

SUNSET REVIEW: EVALUATION OF THE STATE BOARD OF PHYSICIANS AND ALLIED HEALTH ADVISORY COMMITTEES



DEPARTMENT OF LEGISLATIVE SERVICES DECEMBER 2016

Sunset Review: Evaluation of the State Board of Physicians and Allied Health Advisory Committees

**Department of Legislative Services
Office of Policy Analysis
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December 2016

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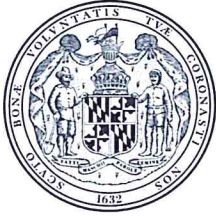
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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

Warren G. Deschenaux
Executive Director

December 1, 2016

The Honorable Thomas V. Mike Miller, Jr.
The Honorable Michael E. Busch
Honorable Members of the General Assembly

Ladies and Gentlemen:

The Department of Legislative Services (DLS) has completed its evaluation of the State Board of Physicians (MBP) as required by the Maryland Program Evaluation Act. This evaluation process is more commonly known as “sunset review” because the agencies subject to evaluation are usually subject to termination; typically, legislative action must be taken to reauthorize them. This report was prepared to assist the committees designated to review the board – the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee – in making their recommendations to the full General Assembly. The board is scheduled to terminate July 1, 2018.

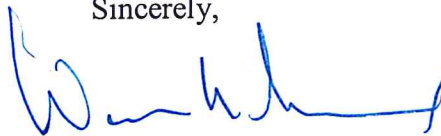
DLS finds that the board generally fulfills its stated mission to protect the public by effectively regulating physicians and allied health professionals. The board has made significant progress and addressed most of the issues from the previous sunset evaluation in 2011. Specifically, the board has improved its licensing process and eliminated the complaint backlog. The board has also implemented a two-panel disciplinary system and continues to process complaints with no backlog. However, as the two-panel system has been fully operational for only two years, DLS could not evaluate the long-term efficacy of the new system. Further, implementation of criminal history records checks was initially delayed; thus, DLS could not evaluate the effect of this requirement on the board or licensees. Finally, some issues from the 2011 sunset evaluation continue to linger, such as licensing fees and compliance with the Open Meetings Act.

DLS recommends that the General Assembly extend the termination dates of MBP and its allied health advisory committees for an additional five years. Further, the scope of the next sunset evaluation should be limited to (1) the implementation of recommendations made in this report; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the board and licensees. DLS also recommends that MBP include certain additional information in follow-up reports. Draft legislation to implement the recommended statutory changes is included as an appendix to this report.

The Honorable Thomas V. Mike Miller, Jr.
The Honorable Michael E. Busch
Honorable Members of the General Assembly
December 1, 2016
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We would like to acknowledge the cooperation and assistance provided by the board and the Department of Health and Mental Hygiene throughout the review process. MBP was provided a draft copy of the report for factual review and comment prior to its publication; written comments from MBP are included as an appendix to this report.

Sincerely,



Warren G. Deschenaux
Executive Director

WGD/JBC/mlm

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Executive Summary

Pursuant to the Maryland Program Evaluation Act, the Department of Legislative Services (DLS) has evaluated the State Board of Physicians (MBP), which is scheduled to terminate July 1, 2018. DLS finds that the board generally fulfills its stated mission to protect the public by effectively regulating physicians and allied health professionals. Further, board members and staff are dedicated and highly cognizant of MBP's mission. The board has made significant progress and addressed most of the issues identified in the 2011 sunset evaluation.

However, due to relatively recent implementation, DLS was unable to fully evaluate some key changes, specifically the board's two-panel disciplinary system and the impact of criminal history records checks (CHRCs) on the board and licensees. Additionally, DLS finds that the board could continue to improve certain aspects of its operations and that some issues identified in the 2011 sunset evaluation remain. Based on these findings, DLS recommends extending the termination date for MBP and the related allied health advisory committees by five years (until July 1, 2023). This report presents DLS' findings and a total of 19 recommendations, summarized below.

Licensing is a core function of MBP. The board licenses physicians and 10 allied health professions. The board aims to issue licenses to 95% of qualified applicants within 10 days of receipt of the last qualifying document. The board generally meets this goal for physicians, but not for allied health professionals. The board attributes this to database issues, staffing issues, and the increase in the number of allied health professions licensed by MBP.

Recommendation 1: The board should work to improve the administrative process for issuing licenses promptly, especially for allied health professionals, and report on efforts to meet the 10-day goal in a follow-up report to the General Assembly.

The 2011 sunset evaluation of MBP recommended that the board amend its regulations to reflect the fees charged by the board. In this evaluation, DLS found that the board's regulations still do not reflect the current fees charged for physicians and continue to list a separate rehabilitation program fee for physicians and physician assistants, even though this separate fee was repealed in statute. Fees listed on the board's website also do not match fees currently charged or authorized in regulations.

Recommendation 2: MBP should amend its regulations and update its website to accurately reflect current fees.

In 2014, MBP revised regulations to remove the late renewal process for physicians and require instead that physicians apply for reinstatement after the renewal period. Statute authorizes MBP to fine physicians who fail to renew their licenses but continue to practice medicine; however, this authority does not apply if the physician applies for renewal within 60 days after the license expires. In fiscal 2015, the board inappropriately fined physicians who applied for reinstatement within 60 days of license expiration. During the evaluation process, DLS informed the board about this issue; the board promptly rescinded the orders and refunded the collected fines.

Recommendation 3: The board should reestablish a late renewal process that would be available to physicians for a 60-day period after the license expiration date rather than requiring them to use the reinstatement process. Statute should be amended to clarify that a physician has 60 days after the license expiration date in order to renew the license.

Pursuant to Chapter 34 of 2015, effective July 1, 2015, applicants for initial licensure must submit to a CHRC as a qualification for initial licensure; effective October 1, 2016, licensees applying for renewal or reinstatement must submit to a CHRC. Despite these statutory requirements, the board has been issuing initial licenses since July 1, 2015, without the required CHRC. The board only began requiring CHRCs for initial licenses on October 1, 2016 – the same effective date as the requirement for renewal and reinstatement. The board attributes this delay to personnel shortages and delayed authorization and availability of the federal “rap back” subscription service. Since implementation of CHRCs only began on October 1, 2016, and the volume of CHRCs will peak in fiscal 2018 and 2019 (when licensees renew), the full impact of the CHRC process on MBP operations and licensees will not be known until fiscal 2019.

Recommendation 4: Statute should be amended to require MBP to submit an annual report on the results of CHRCs and related implementation. Specifically, MBP should be required to report the following information for physicians and allied health professionals: (1) the number of initial and renewal licenses issued; (2) the number of positive and negative CHRC results received; (3) the number of individuals denied initial or renewal licensure due to positive CHRC results; and (4) the number of individuals denied

licensure due to reasons other than a positive CHRC. Further, MBP should include in the fiscal 2019 CHRC report information regarding whether CHRCs are causing licensure delays, whether existing staff are able to manage the CHRC workload, and any other concerns with the CHRC process.

Although statute prohibits MBP from renewing or reinstating a license if the CHRC “has not been received,” the board must also consider specified factors in determining whether to renew or reinstate a license. The board interprets the latter provision as prohibiting the board from renewing or reinstating licenses without considering the specified factors. The board expressed concern that this will interfere with the board’s current automatic online renewal process and cause licensure delays, as the board must investigate positive CHRC results before making a determination to renew or deny a license.

Recommendation 5: Given MBP’s concerns about the timing of receipt and investigation of CHRC results on the renewal process, statute should be amended to clarify that the listed factors are to be considered by the board when determining whether to take disciplinary action based on the results of CHRCs against a licensee who renewed or reinstated the license.

MBP reviews and approves delegation agreements between physicians and physician assistants (PAs). Representatives from PA groups expressed frustration to DLS that the board is taking too long to review delegation agreements between a physician and a PA when the agreement involves only core duties, which prevents PAs from assuming those duties in a timely manner.

Recommendation 6: The board, in consultation with the Physician Assistant Advisory Committee, should study ways to expedite the process for PAs to assume the duties under a delegation agreement and report their findings and recommendations in a follow-up report.

Complaint resolution is another core function of MBP. Nationally, state medical boards are under scrutiny for how they handle disciplinary cases – particularly cases involving sexual misconduct – and whether they offer sufficient transparency to the public. Although MBP maintains detailed practitioner profiles for each licensee with summaries of charges and board actions, DLS found that cases involving sexual misconduct can be difficult to identify, as order summaries posted on licensee profiles sometimes do not reference the board’s sexual misconduct regulations or the grounds the licensee violated; even if grounds are referenced, a description of the underlying sexual misconduct may be absent from the summaries. Although the details of each case can be ascertained by reviewing the full board order, these documents are often lengthy and complex.

Recommendation 7: The board should ensure that the sexual misconduct regulations are referenced in the order summaries in cases where the licensee was specifically found to have violated them. Additionally, the board should comment in a follow-up report on the feasibility of describing the underlying sexual misconduct in order summaries or other steps that the board can take to make it easier for the public to determine whether a case involved sexual misconduct.

