review of MBC available at the following link: 2021 MBC Background Paper.

MBC reports that while many of these sources for mandatory reports appear to be complying with their respective reporting requirements, it is not possible to verify whether MBC is receiving all reports required by law. MBC notes in its 2023 Sunset Report that it has heard anecdotally that licensees may be avoiding settlement reporting requirements by manipulating how payments are split between their insurance company and the physician. With regard to the reports required by court clerks, coroners, and healthcare facilities, MBC intends to conduct outreach and provide regular reminders of their reporting requirements to help ensure that the required reports are submitted in a timely manner.

MBC requested in its January 2022 letter to the Legislature and 2023 Sunset Report that updates be made, including:

- Amend BPC Section 805.8 to clarify that "wellness committees," medical groups, health insurance providers, health care service plan providers, and locum tenens agencies are required to report complaints of alleged sexual misconduct to MBC, or other appropriate licensing agency

- Require any organization that employs or contracts with a physician to report any discipline imposed, or change in contracted services, with a physician due to a medical disciplinary cause or reason.

Staff Recommendation: ***MBC should provide an update on the potential patient safety benefit these changes may result in. The Committees may wish to amend the Act to provide MBC additional information about licensees.***

ISSUE #10: (EVIDENTIARY STANDARD.) MBC is held to a burden of proof standard in its disciplinary cases that it states is higher than what is required in the vast majority of states and other jurisdictions. Should the MBC evidentiary standard be updated from "clear and convincing" to "preponderance of evidence"?

Background: MBC reports, "In order to successfully prosecute a physician for unprofessional conduct, California case law currently requires the Board to meet a higher burden of proof than most other jurisdictions throughout the nation. As a result, investigations in this state are needlessly more time consuming and costly."

According to MBC, "the Board is at a significant disadvantage, in comparison to most other medical boards, when attempting to investigate and prosecute a licensee suspected of failing to properly care for their patients or otherwise act in an unprofessional manner. Prior to taking disciplinary action, the Board must first investigate to gather evidence sufficient to prove that discipline is appropriate and necessary. Discipline is tailored to the facts and circumstances of each case and, generally, may include public reprimands, probation, suspension, or revocation. The Board is required, under current case law (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856), to obtain 'clear and convincing proof to a reasonable certainty.' This is a higher burden of proof than in 41 other jurisdictions throughout the U.S. states and territories, which generally apply a 'preponderance of evidence' standard. As a result, California is out of step with most other jurisdictions, making it more difficult, time consuming, and expensive to prosecute instances of unprofessional conduct in this state."

MBC writes that "The 'clear and convincing' standard requires less evidence than the 'beyond a reasonable doubt' standard which is used in criminal prosecutions, but is higher than 'preponderance of evidence,' which is also used in civil litigation and is defined typically as 'evidence that shows it is more likely than not that a fact is true.'"

Staff Recommendation: ***MBC should provide the Committees an update on discussions with partners in its disciplinary process, including HQIU, OAG, and others about transitioning to a new standard. The Committees should evaluate the feasibility and merit of making this change to apply a preponderance of evidence standard, and whether a clear and convincing standard should always be applied to cases resulting in significant patient harm that would be the cause for license revocation.***

ISSUE #11: (NOTICE OF SUBSEQUENT ARRESTS.) Does the Act need to be amended to ensure MBC is receiving timely information about licensees?

Background: Among other provisions, Penal Code section 11105.2 requires the California DOJ to notify MBC when a licensee is arrested or convicted for state (within California) and federal (outside California) criminal activity. MBC currently receives the subsequent arrest and conviction reports for state, but not for federal arrests and convictions. DOJ and MBC have been collaborating to ensure that MBC can receive subsequent federal arrest and conviction reports through the FBI-administered program. MBC has requested that the Act be amended to authorize MBC to receive this information.