Statute requires all health occupations boards to submit a statistical report to the Secretary of Health and Mental Hygiene

regarding the number of sexual misconduct complaints received and the resolution of each complaint. The Department of Health and Mental Hygiene (DHMH) compiles this information into an annual report for the General Assembly. However, since statute does not mandate any specific reporting measures, the reports submitted by DHMH are somewhat vague. For example, according to these reports, most sexual misconduct complaints received by MBP resulted in “other actions,” but the reports contained no additional detail as to what these “other actions” involved.

Recommendation 8: Statute should be amended to require that sexual misconduct reports specify for each health occupations board (1) the total number of sexual misconduct complaints received; (2) the number of practitioners and complainants involved in the complaints; (3) the number of complaints still under investigation; (4) the number of complaints that were closed with no disciplinary action; (5) the number of complaints that resulted in informal or nonpublic action; (6) the number of complaints resulting in denials of licensure, reprimands, probations, suspensions, and revocations; (7) the number of complaints that were referred to the Office of the Attorney General for prosecutorial action; (8) the number of complaints that were forwarded to law enforcement for possible criminal prosecution; and (9) if other actions were taken, a detailed breakdown of the types of action.

Although MBP adopted a two-panel disciplinary system, statute requires certain disciplinary proceedings to be considered by the full board. The full board only meets in person four times per year; thus, at the beginning of each panel meeting, the other

panel must call in to act on these cases, which sometimes leads to scheduling confusion and other issues. Shifting these cases to the panels may alleviate logistical delays; however, since the effectiveness and efficiency of the two-panel system has not been fully evaluated, DLS finds it premature to recommend such changes at this time.

Recommendation 9: The next sunset evaluation of MBP should examine the desirability of shifting proceedings involving the unauthorized practice of medicine, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders from the full board to the disciplinary panels.

After a panel is assigned a complaint, statute requires a disciplinary panel to refer “any allegation in the complaint” based on standard of care for two peer reviews. However, statute also requires complaints to be assigned after the completion of a preliminary investigation. The preliminary investigation may show that a standard of care allegation has no factual basis or that a different disciplinary ground is more appropriate. Thus, only those standard of care allegations that are substantiated or found to be appropriate after the preliminary investigation should be referred for peer review, rather than “any allegation in the complaint.”

Recommendation 10: Statute should be amended to clarify that the panel must refer a complaint for peer review if the panel decides, after reviewing the results of the preliminary investigation, that the licensee may have committed a standard of care violation.

Chapters 153 and 399 of 2014 added naturopathic doctors to the jurisdiction of the board (licensing began in March 2016).

However, the definition of “allied health professional” was not amended to include naturopathic doctors, nor were other changes made so that the board would be required to treat them the same as other allied health professionals during the complaint resolution process.

Recommendation 11: Statute should be amended to require that complaints against naturopathic doctors be handled in the same manner as complaints against other allied health professionals.

Unlicensed medical practitioners (UMPs) are medical students and medical graduates completing clinical training and postgraduate training, respectively. Statute authorizes UMPs to practice medicine without a license. The board adopted regulations in 1995 that authorize the board to take disciplinary action against UMPs in the same manner, and for the same disciplinary grounds, as licensed physicians. While the board rarely takes disciplinary action against UMPs, the board’s statutory authority for these regulations is unclear.

Recommendation 12: Statute should be amended to (1) distinguish between individuals who are truly excepted from licensure and UMPs and (2) explicitly allow the board to discipline UMPs in the same manner that applicants for licensure and licensees are disciplined.

Statute requires each hospital and related institution to report the number of denials or limitations on physician privileges and disciplinary actions taken against employed physicians or individuals in a postgraduate medical training program to MBP every six months; alternative health systems are required to report similar information. These entities must also submit a report to MBP within 10 days of any action taken.

Compliance with these reporting requirements has improved markedly since the 2011 sunset evaluation due to board outreach; new regulations also strengthen the board's ability to enforce the requirements. While the 10-day reports are helpful as they prompt timely investigations, the six-month reports are not useful and are confusing for reporting entities to complete.

Recommendation 13: Statute should be amended to repeal the six-month mandated reporting requirement.

The 2011 sunset evaluation found that, contrary to statutory requirements, a pool of administrative law judges (ALJs) had not been designated by the Office of Administrative Hearings (OAH) to hear cases referred by MBP and that MBP had provided only a few trainings to OAH. The report suggested that MBP may wish to work with OAH to assess further actions. The Chief Administrative Law Judge currently contends that a pool of judges for MBP cases is not necessary due to a variety of factors. Further, MBP and OAH participate in cross-training with each other and have regular meetings to discuss any issues.

Recommendation 14: Chapter 539 of 2007 should be amended to repeal the requirement that the Chief Administrative Law Judge designate a pool of ALJs to hear cases referred by MBP. Conversely, the requirement in Chapter 539 that MBP provide annual training to OAH should be codified. Also, MBP and OAH should update each other, as necessary, regarding developments and changes in procedures that affect the other entity and the efficiency of the complaint process.

During this evaluation, DLS identified some issues relating to MBP's fiscal condition that should be addressed in

follow-up reports. MBP has consistently maintained a healthy fund balance, with a projected fund balance of 55% of expenditures in fiscal 2017. Additionally, due to legislative changes, the board will contribute less toward the Maryland Loan Assistance Repayment Program (MLARP) and will no longer contribute toward the Health Personnel Shortage Incentive Grant Program (HPSIG) beginning in fiscal 2017, resulting in significantly more retained revenue. MBP has also improved its tracking of fiscal information for allied health professions; its new information technology system may also reduce costs. In light of these factors, an internal cost analysis is likely warranted, including a reassessment of fee schedules. Further, as the vacancy rate has increased since fiscal 2012, the board should comment on the issue of filling staff vacancies and the impact of vacancies on the board's fund balance.

Recommendation 15: The board should report revenues and expenditures by practitioner type in its annual reports required under § 14-205 of the Health Occupations Article, beginning with the fiscal 2017 annual report. Further, in fiscal 2018, the board should conduct an internal fiscal analysis and reassess its fee schedules. The board should submit a follow-up report to DLS by October 1, 2018, with the results of the internal fiscal analysis, including any possible changes to the board's fee schedules for physicians and allied health professionals. The board should specifically comment on the board's fund balance in light of the additional retained revenue from the MLARP and HPSIG changes, as well as the ongoing issue of filling staff vacancies and the impact filling these vacancies on the board's expenditures and fund balance.

DLS found that the board still needs to improve the transparency of board matters and operations. The 2011 sunset evaluation noted that the board violated the Open Meetings Act by discussing certain topics in the board's closed sessions. While board counsel has become more active in reviewing agendas to prevent violations of the Open Meetings Act, the issue still persists. Additionally, the board does not cite appropriate reasons for closing meetings when discussing nondisciplinary items.

Recommendation 16: To enhance compliance with the Open Meetings Act, if the board or a disciplinary panel begins to discuss a matter in closed session that violates the Act, board counsel should advise the board or disciplinary panel that it is violating the Act and the board or disciplinary panel should cease discussion. Also, the board or disciplinary panel should state other statutory exceptions for closing a meeting in the written statement when nondisciplinary items are on the agenda.

Board members and staff consistently state that the full board only meets four times per year; individuals outside of the board also made similar statements to DLS during the course of this evaluation. However, while the full board only meets *in person* 4 times per year, the full board actually meets 20 times per year, since one panel calls-in to the other panel's meeting to conduct full-board business – including nondisciplinary items. These meetings are still labeled as “panel meetings” on board documents and on the board's website, even though the full board participated in the meetings.

Recommendation 17: To enhance public transparency, all documents and website information should clearly label all meetings in which the full board meets,

either in person or through conference call, as meetings of the full board, rather than as meetings of a disciplinary panel.

Finally, the Drug Therapy Management Program authorizes physicians and pharmacists to enter into a therapy management contract that specifies treatment protocols for patient care. The 2011 sunset evaluation found that participation in the program was low and recommended that statute be amended to require physicians and pharmacists to only submit copies of the agreements to their respective board, rather than obtain approval from both boards. This change was enacted through legislation. However, the State Board of Pharmacy and MBP subsequently entered into a memorandum of agreement that participating physicians and pharmacists need only submit documentation to the State Board of Pharmacy, which would then forward the documents to MBP. Although the process seems to be working well, it does not align with current statute.

Recommendation 18: Statute should be amended to allow health occupations boards that have jurisdiction over authorized prescribers who have entered into a prescriber-pharmacist agreement to enter into an agreement with the State Board of Pharmacy to require that the authorized prescribers submit the agreement and any subsequent modifications to the agreement to the State Board of Pharmacy.