Staff Recommendation: ***MBC should update the Committees on this effort, the impact to MBC enforcement work anticipated through receipt of this additional information, and what steps are necessary for MBC to receive important information about its licensees.***

ISSUE #12: (LETTER OF ADVICE.) At MBC's request, SB 806 included authority for MBC to issue an administrative confidential letter of advice to a licensee to resolve a complaint for an alleged minor violation of the Act that is not related to patient care. MBC believes this language is too restrictive and would like additional authority.

Background: SB 806 authorized MBC to delegate to its Executive Director, the ability to issue a confidential letter of advice to a physician alleged to have committed a minor violation of the law unrelated to patient care. According to MBC, these letters may include a requirement to take educational courses that further a licensee's knowledge of certain areas of their practice. MBC states that these letters are intended to encourage quick, non-adversarial resolution of issues of minor concern, while providing a meaningful opportunity to correct practice issues before they become significant. MBC continues to request broader authority to issue these letters by allowing for their use related to violations that are not related to a licensee's fitness to practice, rather than violation unrelated to patient care.

Staff Recommendation: ***Substituting a robust enforcement process for issuance of a letter by MBC staff was the source of concern throughout MBC's prior sunset review oversight and led to the limitation on use of this tool. MBC should provide redacted examples of the types of enforcement cases it believes this letter should be utilized for and should provide justification as to how this benefits patients and the public.***

ISSUE #13: (ACCESS TO PERSONAL INFORMATION CONTAINED IN ENFORCEMENT FILES.) Should MBC be authorized to provide consumers a copy of their medical records obtained during an investigation?

Background: The law generally provides that the MBC's enforcement files (including records and data gathered during an investigation) are confidential and may not be released to the public unless and until such information is made public, such as through the filing of an accusation. MBC states that

from time-to-time, it receives requests from consumers seeking a copy of their medical records, and related personal information, that MBC obtains during an investigation. MBC produces copies of documents exchanged between the consumer and MBC, but does not share documents MBC obtained from other sources as part of an investigation. MBC says that consumers may have difficulty determining whether the records a person received from their provider are different from what their provider shared with MBC or in a civil action. As such, MBC requests that BPC Section 800 be amended to enable MBC to provide a certified copy of someone's records that MBC obtained during an investigation.

Staff Recommendation: ***Particularly given MBC's fiscal concerns, MBC should provide additional information about the increased workload this change could result in and its goals if granted this authority. MBC should explain what impact this might have on various proceedings and the rationale that led to this request, for example, if MBC is aware of altered patient records that affect the individual's care and well-being.***

ISSUE #14: (TIMEFRAME TO REQUEST PROBATION MODIFICATION.) MBC believes its resources and time are potentially inefficient in processing multiple requests for licensure reinstatement or probation modification after MBC has already imposed discipline. Should the timeframes be adjusted?

Background: BPC Section 2307 authorizes a licensee, whose certificate has been surrendered while the individuals is under investigation or while charges are pending, or whose certificate has been revoked or suspended or placed on probation, to petition MBC for reinstatement, or to modify a penalty imposed, including modifying or terminating probation. The individual is bound to certain time limits, including:

- At least three years for licensure reinstatement of a license surrendered or revoked for unprofessional conduct, except that MBC may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

- At least two years for early termination of probation of three years or more.

- At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

Between July 1, 2013, and June 30, 2022, MBC has granted only 37 percent of the petitions requesting reinstatement of a physician's license (during this time period, there were outcomes for 161 petitions, with 59 granted). MBC reports that in FY 19/20, the most recent year with no pending petitions, MBC granted approximately 58 percent of the petitions for termination of probation and denied all of the petitions for modification for probation.

Considering the low petition approval rate and very high costs associated with these requests, MBC requests amending BPC Section 2307 to lengthen the time someone who is disciplined can again request modifications. Specifically, MBC would like to ensure that only after five years someone can seek reinstatement, and would like to eliminate the option to petition after one year if the license was revoked or surrendered due to mental or physical illness impacting patient safety. For licensees on probation, MBC would like to amend the Act so that after two years or after more than half of their probation term has elapsed, whichever is greater, a licensee may seek early termination of probation. MBC believes that a petition for early termination of probation should be rejected automatically if MBC files its own petition to revoke that licensee's probation. MBC wants to also extend the timeframe for repeat petitions and have authorization to deny, without a hearing or argument, a petition filed within three years of the date of a decision related to a prior petition for that same licensee.

Staff Recommendation: ***The Committees may wish to amend the Act to ensure that its resources and time are not expended on proceedings that may not change a particular prior disciplinary outcome.***

ISSUE #15: (ENFORCEMENT ENHANCEMENTS.) MBC believes that various enhancements to the Act are necessary for MBC to ensure public protection and continues to request updates to the Act accordingly.

Background: Amendments to the Act may assist MBC in its ability to take swift disciplinary action when necessary and warranted. MBC has requested many of the same updates to the Act dating back to its two prior sunset review oversight experiences, and through its January 2022 letter to the Legislature, that are now contained in its 2023 Sunset Report.

> *Additional inspection authority and records review.* MBC is authorized to conduct inspections and review medical records in the office of a licensee, but subject to such severe limitations that MBC reports that these inspections and records review are virtually meaningless and ineffective. MBC proposes updating the Act to enable qualified and properly trained investigators with the CIO and with the HQIU, along with medical consultants when desired, to conduct inspections and review patient medical records of licensed medical professionals in their professional office. The proposal would enable CIO and HQIU investigators and medical consultants to view the records of specific patients to assist in targeting, with greater precision, the information sought in an investigative subpoena. MBC believes this review would greatly strengthen its position in subpoena enforcement actions, wherein MBC is required to establish good cause to believe that misconduct has occurred, sufficient to overcome a patient's right to privacy.
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> MBC believes that this enhanced inspection authority would also assist in determining whether necessary in-house processes at the office or facility where an incident occurred were capable of being performed safely when patient treatment may be the subject of an investigation. MBC says that investigators will be able to observe, for example, whether crash carts and other equipment expected to be found in an OSS or medical office are present and in good working

order. MBC believes that early on-premise investigation will also help investigators to quickly determine whether further investigation is warranted. In certain cases, MBC states that a draft investigation report could be provided to an MBC medical consultant for further assessment, and could result in earlier closure of meritless complaints or cases where there is insufficient evidence to prove a case by clear and convincing evidence.

MBC's proposed legislation is similar to that in Government Code section 12528.1, enacted in 2005, which permits the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) to conduct inspections of Medi-Cal providers for the underlying purpose of carrying out the investigation and enforcement duties of the BMFEA.

BPC section 2225(a) limits any in office review of records to those that pertain to patients who have complained to MBC. Given that limitation, in most cases investigators will simply request a copy of the records pursuant to a release signed by the patient, rather than inspecting the records in the office of the licensee. To make MBC's inspection authority more meaningful, and, in particular, to assist investigators in developing good cause to support a subpoena for the records of uncooperative patients, MBC seeks to amend this section of law to allow records to be reviewed.

Obtaining pharmacy records in a timely manner. HQIU and MBC staff may experience months-long delays obtaining pharmacy records, as the law does not provide a clear and definite timeframe for pharmacies to turn over their records to investigators. BPC Section 4081 requires a pharmacy to maintain various records for a period of at least three years and make them available for inspection to authorized officers of the law within business hours. BPC Section 4332 states that any person who fails, upon request by an authorized person, to produce or provide pharmacy records within "a reasonable time" is guilty of a misdemeanor. MBC investigators indicate that a reasonable time standard is vague and difficult to enforce, sometimes leading to a lengthy delay to receive necessary records. MBC believes that BPC section 4081 should be amended to include a time-bound deadline so that its investigators may obtain pharmacy records without needless delays.