Overall, DLS observed significant progress for MBP and its related allied health advisory committees. MBP has implemented many of the recommendations from the 2011 sunset evaluation or otherwise addressed most issues raised. However, DLS was unable to fully evaluate the board's implementation of a two-panel disciplinary

system and CHRCs. Further, a few issues previously noted in the 2011 sunset evaluation remain. Therefore, the scope of the next sunset evaluation should focus on the board's two-panel system, CHRC implementation, and progress in addressing this report's recommendations. Any additional information requested in this report can be included in the sunset follow-up reports currently required under Chapter 401 of 2013.

Recommendation 19: Statute should be amended to extend the termination date for the State Board of Physicians and the related allied health advisory committees until July 1, 2023. Further, uncodified language should be adopted to limit the scope of the next sunset evaluation to evaluating (1) the implementation of recommendations made in this report;

(2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the board and licensees. Uncodified language should be adopted to require that the board include in the follow-up report required to be submitted on or before October 1, 2017, under Chapter 401 of 2013, any issues specifically noted in this report for inclusion in a subsequent follow-up report, except for fiscal issues. Finally, uncodified language should be adopted in the 2017 session of the General Assembly to require that the board include in the follow-up report required to be submitted on or before October 1, 2018, under Chapter 401 of 2013, any fiscal issues specifically noted in this report for inclusion in a subsequent follow-up report.

Chapter 1. Introduction and Background on the State Board of Physicians

Primary Recommendation: Extend the termination dates of the State Board of Physicians and the related allied health advisory committees by five years until July 1, 2023

Limit the scope of the next sunset evaluation to (1) evaluating the implementation of recommendations made in this report; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the board and licensees

Date Established: 2003 (replaced State Board of Physician Quality Assurance)

Most Recent Prior Evaluation: Full evaluation, 2011

Primary recommendation: Extend termination date by one year until July 1, 2014. Subsequent recommendation in January 2013 (following independent review by the University of Maryland, Baltimore and additional review by the Department of Legislative Services): Extend termination date by five years to July 1, 2018 (enacted by Chapter 401 of 2013)

Composition: Twenty-two members (14 physicians; 1 representative of the Department of Health and Mental Hygiene; 1 physician assistant; 5 consumers; 1 public member knowledgeable in risk management or quality assurance)

Staff: Authorized positions (71.1); contractual positions (5.5); vacancies (8)

Regulated Professions: Physicians (30,942 active), unlicensed medical practitioners (2,673), physician assistants (3,402), radiographers (5,715), nuclear medicine technologists (626), radiation therapists (371), radiologist assistants (5), radiographers/radiation therapists (50), respiratory care practitioners (2,718), athletic trainers (598), polysomnographers (418), perfusionists (91), naturopathic doctors (21), and psychiatric assistants (5)

Authorizing Statute: Titles 14 and 15, Health Occupations Article

The Sunset Review Process

This evaluation was undertaken under the auspices of the Maryland Program Evaluation Act (§ 8-401 *et seq.* of the State Government Article), which establishes a process better known as “sunset review” because most of the agencies subject to review are also subject to termination.

The State Board of Physicians (MBP) and its allied health advisory committees last underwent a full evaluation as part of sunset review in 2011. The Department of Legislative Services (DLS) offered a total of 46 recommendations related to licensing, complaint resolution, board resources, and other issues. DLS recommended that the termination dates for MBP and the advisory committees be extended for only one year as the board had failed to implement key recommendations and requirements from previous sunset evaluations and legislation. During the 2012 session, legislation introduced to implement the statutory changes recommended in the evaluation did not pass.

As a result of the sunset recommendations, MBP entered into a memorandum of understanding with the University of Maryland, Baltimore (UMB) to conduct an independent review of the board. In July 2012, UMB issued a report (the Perman Report) to the board containing 18 recommendations, most of which related to the board’s complaint resolution process. Between 2012 and 2013, DLS observed significant positive changes at the board that began to address issues raised in both the sunset evaluation and the Perman Report. In January 2013, DLS recommended, among other things, that the General Assembly extend the termination dates of the board and the advisory committees by five years to July 1, 2018, and require DLS to conduct a direct full evaluation of MBP in 2016. Chapter 401 of 2013 implemented these recommendations, as well as most of the recommendations contained in the 2011 DLS sunset report and 2012 Perman Report.

This full evaluation was undertaken to provide the General Assembly with information in making the determination about whether to reauthorize MBP and its advisory committees and for what period of time. This report represents the sixth full evaluation of the board. Recommendations are made throughout this document.

MBP’s mission is to protect the public by regulating physicians and allied health professionals. Thus, in addition to assessing the board’s progress in implementing the recommendations from the 2011 sunset evaluation, this report also focuses on how well the board fulfills its stated mission and responsibilities.

Evaluation Methodology

In conducting this evaluation of MBP, DLS reviewed board-related statutes and regulations and internal board documents, including board minutes, financial records, and annual reports. **Appendix 2** lists more specifically the documents reviewed. In addition, DLS attended disciplinary panel and advisory committee meetings and conducted interviews (personal and telephone) with an extensive range of interested parties, including board and allied health

advisory committee members, key board staff, board counsel, a representative from the Office of the Attorney General, and a representative of the Medical and Chirurgical Faculty of the State of Maryland.

Report Structure

This report consists of five chapters. **Chapter 1** offers an overview of the sunset process, an update on the board's implementation of the recommendations from the 2011 sunset review, background on MBP, and a summary of legislative changes to the board since the last sunset review. **Chapter 2** discusses the board's licensing and renewal processes. Complaint and disciplinary issues are discussed in **Chapter 3**. **Chapter 4** discusses resource and administrative issues. **Chapter 5** is a brief conclusion.

As supplements to the report, eight appendices are included. **Appendix 1** contains draft legislation to implement the statutory recommendations contained in this report. **Appendix 2** provides more details about the documents reviewed in the course of the sunset review. **Appendix 3** contains the membership composition and duties of the seven allied health advisory committees. **Appendix 4** contains a summary of recommendations from the 2011 full sunset review and the outcome of those recommendations. **Appendix 5** contains the major legislative changes affecting MBP since the 2011 sunset evaluation. MBP reviewed a draft of this report and provided the written comments included as **Appendix 6**. Appropriate factual corrections and clarifications have been made throughout the document; therefore, references in written comments may not reflect this published version of the report.

Duties and Composition of the State Board of Physicians

MBP is charged with enforcing the Maryland Medical Practice Act and the Maryland Physician Assistants Act. Among its duties, MBP must (1) adopt regulations to carry out the provisions of law for which it is responsible; (2) establish policies for board operations; (3) oversee licensing of physicians and allied health professionals; (4) review and investigate complaints; (5) report on all disciplinary actions, license denials, and license surrenders; (6) appoint members of the disciplinary panels; and (7) develop and approve an annual report.

As shown in **Exhibit 1.1**, in fiscal 2016 the board issued a total of more than 22,000 new and renewal licenses to physicians, unlicensed medical practitioners (medical students completing clinical training and medical graduates completing postgraduate training), and multiple categories of allied health professionals. Due to the biennial renewal cycle, the board actually had regulatory authority over a total of more than 50,000 individuals in fiscal 2016. In that same year, the board dealt with 1,294 complaints.

Exhibit 1.1
Major Workload Indicators for the State Board of Physicians
Fiscal 2012-2016

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>
Physician Licenses					
New	1,902	1,800	1,765	1,911	1,964
Renewal and Reinstatement	12,312	14,932	12,960	15,263	13,139
Unlicensed Medical Practitioners ¹	2,899	2,650	1,934	2,552	2,673
Allied Health Licenses					
New	1,355	1,083	1,474	1,073	1,111
Renewal and Reinstatement	2,889	8,816	3,333	9,538	3,599
Total Licenses Issued	21,357	29,281	21,466	30,337	22,486
Total Complaints²	1,991	1,242	1,272	1,180	1,367

¹ Unlicensed medical practitioners are medical students completing clinical training and medical graduates completing postgraduate training in the State.

² Total complaints includes complaints received in the fiscal year as well as complaints still pending from previous fiscal years.

Source: *Fiscal 2014, 2015, 2016, and 2017 Budget Books*; State Board of Physicians

MBP is composed of 22 members. By statute, the membership is drawn as follows:

- 11 practicing licensed physicians, including 1 doctor of osteopathy, appointed in accordance with a statutory nominating process;
- 1 practicing licensed physician appointed at the Governor's discretion;
- 2 practicing licensed physicians with full-time faculty appointments who serve as representatives of academic medical institutions and are appointed from lists of names submitted by the Johns Hopkins University School of Medicine and the University of Maryland School of Medicine;
- 1 representative from the Department of Health and Mental Hygiene (DHMH) nominated by the Secretary;
- 1 certified physician assistant appointed at the Governor's discretion in accordance with a statutory nominating process;
- 5 consumer members; and

- 1 public member knowledgeable in risk management or quality assurance matters appointed from a list submitted by the Maryland Hospital Association.

All board members serve staggered four-year terms. No member may serve more than two consecutive full terms. The Governor appoints a chair and, from among its members, the board elects any other officers that the board considers necessary. The chair of the board assigns each board member to a disciplinary panel and selects a member of each panel to be chair of the disciplinary panel.

Board Regulates Multiple Allied Health Professions

Statutory provisions place several allied health professions under the jurisdiction of MBP and establish seven allied health advisory committees that assist MBP in its oversight role. These committees are composed of representatives of the regulated professions, physicians, and consumers. The allied health professions under the jurisdiction of MBP are: (1) physician assistants; (2) radiographers, radiation therapists, nuclear medicine technologists, and radiologist assistants; (3) respiratory care practitioners; (4) polysomnographic technologists; (5) athletic trainers; (6) perfusionists; and (7) naturopathic doctors. **Appendix 3** contains the membership composition and duties of the seven allied health advisory committees. Each committee is subject to separate sunset review provisions requiring an evaluation in 2016.

Previous Sunset Recommendations Largely Implemented by Board

As discussed earlier, DLS' 2011 sunset review of MBP made significant recommendations, the majority of which were enacted by Chapter 401 of 2013. For example, Chapter 401 required that a summary of charges filed against a licensee and a copy of the charging document be posted on the licensee's online profile until the board takes action on or rescinds the charges. The Act also requires MBP, from 2013 through 2018, to annually report to specified committees of the General Assembly on its progress in addressing issues identified by the DLS sunset evaluation and the Perman Report. In addition to the statutory changes made through Chapter 401, other changes were made administratively or by regulation. The outcome of each recommendation is shown in **Appendix 4**. Of the 46 DLS recommendations, MBP has adopted 24 and modified 18, while 4 recommendations were rejected. Chapters 2 through 4 of this report discuss the board's implementation of some of these recommendations in more detail.

Major Legislative Changes Since the 2011 Sunset Review

Since the 2011 sunset review, several statutory changes, including changes impacting the allied health professionals, have affected MBP. Most notably, as a result of the Perman Report, Chapter 401 of 2013 established two disciplinary panels, each consisting of 11 members through which allegations of grounds for disciplinary action must be resolved, and consolidated and

delineated board powers and duties. To provide sufficient membership to divide the board into 2 disciplinary panels, total board membership was increased from 21 to 22 members by adding a second licensed physician with a full-time faculty appointment to serve as a representative of an academic medical institution in the State. Other major statutory changes include requiring MBP to disclose its proceedings, records, and files to the Maryland Health Care Commission for the purpose of investigating quality or utilization of care in certain health care facilities; authorizing MBP to issue a cease and desist order or obtain injunctive relief against an individual for taking certain actions that may be grounds for discipline or pose a threat to the public; requiring applicants and licensees to submit to a criminal history records check as a condition of licensure; and requiring individuals to be licensed to practice naturopathic medicine. Major legislative changes are shown in **Appendix 5**.

Chapter 2. Licensing Issues

Licensing is one of the core functions of the State Board of Physicians (MBP). With the authority to issue and revoke licenses, the board can enforce standards of care for physicians and allied health professionals. The Department of Legislative Services (DLS) found that the board generally meets its licensing performance goals for physicians and has improved the licensing process. However, the licensing process for allied health professionals could be improved and the board needs to align fees posted on the board's website and fees in regulations with the fees currently charged. Although the board met its statutory deadline for the implementation of criminal history records checks for those licensees applying for renewal and reinstatement, implementation was delayed for initial applicants.

Board Issues a Variety of Licenses and Physician Dispensing Permits

In addition to issuing licenses, the board issues dispensing permits to physicians and registers psychiatric assistants. The board also regulates unlicensed medical practitioners (medical students completing clinical training and medical graduates completing postgraduate training in the State). These individuals are not subject to renewal since they are unlicensed. As shown in **Exhibit 2.1**, the board issues a variety of licenses.

While the number of initial licenses issued to physicians has remained relatively constant since fiscal 2012, the number of initial licenses issued to allied health professionals has fluctuated. Generally, the number of initial licenses issued in the first year an allied health profession is regulated is high and then levels off in subsequent years. There was a significant increase in the number of polysomnography licenses issued in fiscal 2014 because the board was required to waive certain educational requirements for individuals who applied for licensure by September 30, 2013, and met other requirements. The number of physician dispensing permits issued has dropped significantly since fiscal 2013 due to a separate permit no longer being required for each practice location, a legislatively mandated fee to cover the cost of inspections by the Department of Health and Mental Hygiene's Office of Controlled Substances Administration (formally known as the Division of Drug Control), and more physicians realizing that a permit is not required to provide drug samples.

Exhibit 2.1
Initial Licenses and Permits Issued by the State Board of Physicians
Fiscal 2012-2016

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>
Physicians	1,902	1,800	1,765	1,911	1,964
Unlicensed Medical Practitioners ¹	2,899	2,650	1,934	2,552	2,673
Allied Health Professionals					
Physician Assistants	299	305	360	349	377
Radiographers	348	324	318	306	281
Nuclear Medicine Technologists	37	38	33	27	36
Radiation Therapists	39	24	32	32	43
Radiologist Assistants	0	1	2	0	1
Respiratory Care Practitioners	195	222	187	202	176
Athletic Trainers ²	404	108	106	120	127
Polysomnographers ³	33	61	354	20	22
Perfusionists ⁴	0	0	82	17	27
Naturopathic Doctors ⁵	0	0	0	0	21
Total Allied Health Professionals	1,355	1,083	1,474	1,073	1,111
Physician Dispensing Permits	385	410	104	135	107

¹ Unlicensed medical practitioners are medical students completing clinical training and medical graduates completing postgraduate training in the State.

² Regulation of athletic trainers began in fiscal 2012.

³ The large increase in polysomnography licenses issued in fiscal 2014 resulted from the waiver of certain educational requirements for individuals who applied for licensure by September 30, 2013, and met other requirements.

⁴ Regulation of perfusionists began in fiscal 2014.

⁵ Regulation of naturopathic doctors began in fiscal 2016.

Source: State Board of Physicians

License Renewal and Reinstatements Show Modest Growth

Licenses issued by the board are renewed on a biennial basis. In addition to renewing the licenses shown in Exhibit 2.1, the board also renews radiographer/radiation therapist licenses (no new applications have been received for this license since prior to fiscal 2012) and psychiatric assistant registrations. As shown in **Exhibit 2.2**, the number of renewal licensees has increased modestly. Furthermore, renewal patterns for physicians and allied health professionals fluctuate, which results in the workload of the board being higher in odd-numbered fiscal years.

Exhibit 2.2
Renewals and Reinstatements Issued by the State Board of Physicians
Fiscal 2012-2016

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>
Physicians	12,312	14,932	12,960	15,263	13,139
Allied Health Professionals					
Physician Assistants	45	2,591	82	2,960	71
Radiographers	83	5,203	87	5,248	119
Nuclear Medicine Technologists	13	611	12	576	13
Radiation Therapists	4	313	4	310	7
Radiologist Assistants	0	2	1	4	0
Radiographers/Radiation Therapists	1	58	2	50	0
Respiratory Care Practitioners	2,631	37	2,685	55	2,727
Athletic Trainers ¹	0	0	444	5	516
Polysomnographers ²	101	1	6	330	66
Perfusionists ³	0	0	0	0	75
Naturopathic Doctors ⁴	0	0	0	0	0
Psychiatric Assistants ⁵	11	0	10	0	5
Total Allied Health Professionals	2,889	8,816	3,333	9,538	3,599

¹ Regulation of athletic trainers began in fiscal 2012.

² Due to a change in policy, polysomnographers began to renew in odd-numbered fiscal years in fiscal 2015.

³ Regulation of perfusionists began in fiscal 2014.

⁴ Regulation of naturopathic doctors began in fiscal 2016.

⁵ The board no longer offers initial registration for psychiatric assistants. Individuals practicing as psychiatric assistants are only subject to registration renewal.