Rescinded medical records release. According to the HQIU, some physicians under investigation have asked their patients to rescind their consent to release their medical records to HQIU investigators. Although the frequency of this is not tracked, HQIU staff suspect this has happened on numerous occasions. Without quick access to medical records, an investigation can be delayed; likely increasing enforcement timeframes, and possibly increasing costs if the legal action is required to pursue enforcement of a subpoena.

Pursuant to Business and Professions Code (BPC) section 2220.7, a physician is prohibited from including in a civil settlement agreement with a patient or other party any provision that prohibits anyone from contacting or cooperating with MBC, filing a complaint with MBC, or withdrawing a complaint previously filed with MBC. Further, Penal Code section 136.1 states that it is a crime for anyone to knowingly and maliciously prevent or dissuade (or attempt to)

any witness or victim from attending or giving testimony at any trial, proceeding, or inquiry authorized by law.

While the above code sections may address other behavior that impedes a government investigation or prosecution, current law does not state that it is unprofessional conduct for a licensee or their representative to ask an individual to rescind a release for medical records or otherwise not cooperate with a MBC investigation and prosecution. MBC would like the Act to be updated to discourage this behavior by making it unprofessional conduct for a licensee, or person acting on their behalf, to take any action intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to MBC or HQIU.

Participation in an interview. Current law requires MBC licensees to attend and participate in an interview requested by MBC when that licensee is under investigation. Failure to participate "in the absence of good cause" is considered unprofessional conduct and could result in discipline. MBC reports that allowing interviews to be postponed for "good cause" is subject to abuse, which leads, in some instances, to unacceptably long delays in the investigation. MBC again requests that the Act be amended to require a licensee to participate in an interview no later than 30 calendar days after being notified by MBC.

Exchange of expert witness testimony. The use of expert testimony is foundational in disciplinary proceedings. Experts retained MBC and retained by licensees under investigation may conflict with one another, which may lead to a hearing before an ALJ. BPC section 2334 requires MBC and counsel for the licensee to exchange expert opinions, and related information, no later than 30 calendar days prior to the originally scheduled hearing date. MBC has advised that this timeframe puts MBC at a disadvantage and has long requested that the Act be amended to require the exchange of this information no later than 90 calendar days prior to the original hearing date instead. MBC believes this change will support the timely resolution of cases by requiring an earlier exchange of expert opinions, which can result in productive settlement negotiations or provide grounds for an accusation being withdrawn. MBC notes that an earlier exchange of expert reports is also expected to reduce the number of delayed hearings.

Statutes of limitations. Under current law, when a licensee refuses to produce medical records pursuant to a lawfully- issued and patient-noticed investigative subpoena, MBC is required to litigate a petition for subpoena enforcement in superior court. BPC section 2225.5(b)(1) currently reads:

> (b)(1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of

an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

MBC reports that during this often-lengthy process, the statute of limitations continues to run on the stalled underlying investigation of the subject. The statute does not begin to toll unless and until the licensee fails to produce the subpoenaed records by the deadline set by the court, after granting MBC's enforcement petition. Moreover, MBC says the delay to the process is compounded because MBC's subpoena enforcement matters are not entitled to be given priority by the courts. As a result, licensees and their counsel have every incentive to draw out the subpoena enforcement litigation, thereby delaying the production of needed evidence in the underlying investigation. Case law allows physicians to argue on behalf of the patient's privacy interests even though, as MBC notes, there is misalignment, and outright conflict, with the MBC public protection interests. Even when MBC proceeds at the quickest pace possible to obtain a superior court order compelling production, investigations are often severely delayed while MBC litigates subpoena enforcement matters, sometimes leaving very little time to fully develop an investigation, obtain expert review of the subpoenaed records, and draft and file an accusation. As an example, in the past four fiscal years, the DOJ, Civil Division, Health Quality Enforcement Section has filed 24 subpoena matters in superior court on behalf MBC, and eight of those matters have gone up on appeal. MBC notes that while the number of subpoena enforcement cases relative to the total number of accusations filed in a fiscal year is small, the time and expense is great.