Source: Fiscal 2014, 2015, and 2016 Budget Books; State Board of Physicians

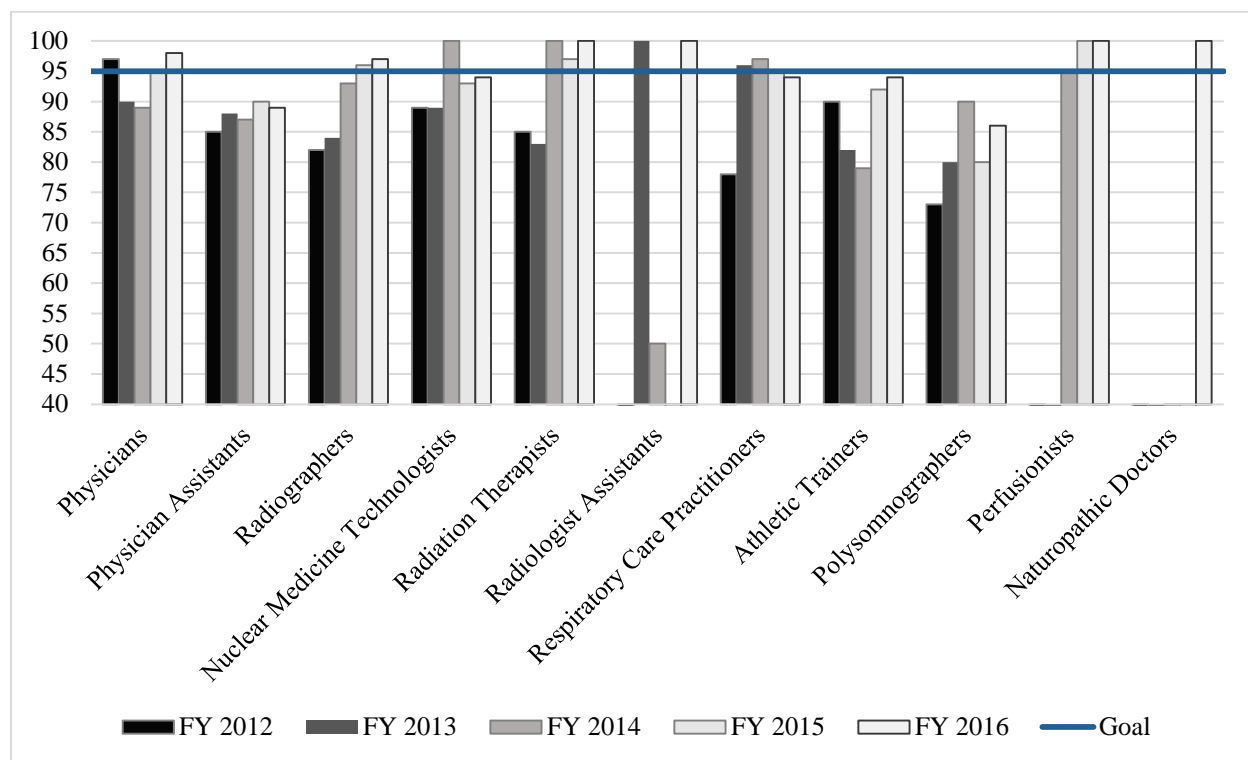
Board Generally Meets Licensing Performance Goals

MBP developed a measure to assess physician licensing performance, which is to issue initial licenses to 95% of qualified applicants within 10 days of receipt of the last qualifying document. This measure is also set forth in the board's *Managing for Results* goals. As shown in **Exhibit 2.3**, MBP generally meets this goal for physicians.

In response to a recommendation made in the 2011 sunset review, the board adopted this measure for the allied health professions. However, MBP generally has not met the goal for allied health. The board attributes this to database issues, staffing issues, and the increase in the number of allied health professions licensed by MBP. The board's database was not originally designed to collect data relating to this performance measure for allied health

professionals. After the database was modified, it was discovered that it was still not capturing all of the information needed to measure whether this goal was being met. This error was corrected in 2015. The low percentages of initial licenses being issued within the 10-day timeframe for a few of the allied health professions in 2012 and 2013 were due to a realignment of board units which led to a disruption in licensure processing. Other staff issues, such as retirements and reassignments, also led to the goal not being met. Finally, the growth in allied health professionals governed by the board and the inability of the board to gain new staff positions to meet this growth has contributed to the board not being able to meet this performance measure.

Exhibit 2.3
Percent of Initial Licenses Issued Within 10 Days of Receipt of Last
Qualifying Document
Fiscal 2012-2016



Notes: The goal of the State Board of Physicians is to issue initial licenses to 95% of qualified applicants within 10 days of receipt of the last qualifying document. No initial licenses were issued for radiologist assistants in fiscal 2012 or 2015. Regulation of perfusionists began in fiscal 2014; regulation of naturopathic doctors began in fiscal 2016.

Source: State Board of Physicians

Recommendation 1: The board should work to improve the administrative process for issuing licenses promptly, especially for allied health professionals, and report on efforts to meet the 10-day goal in a follow-up report to the General Assembly.

Board Continues to Work Toward Streamlining Physician Licensing Process

Since the 2011 sunset evaluation, the board has taken several steps to simplify and streamline the licensing of physicians. For initial licensure, the form for the verification of postgraduate medical education can now be signed by a designee of the postgraduate program, rather than the head of the program. For renewals, the board altered the online renewal system to allow applicants to print the license once the process is completed. Also, the board is working to implement an online reinstatement system that calculates the amount of the reinstatement fee and allows the applicant to pay the fee online. Finally, the board is working toward using the online Federation of State Medical Boards generic application form.

Problems with Certain Licensing Fees Continue

The 2011 sunset evaluation recommended that the board amend its regulations to reflect the current fees charged by the board. The board had increased physician licensing fees to cover the costs of the physician rehabilitation program (due to the repeal of the separate statutorily set fee for that program) and peer review, but it had not amended its regulations to reflect those changes. It was also recommended that the board repeal the separate \$25 fee for the physician assistant rehabilitation program as that was the only profession regulated by the board for which a separate fee still applied.

Chapter 401 of 2013 repealed the requirement; however, as shown in **Exhibit 2.4**, the board's regulations still do not reflect the current fees charged for physician licensing and continue to list a separate rehabilitation program fee for both physicians and physician assistants. Also, fees listed on the board's website either do not include all fees charged by the board for a specific profession or include fees for services provided by the board that are not in regulation. For example, the website does not include the license renewal fee charged to physicians or the reinstatement fee charged to perfusionists. The website lists a name change fee for the allied health professions, but this fee is not in regulations. Furthermore, neither the board's regulations nor the website have been updated to reflect certain fees charged to perfusionists; rather, the regulations and the website state that fees are to be determined.

Recommendation 2: MBP should amend its regulations and update its website to accurately reflect current fees.

Exhibit 2.4
Selected Fee Levels for Physician and Allied Health Licensure and Services

	<u>Fee in COMAR</u>	<u>Fee Charged by Board</u>	<u>Fee on Board Website</u>
Physicians			
Initial Application	\$260	\$310†	\$790††
Initial Physician License	480	480	See above
Initial Physician Rehabilitation Program	50	0†	N/A**,†
Biennial License Renewal	436	522*,†	N/A**,†
Reinstatement (if eligible for renewal in previous year)	650	700†	700†
Reinstatement (if not eligible for renewal in previous year)	550	600†	600†
Physician Rehabilitation Program	50	0†	N/A**,†
Physician Assistants			
Initial Application	200	225†	225†
Biennial License Renewal	171*	196*,†	196*,†
Physician Assistant Rehabilitation Program	25	0†	N/A**,†
Reinstatement	200	225†	225†
Polysomnographic Technologists			
Initial Application	236*	200	200
Biennial License Renewal	186*	186*	186*
Reinstatement	236*	200	N/A**
Perfusionists			
Initial Application (after 10/1/2015)	TBD***	300	TBD***
Biennial License Renewal	TBD***	257*	257*
Reinstatement	TBD***	300	TBD***
Allied Health Name Change Fee	N/A**	25	25

†The initial application, biennial license renewal, and reinstatement fees for physicians and physician assistants charged by the State Board of Physicians and reflected on its website encompass the rehabilitation program fee.

††The board's website does not list the licensure application fee and the physician license fee separately but combines them into the total fee charged along with the rehabilitation program fees.

*Includes the \$36 Maryland Health Care Commission fee that the board is required to charge.

**Fee is not listed.

***The amount of the fee is not listed; rather, fee is "to be determined" or "TBD."

Source: Code of Maryland Regulations; State Board of Physicians

Board Fined Physicians Who Let Licenses Lapse for Less than 60 Days

In 2014, MBP revised its regulations to remove the late renewal process for physicians and require a physician whose license lapses to apply for reinstatement. Physicians who fail to renew their licenses, but continue to practice, are practicing medicine without a license under § 14-601 of the Health Occupations Article and board regulations. A review of board disciplinary orders for fiscal 2015 showed that the board fined physicians who let their licenses lapse, no matter how soon after the expiration of their license those physicians applied for reinstatement.

In the disciplinary orders, the board incorrectly cited § 14-405.1 of the Health Occupations Article and either Code of Maryland Regulations (COMAR) 10.32.02.06 or 10.32.02.10 as authority for the fine. These statutory provisions and regulations do not apply in cases involving the unlicensed practice of medicine. The provisions of law that specifically authorize the board to fine for the unlicensed practice of medicine are § 14-606(a)(4) of the Health Occupations Article and COMAR 10.32.01.08(J). Under those provisions, the board may impose a fine of up to \$50,000. However, the authority does not apply to a physician who let the license lapse if the physician applies for renewal within 60 days after the expiration of the license. Although the board does not allow a physician to apply for late renewal, but rather requires reinstatement, the intent of the statute and the regulation remain. Because the physicians who were fined in the fiscal 2015 orders applied for reinstatement within 60 days of the expiration of their licenses, the board did not have the authority to impose fines on them for the unlicensed practice of medicine.

In response to DLS questions about this issue, board counsel concurred that the board did not have this authority and advised the board to (1) rescind the orders; (2) notify the physicians; (3) refund the fines; (4) correct any reports made to any other entities; and (5) take any other action necessary to correct the errors. The board has followed that advice. The amount of fines refunded by the board is \$16,000.