MBC believes that for the purposes of public protection and for evidence and resource preservation, the date of the superior court's issuance of the order to show cause would be an appropriate time to toll the statute of limitations. MBC would still have a strong incentive to promptly bring its subpoena enforcement actions, but having brought such an action, any delays in the litigation would not benefit either party, and the respondent licensee will not be able to use the subpoena enforcement action to their advantage to try to run out the statute of limitations.

Patient records retention. Physicians and surgeons are bound by laws related to maintaining adequate and accurate records relating about the services they provide to patients (patient records). Physicians and surgeons have to maintain records for a length of time that corresponds to the standard of care, which of course may vary depending upon the services rendered, rather than for a timeframe specified in the Act. As previously noted, the statute of limitations generally requires MBC to file an accusation against a licensee within three years after MBC becomes aware of the alleged act or omission, or seven years from when the alleged act or omission occurred, whichever is sooner. MBC believes that aligning the minimum timeframe to maintain records to the general statutes of limitation will help ensure records are available, if necessary, to support an investigation. MBC requests that the Act be amended to require records to be maintained for at least seven years after the last date of service to a patient.

Staff Recommendation: ***The Committees may wish to amend the Act to ensure MBC has the necessary tools to take swift action.***

ISSUE # 16: (ENFORCEMENT MONITOR.) SB 806 required an independent enforcement monitor to review MBC enforcement processes, an effort previously undertaken 20 years ago. What were the findings from the preliminary report?

Background: MBC enforcement processes have long been a source of particular interest to the Committees and Legislature.

SB 806 mandated that the DCA Director appoint an independent enforcement monitor who has not previously been employed by, under contract with, in any financial relationship with, or affiliated with an organization that represents patient or physician and surgeon interests, including, but not limited to, a professional association, lobbyist employer, advocacy organization, or party that has appeared before the board or the Legislature. The enforcement monitor was tasked with monitoring and evaluating MBC's enforcement efforts with specific concentration on the handling and processing of complaints and timely application of sanctions or discipline imposed on licensees and persons in order to protect the public. The 2023 Preliminary Monitor Report offered four main findings, many of which have been previously discussed through various sunset review oversight efforts and other steps aimed at increasing MBC efficiency and accountability:

1. **Inadequate investigator workforce staffing, resulting in case delays, disruptions, and inconsistent investigations.** The monitor found what has previously been cited as a historic challenge with MBC enforcement efficiency, that HQIU faces high vacancy and staff turnover rates. The 2023 Preliminary Monitor Report notes, "Based on the monitor's inquiry with staff members, the high vacancy and turnover rate has caused delays in case completion; created disruption among investigators in managing open caseloads; and affected the quality of investigations. Additionally, the high volume of workload has reduced staff morale, leading to continued staff turnover…Due to the complexity and level of effort required to perform the processes identified, a viable and sustainable workforce with nominal turnover must be maintained. The monitor recommends increasing medical enforcement investigator compensation rates to a level equivalent to that of their counterparts with similar workloads at the Department of Justice. Additionally, the caseload assignment process should be enhanced so that the highest priority of standard of care allegations (resulting in the highest risk to public protection) are assigned to sworn investigators, while the lower priority cases (resulting in lower risk to public protection) are assigned to nonsworn staff members. Doing so will help reduce current caseload assignments to a manageable level."

2. **Lack of structured collaboration between HQIU and HQE during investigation and administrative action phases.** The monitor discussed collaboration in the enforcement process. Following the 2004 release of the previously statutorily mandated enforcement program monitor report, MBC implemented a vertical prosecution model, or MBC's Vertical

Enforcement Prosecution (VE). VE required DAGs to be involved in MBC's investigation activities as well as its prosecution activities (DAGs serve as the attorneys of record to DCA licensing boards and are responsible for initiating and taking legal steps for administrative disciplinary action against the holder of a professional license). Through VE, DAGs and HQIU investigators were jointly assigned to an investigation from the outset. This team approach was intended to encourage early coordination and faster decisions, filings, and results given that true VE allows a prosecutor to learn a case as it is being built and in theory allows the DAG to assist in securing medical records, physician interviews, select expert witness and other critical elements of a successful case.