Recommendation 3: The board should reestablish a late renewal process that would be available to physicians for a 60-day period after the license expiration date rather than requiring them to use the reinstatement process. Statute should be amended to clarify that a physician has 60 days after the license expiration date in order to renew the license.

Criminal History Records Checks Implementation Initially Delayed but Now Operational

In the January 2007 update of the 2005 sunset evaluation of the board, DLS recommended that statute be amended to require the board to include national and State criminal history records checks (CHRCs) in its initial application and licensure renewal process because data suggested that a small number of physicians did not self-report criminal convictions as required on license application and renewal forms. However, the board disagreed with the recommendation at the time, stating that CHRCs would increase the cost of licensure and cause unnecessary delays in the licensing process. Subsequently, this recommendation was amended out of the 2007 sunset legislation.

In the 2011 sunset evaluation, DLS advised that there was no need for MBP to require CHRCs, noting that there was likely a low level of board licensees with “positive” reports (a criminal history was identified) and that the State Board of Nursing and State Board of Pharmacy had encountered issues in CHRC implementation, such as significant workload and delayed issuance of licenses, respectively.

However, in 2014, MBP began developing a proposal to require CHRCs after it was discovered that a Maryland physician had been practicing in the State for almost two decades despite having previously served a prison sentence for rape in Florida in 1987; the physician served 4 years of a 10-year sentence and began practicing medicine in Maryland in 1996. The physician was charged with sexually assaulting a patient in Maryland in 2014. The charges were eventually dropped ahead of the scheduled trial after the physician agreed to surrender his license.

Chapter 34 of 2015 required applicants and licensees of MBP to submit to a CHRC as a qualification for licensure and created new grounds for disciplinary action if a licensee failed to submit to a CHRC. The CHRC requirement for initial licenses took effect July 1, 2015, while the requirement for renewals and reinstatements was delayed until October 1, 2016.

Board Did Not Require Criminal History Records Checks for Initial Applicants until October 1, 2016

Despite the requirements of Chapter 34 of 2015, the board advises that it has been issuing licenses to applicants for initial licensure since July 1, 2015, without the required CHRC. The board began requiring CHRCs for applicants for initial licensure on October 1, 2016 – the same effective date as the CHRC requirement for licensees applying for renewal or reinstatement.

According to the board, implementation of CHRCs was delayed due to personnel shortages. The board requested three additional positions for CHRC implementation in its fiscal 2016 budget request, but this request was denied. Additionally, three vacant positions that the board was planning to earmark for CHRC were abolished by the Department of Budget and Management in fiscal 2016. Furthermore, after consulting with other health occupations boards and other state medical boards on the processes involved in implementing CHRCs, the board increased its request to five additional positions in its fiscal 2017 budget request. This request was also denied.

The board advises that delayed authorization and availability of the federal “rap back” subscription service from the Criminal Justice Information System (CJIS), which generates updated arrest and conviction information for individuals who undergo CHRCs, also contributed to delayed implementation. The board had previously believed this service would be operational in time for CHRC implementation. MBP met with CJIS in June 2015 to discuss implementation and the necessary approval procedures, which included approval by the Federal Bureau of Investigation (FBI). MBP received approval from the FBI in October 2015 and approval from CJIS in April 2016; however, CJIS informed the board that the rap back service was not yet operational and that the timeframe for availability was unknown.

The board advises that CHRC procedures became fully operational on October 1, 2016. The board's website currently states that "CHRCs will be required for all reinstatements, renewal, and initial licensure applications for ALL licensees beginning October 1, 2016." The website also includes instructions for applicants and licensees to undergo the required CHRCs.

Board Has Parameters for Reviewing Criminal History Records Check Results

Pursuant to Chapter 34 of 2015, on receipt of CHRC information, the board must consider the following factors in determining whether to grant, renew, or reinstate a license: (1) the age at which the crime was committed; (2) the nature of the crime; (3) the circumstances surrounding the crime; (4) the length of time that has passed since the crime; (5) subsequent work history; (6) employment and character references; and (7) other evidence that demonstrates whether the applicant poses a threat to public health or safety. In March 2016, MBP approved internal parameters for handling positive CHRC results (a criminal history was identified).

Board Should Report Impact of Criminal History Records Checks on Board Operations and Licensure

The board anticipates that between 5% and 10% of CHRCs will result in a positive result (a criminal history was identified) necessitating further inquiry. Historically, the board has denied only 13 licenses due to criminal history or lack of good moral character between fiscal 2011 and 2016. Given that implementation of CHRCs for applicants and licensees only began on October 1, 2016, it is difficult to assess the impact of CHRCs on licensure or whether the board is managing the process well. Further, the volume of CHRCs will peak in fiscal 2018 and 2019, as half of physician licensees will renew by September 30, 2017 (fiscal 2018), and the remainder by September 30, 2018 (fiscal 2019). Further, most allied health professions will renew in fiscal 2019. Thus, the full impact of the CHRC process on board operations and licensees will not be known until fiscal 2019.

The State Board of Nursing is required to submit an annual report to the Governor, the Secretary of Health and Mental Hygiene, and the General Assembly with specified information on the impact of CHRCs on licensure. A similar reporting requirement for MBP would provide further information and allow a more accurate assessment of the board's CHRC implementation and the impact of CHRCs on applicants and licensees.

Recommendation 4: Statute should be amended to require MBP to submit an annual report on the results of CHRCs and related implementation. Specifically, MBP should be required to report the following information for physicians and allied health professionals: (1) the number of initial and renewal licenses issued; (2) the number of positive and negative CHRC results received; (3) the number of individuals denied initial or renewal licensure due to positive CHRC results; and (4) the number of individuals denied licensure due to reasons other than a positive CHRC. Further, MBP should include in the fiscal 2019 CHRC report

information regarding whether CHRCs are causing licensure delays, whether existing staff are able to manage the CHRC workload, and any other concerns with the CHRC process.

Criminal History Records Check Requirements for Renewals Should Be Clarified

MBP advises that the CHRC requirements for renewal applications are unclear. Although statute prohibits the board from renewing or reinstating a license if the CHRC “has not been received,” the board must consider specified factors in determining whether to renew or reinstate a license. The board interprets the latter provision as prohibiting the board from renewing or reinstating licenses without considering the specified CHRC factors.

Currently, license renewal is an automatic, online process – if a licensee responds “yes” to a character and fitness question, the license is still granted, but the board conducts an investigation and takes disciplinary action, if appropriate, against the licensee at a later date. The board has expressed concern that requiring the board to consider CHRC factors before granting a renewal license will cause delays in the renewal process, as the board must investigate positive CHRC results before making a determination. Thus, licenses may expire (and the board may lose jurisdiction over the licensee) before the board determines whether to renew the license.

DLS reviewed the CHRC statutes for other health occupations boards. Of the six other boards that require CHRCs for renewal applications, four boards are prohibited from renewing or reinstating a license if the CHRC information “has not been received.” Three of the four boards are required to consider specified CHRC factors when determining “whether to renew or reinstate” a license; one board is required to consider specified CHRC factors when determining “whether to grant” a license. Thus, statutes for four health occupations boards have the same or similar language as MBP. However, one of these boards – the State Board of Nursing – may issue temporary licenses while CHRC information is being reviewed. MBP does not have this option. Additionally, CHRC requirements for two of these boards only took effect October 1, 2016; thus, CHRC implementation for these two boards has just begun.

Recommendation 5: Given MBP’s concerns about the timing of receipt and investigation of CHRC results on the renewal process, statute should be amended to clarify that the listed factors are to be considered by the board when determining whether to take disciplinary action based on the results of CHRCs against a licensee who renewed or reinstated the license.

Allied Health Licensure Issues Involve Physician Delegation Agreements and Fees for Naturopathic Doctors

Physician Assistant Delegation Agreement Review Process Needs Further Study

During the course of the sunset review, DLS staff heard complaints from representatives of physician assistant (PA) groups that the board is taking too long to review delegation agreements between a physician and a PA when the delegation agreement involves only core duties. The statute governing delegation agreements specifies that if a delegation agreement does not include advanced duties or the advanced duties have been approved under the provisions of law relating to advanced duties performed at hospitals and ambulatory surgical facilities, a PA may assume the duties under a delegation agreement on the date the board receives the delegation agreement.

Board regulations establish that the board may disapprove a delegation agreement that does not comply with statutory or regulatory requirements. Board staff advises that the board acknowledges receipt of the delegation agreement only after determining that the delegation agreement has all of the required information and payment is received. Board staff indicates that, of the 1,239 delegation agreements submitted to the board in fiscal 2016, 684 were processed within 10 days of receipt, while the remaining 555 required follow up due to incomplete or inaccurate information. The average time for processing a delegation agreement is 13 calendar days. Nevertheless, the board's website states under "frequently asked questions" that the process may take up to 7 weeks.

Some PAs would like to modify the law to require the delegation agreement be kept at the practice level only and not filed with the board. Several states and the District of Columbia require only that the delegation agreement or protocol be kept at the practice level. Requiring a delegation agreement to be kept at the practice level and not submitted to the board may allow a PA to begin practicing under a delegation agreement more quickly than occurs under current law.

Recommendation 6: The board, in consultation with the Physician Assistant Advisory Committee, should study ways to expedite the process for PAs to assume the duties under a delegation agreement and report their findings and recommendations in a follow-up report.

Controversy Over Fees Delayed Naturopath Regulations

Chapters 153 and 399 of 2014 required the licensure of naturopathic doctors beginning March 1, 2016. Although the board met the statutory deadline, licensure got underway before licensure regulations were adopted by the board due to a controversy over fees.

The fiscal and policy notes for Chapters 153 and 399 assumed a significant special fund revenue increase for the board beginning in fiscal 2016 from new licensing fee revenues from naturopathic doctors. The fiscal and policy notes also assumed that licensing fee revenues would be sufficient to cover estimated board expenditures, including the cost of hiring one full-time

administrative officer in fiscal 2015, which would transition to a part-time (50%) position in fiscal 2017. Expenditures related to the licensure of naturopathic doctors were projected to increase from \$58,600 in fiscal 2015 to \$75,100 in fiscal 2016, and then decline to \$26,600 in fiscal 2017. Due to the projected small number of naturopathic doctors being licensed (estimated at 26), the fiscal and policy notes advised fees might need to be set as high as \$5,140 initially if they were to cover costs; however, statute requires the board to set *reasonable* fees that *approximate* the cost of maintaining the licensure program.

The board voted on February 16, 2016, at an emergency meeting, to establish the biennial licensure fee at \$790, the same initial licensure fee paid by physicians. The board acknowledged that the fee did not cover all of the expenses associated with the regulatory oversight of the new profession. The Maryland Naturopathic Doctor Association had objected to an earlier proposal to set the fee at \$4,786. MBP is absorbing the costs not covered by the fee with existing resources.

Although MBP began charging the \$790 fee to naturopathic doctors applying for licensure in March 2016, the board did not submit the proposed regulations to the Joint Committee on Administrative, Executive, and Legislative Review until May 10, 2016. The board advised that the \$790 fee was anticipated to result in \$20,540 in licensing revenue in fiscal 2016. Under the regulations, license renewal takes place in even-numbered fiscal years, and the license renewal fee is set at \$486. The regulations took effect September 12, 2016.

Chapter 3. Complaint Resolution Issues

One of the State Board of Physician's (MBP's) most critical functions in fulfilling its mission to protect the public is to investigate complaints and take disciplinary action against individuals found to be in violation of the Maryland Medical Practice Act, laws governing allied health professionals, and/or board regulations. This chapter focuses on how well the board fulfills this function and assesses the board's implementation of key recommendations from the 2011 sunset evaluation relating to the complaint resolution process.

The Department of Legislative Services (DLS) found that the board has implemented major recommendations from the 2011 sunset evaluation and generally fulfills its stated mission to protect the public by efficiently processing complaints and disciplining licensees. MBP cleared its backlog of unresolved cases, successfully implemented its new two-panel disciplinary system, and continues to process cases with no backlog. Although the long-term effectiveness of the two-panel system remains to be seen, the board appears to manage its workload better than in previous years. However, DLS also identified areas in need of improvement, including transparency surrounding sexual misconduct cases; the board's efficiency in handling cases involving the unlicensed practice of medicine and related issues; and requirements related to standard of care cases, unlicensed medical practitioners, hospital disciplinary reporting, and training for administrative law judges (ALJs) in the Office of Administrative Hearings (OAH).

2011 Sunset Recommendations and 2012 Perman Report

The 2011 sunset evaluation found MBP's complaint resolution process lengthy and complex. Notably, the report highlighted the board's considerable backlog in unresolved cases, with an average of 150 pending cases per fiscal year from fiscal 2007 to 2011. The report recommended requiring MBP and the Department of Health and Mental Hygiene (DHMH) to jointly develop and implement a strategy for reducing the backlog of complaint cases by December 31, 2012. The report also recommended that MBP be required to include a strategy, and to show the effects of the strategy, for reducing the backlog in a subsequent follow-up report to DLS.

In April 2012, MBP requested the University of Maryland, Baltimore (UMB) to (1) evaluate the board's complaint resolution procedures; (2) assist the board in preparing a response to the complaint resolution issues identified in the 2011 sunset evaluation; and (3) provide analysis and advice concerning other issues addressed in the 2011 sunset evaluation, as appropriate. UMB issued its report (the Perman Report) in July 2012.

Among other recommendations, the Perman Report recommended establishing a two-panel disciplinary system to address the backlog of complaints, with each panel acting separately and having the authority to make a final determination in a case. Chapter 401 of 2013 established this

two-panel disciplinary system and required MBP to submit follow-up reports on the status of the backlog to DLS.

The Two-panel System and the Complaint Resolution Process

The two-panel disciplinary system consists of the same general stages as the prior full-board system: (1) complaint receipt and preliminary investigation; (2) full investigation to vote to charge; (3) transmittal to the Office of the Attorney General (OAG) to final board action; and (4) potential judicial review.

Each disciplinary panel consists of 11 board members, with 6 practicing licensed physicians; 1 practicing licensed physician with a full-time faculty appointment; 1 representative of DHMH or a licensed physician assistant; and 3 consumer members. Complaints generally are randomly assigned to 1 of the 2 panels and proceed through the process with the same panel at each stage (with the exception of post-administrative hearing procedures). Each panel meets once per month; the agenda for each meeting consists of cases in various stages of the complaint resolution process. The panels may not refer cases to the full board, nor may the full board vote on a panel's decision. Cases involving the unlicensed practice of medicine, however, must be handled by the full board.

Once a complaint is received, board staff conducts a preliminary investigation of the complaint, which includes sending a copy of the complaint to the respondent with a request for a response. The results of the preliminary investigation are then presented to the panel, which may decide to close the case with no action, close the case with an advisory letter (informal, nonpublic action), or instruct board staff to conduct a full investigation. Approximately 90% of cases are closed with no action or closed with an advisory letter at this stage.

During the full investigation, the panel may also refer the case for peer review (through its contracted peer review entity) to solicit additional expertise; cases involving standard of care require two peer reviews. The respondent is sent a copy of the peer review results and may submit a response.

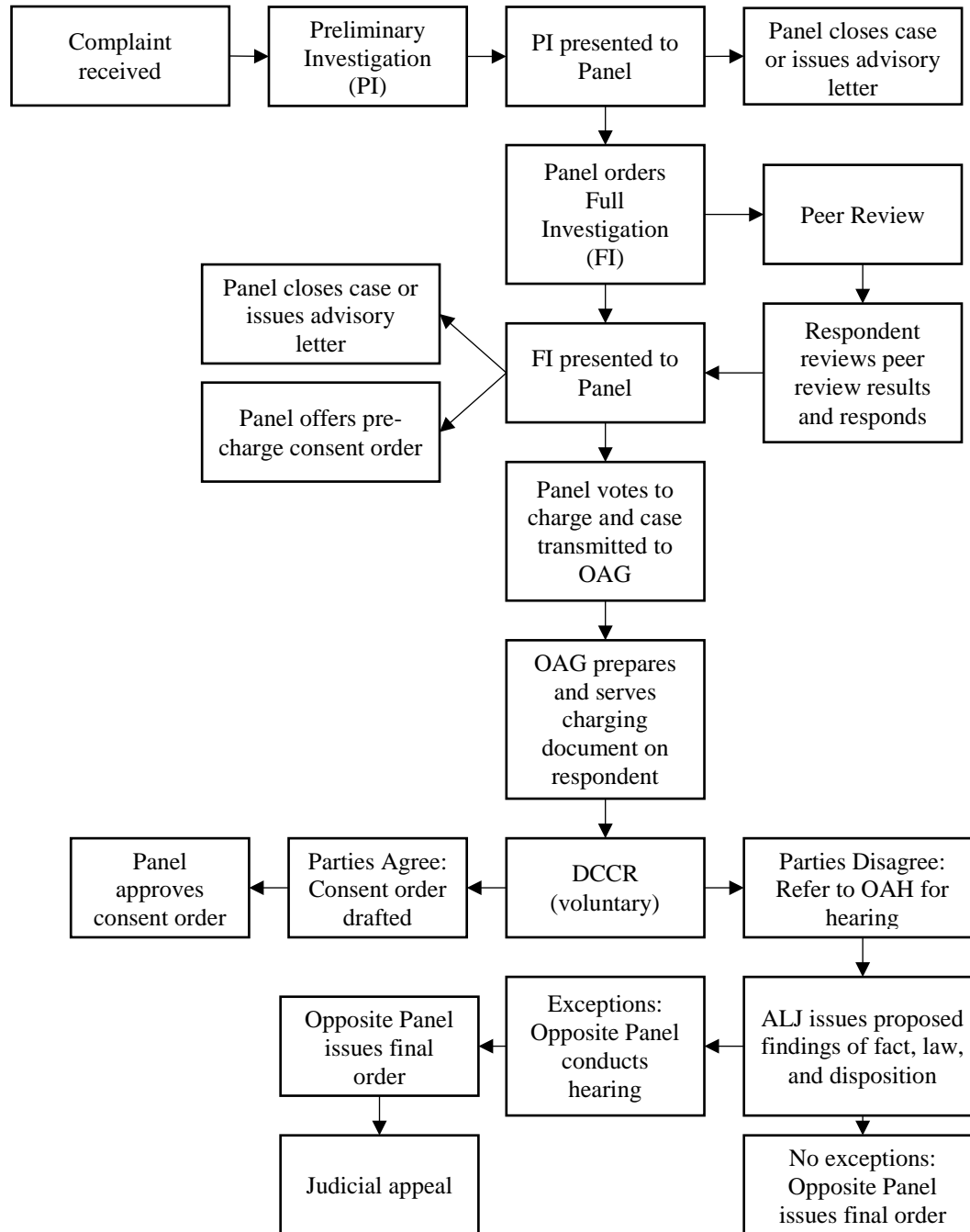
The results of the full investigation are then presented to the panel, which may (1) close the case with no action; (2) issue an advisory letter; (3) offer the respondent a pre-charge consent order if there is not a factual dispute; or (4) vote to charge the respondent. If the panel votes to charge the respondent, the case is transmitted to OAG, which then prepares and serves the respondent with a charging document.