VE differed from the process used by other boards within DCA – other boards typically conduct investigations with their own enforcement staff or DOI and then forward those investigations and cases to DAGs for appropriate administrative filings. The initial report of the previous monitor called for MBC investigators to transfer from MBC to OAG's Health Quality Enforcement (HQE) section, which prosecutes MBC cases.

Despite VE and other enhancements, MBC's enforcement activities were still called into question during prior reviews of MBC. MBC was seen as continuing to fail to aggressively investigate and pursue actions against dangerous physicians. In response, SB 304 of 2013 again proposed the transfer of MBC investigators to HQE but ultimately required MBC to instead transfer its investigators to DCA's DOI, establishing the framework for the current HQIU. DOI and OAG worked to establish formal policies and procedures for VE following the transfer of investigators to DOI as of July 1, 2014. In July 2015, the VE Prosecution Protocol manual was formalized, providing guidelines for staff members conducting investigations and strategies to resolve disagreements between investigators and HQE DAGs. The manual also outlined cooperation and communication expectations between the two offices. According to internal surveys conducted among investigators within HQIU, many investigators resented any implication that their work required supervision or control by OAG attorneys. Claims of low morale within HQIU were generally supported by persistent vacancy rates and high turnover. The manual emphasized collaboration and conflict resolution between HQIU and HQE, stemming from strained personnel issues between the two offices. The manual sought to address disagreements by providing clarified definitions regarding the roles of each office and the expected amounts of direction and supervision HQE should provide HQIU. For example, the manual included a clarification that DAGs directed investigations but not the investigators themselves.

The initial intent and structure of the VE model did not appear to be upheld, as cases were being conducted with the "handoff method". The entire purpose of the VE model was to eliminate this handoff method by aligning investigators and legal staff to handle cases together, instead of the traditional route of investigator gathering information and "handing" the case off to legal staff. With high levels of staff turnover in HQIU and shifting assignments in HQE, cases were not handled by the same investigator and same DAG from start to finish.

A March 2016 MBC report on VE showed that MBC spent $18.6 million to implement the program and provided statistical data showing that the average investigation timeframe increased.

In 2019, statutory requirements for VE were repealed pursuant to SB 798. According to the 2023 Preliminary Monitor Report:

> "Medical standards of care cases are complex, multi-faceted and unique to each investigation and subsequent accusation phase(s). The investigation and subsequent administrative actions are inextricably linked; what occurs (or doesn't occur) in an investigation directly influences the subsequent "actionable" events. Consequently, to achieve efficient, effective and intended outcomes in these sequenced processes using distinct professional disciplines require collaborative engagement among all affected parties and entities throughout the investigation process.
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> The elimination of a formal collaboration process has decreased investigator and prosecutor productivity and efficiency. That is, when a completed investigation is submitted to HQE for accusation, the attorneys are seeing the case for the first time without any knowledge of investigative actions taken. That shortcoming decreases HQE attorney efficiency and effectiveness, thus diminishing their initial understanding of the case. Completed investigations are transmitted to HQE for legal review. When transmittals are missing investigative actions or relevant and/ or material evidence, HQE's ability to meet its filing burden is impacted. When evidence is lacking, cases are rejected or returned for supplemental investigation in order to obtain evidence that would allow HQE to accept the matter for prosecution and recommend the filing of a disciplinary matter. The monitor's analysis disclosed that the number of cases rejected and returned for supplemental investigation has increased since the elimination of VE.
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> The monitor recommends restoration of a more structured collaboration approach between HQIU and HQE, by implementing best practices for investigative and prosecutorial case management. The collaborative process could be developed by instituting a pilot program that partners HQIU and HQE offices in northern and southern parts of the state…This pilot program will build a strong working relationship between HQIU and HQE staff based on trust, which is the key ingredient for successful collaboration between the two organizations…"

3. **Shortage of specialized medical experts.** Long a challenge faced by MBC, the 2023 Preliminary Monitor Report further confirmed "an ongoing shortage of experts in certain medical specialties…The monitor encourages MBC to conduct a medical expert compensation rate study to determine the level of compensation needed to help hire and retain qualified medical experts. The monitor also recommends development of an outreach program to recruit specialized medical providers capable of presenting recruitment job fairs combined with outreach programs that would involve medical organizations, associations, societies, schools

and other applicable entities. The monitor found that a significant number of medical experts are "restricted," a term that designates medical experts who need further guidance before they can be authorized to perform medical expert services, or a complaint has been filed with the board against the expert…"

4. **Lack of sufficient funding for MBC program operations.** The 2023 Preliminary Monitor Report confirmed what MBC and the Committees have raised for the past number of years; current revenue is not adequate to support MBC operations. According to the 2023 Preliminary Monitor Report, "Over the past four (4) fiscal years, expenses increased 15.7%, or at an annualized rate of 3.9%. Many of these increases, such as employee salaries and benefits and billable rates for services by HQIU, OAG and OAH, are outside the control of MBC…If [revenue] increases do not fully materialize, additional loans and/ or significant reductions in program operations will be implemented. To overcome the structural funding imbalance, the monitor recommends establishing a licensee fee-funding model with automatic periodic adjustments tied to a recognized monetary barometer, such as the Consumer Price Index (CPI) or similar index. The mechanism for implementing such adjustments should be studied by MBC with participation from its key stakeholders, then proposed for legislative approval."

Staff Recommendation: ***The Committees should explore options for reform to MBC processes and should continue to track the monitor's work. The Committees may wish to explore potential improvements to enforcement outcomes that could be gained if MBC investigators are again housed at MBC. The Committees may wish to review whether MBC cases should continue to be prosecuted by OAG or if an alternative path exists.***

TECHNICAL CHANGES

ISSUE #17: (TECHNICAL CHANGES MAY IMPROVE EFFECTIVENESS OF THE MEDICAL PRACTICE ACT AND MBC OPERATIONS.) There are amendments to the Act that are technical in nature but may improve MBC operations and the enforcement of the Medical Practice Act.

Background: There are instances in the Medical Practice Act where technical clarifications may improve MBC operations and application of the statutes governing MBC's work.

Staff Recommendation: ***The Committees may wish to amend the Act to include technical clarifications.***

CONTINUED REGULATION OF PHYSICIANS AND SURGEONS AND VARIOUS OTHER HEALTH PROFESSIONALS BY THE MEDICAL BOARD OF CALIFORNIA

ISSUE #18: (CONTINUED REGULATION BY MEDICAL BOARD OF CALIFORNIA.) Should the licensing and regulation of physicians and surgeons and other allied health professionals be continued and be regulated by the current MBC membership?

Background: Patients and the public are best protected by a strong regulatory board with oversight for physicians and surgeons and associated allied professions. Physicians remain among the most highly trusted professions, as demonstrated in national patient surveys, and millions of Californians receive quality care from MBC licensees every day. While the percentage of licensees who are subject to formal discipline is small in comparison to the large number of licensees, the cost to patients and the public is incredibly high when MBC enforcement stalls. Balancing swift, patient-centered action with appropriate due process that all licensees must be afforded remains key to ensure MBC does its job. An evaluation of the alternatives to status quo must take place in order to promote patients and the public when determining necessary reforms to the Act and MBC operations.

Staff Recommendation: ***The MBC should be continued, and reviewed again on a future date to be determined.***