Once charged, the respondent is given the option to attend a case resolution conference, referred to as the Disciplinary Committee for Case Resolution (DCCR) – a voluntary, informal, and confidential proceeding before the panel. If no agreement is reached (or if the respondent declines to participate in DCCR), the case is referred to OAH for a hearing before an ALJ.

The hearing at OAH is conducted in accordance with the Administrative Procedure Act. The ALJ issues *proposed* findings of fact, law, and disposition; the board is not bound by these findings. If OAG and the respondent have no exceptions (disagreements) with the ALJ's decision, the case is referred to the opposite board panel (*i.e.*, the panel that did not originally handle the case) for a final order. If exceptions are filed, the opposite panel conducts an exceptions hearing and subsequently issues a final order. If the respondent disagrees with a panel's final order, the respondent may judicially appeal; however, the panel's order may not be stayed pending review.

Exhibit 3.1 shows the complaint investigation process from receipt to resolution.

Exhibit 3.1
State Board of Physicians
Complaint Investigation Process from Receipt to Resolution



Source: State Board of Physicians; Department of Legislative Services

Board Successfully Implemented Two-panel System, but Long-term Effectiveness Yet to Be Determined

The two-panel system was fully implemented in calendar 2014; therefore, the system has been operational for approximately two years. Given the relatively short timeframe in which the two-panel system has been in place, it is difficult to accurately assess its efficacy or whether this system is preferable to the prior full-board system. Nevertheless, available data indicates the board has successfully implemented the two-panel system and is, so far, managing its workload better than in previous years. However, board members and staff have noted some concerns with the new system; it is not yet known what effect, if any, these concerns may have in the long term.

Board Eliminated Complaint Backlog Prior to Two-panel System

In fiscal 2012, the board reorganized its Compliance Unit into teams, with one team specifically dedicated to addressing the backlog of cases. According to board reports, the board cleared 85% of pending cases in fiscal 2012; the backlog was eliminated by the end of fiscal 2013. During interviews with DLS, board staff noted that the backlog was reduced *before* the two-panel system was implemented; therefore, staff does not attribute elimination of the backlog to the new two-panel system. Rather, staff advised that the board was able to address the backlog through personnel and internal procedural changes, which resulted in more efficient processing of cases (*e.g.*, staff reorganization, delegation of additional duties to staff, and systematic review of backlogged cases to identify those that could readily move to the next stage of the complaint resolution process).

Despite Consistent Complaint Volume, Backlog Has Not Returned

Exhibit 3.2 shows the board's complaint volume and disciplinary activity from fiscal 2012 through 2016. The board continues to receive approximately 1,000 new complaints per year. The high number of pending complaints from a previous year in fiscal 2012 is indicative of the large backlog of unresolved cases at that time; this number decreased by about 70% in fiscal 2013 (as the board cleared the backlog) and remained relatively constant through fiscal 2016. Similarly, the high number of complaints closed in fiscal 2012 reflects the board's attempts to reduce the backlog; notably, the board closed 1,272 complaints (73% of total complaints) with no action in fiscal 2012. Board staff advises that the majority of pending cases were complaints that simply had not been moved through the process but were easy to close.

Exhibit 3.2
Complaint Volume and Disposition of Complaints
Fiscal 2012-2016

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>
<u>Complaint Volume</u>					
Complaints Pending from a Previous Year	835	254	254	248	294
New Complaints	1,156	988	1,018	932	1,073
Total Complaints Received	1,991	1,242	1,272	1,180	1,367
<u>Disposition of Complaints</u>					
Closed with No Action	1,272	633	553	498	607
Closed with Advisory Opinion	261	238	200	161	220
Closed with Formal Action	214	342	271	227	272
Total Complaints Closed	1,747	1,213	1,024	886	1,099

Note: Total complaints closed does not equal total complaints received as not all complaints are resolved in the same fiscal year they are received.

Source: *Fiscal 2014, 2015, 2016, and 2017 Budget Books*; State Board of Physicians

Board Generally Resolving Complaints within Statutorily Required Timeframe

Section 14-401.1(k) of the Health Occupations Article stipulates that complaints should be completed “as expeditiously as possible and, in any event, within 18 months after the complaint was received.” The board has generally met this goal (which equates to about 548 days) for cases that do not go through OAH. On average, from fiscal 2012 through 2016, the board resolved cases involving physicians in 428 days (1.2 years) and cases involving allied health professionals in 320 days (0.9 years). Cases involving the unlicensed practice of medicine took longer to resolve (476 days, or 1.3 years).

Additionally, the board refers approximately 10 cases per calendar year to OAH. Cases that go through the OAH process take significantly longer to resolve, as the process could involve both DCCR (prior to referral to OAH) and an exceptions hearing (after the OAH hearing) before the board issues a final decision and order. Between calendar 2012 and 2016, the board referred 50 cases to OAH; on average, these cases took 1,054 days (2.9 years) to resolve (from complaint receipt to the board’s final decision and order).

Concerns with the Two-panel System

Board staff indicates that the two-panel system has resulted in some internal inefficiencies and has not noticeably improved the timely resolution of complaints. Staff must now prepare cases

biweekly for two separate panels (with each meeting involving cases in different stages of the complaint resolution process) and must ensure that each case (and all information related to the case) progresses through the complaint resolution process with the correct panel, which has resulted in more work for staff. However, board staff was unable to provide data showing the suggested internal inefficiencies and acknowledged that the board has been able to process complaints with no backlog.

A slight majority of board members who were interviewed indicated that they generally favored the new system as a time saver. Some other board members favored the previous system due to concerns about inconsistency and expertise on the panels and because the complaint backlog was eliminated under the previous system. A few board members noted that they lacked the experience necessary to judge whether the current or previous system was better.

Some board staff and board members also expressed concern that the expertise on each panel is different and that, because cases are randomly assigned, some cases may not receive the benefit of the proper expertise. Staff advised that, given the composition of the board, it is not possible to ensure that each panel has the same specialties represented (*e.g.*, pain management, obstetrics/gynecology, etc.). Some board members noted that under the prior full-board system, cases received the attention of the full board and so could benefit from the full board's various expertise; some board members also expressed frustration that, although a member on the opposite panel may have the requisite expertise, the panels are prohibited from consulting each other under the current system.

DLS asked board staff if the panels are generally consistent regarding the types of cases assigned and the sanctions imposed. Board staff indicated that, while there may be slight inconsistencies between panels, they had not noticed any egregious differences. Some board members noted that some differences were to be expected given the different compositions of each panel and the unique situations of each case. **Exhibit 3.3** shows the actions taken by each panel in fiscal 2015.

As shown in Exhibit 3.3, each panel has taken certain types of actions more than the other panel. For example, Panel B summarily suspended licenses three times as often as Panel A, while Panel A issued cease and desist orders five times as often as Panel B. Because actions taken in disciplinary cases tend to hinge on the specific facts of the cases, one possible explanation for the differences in sanctioning is that the types and facts of cases randomly assigned to each panel warrant the differences in sanctions. The differences may not be indicative of a broader trend. Both board staff and board counsel are aware of the need for consistency in sanctioning between the two panels for similar types of cases and take steps, such as reminding a panel of what type of action has been typically taken in certain types of cases, to try to avoid any unwarranted inconsistencies.

Exhibit 3.3
Actions Taken by Panel
Fiscal 2015

<u>Action Taken</u>	<u>Panel A</u>	<u>Panel B</u>
Summary Suspension	2	6
Revocation	7	8
Surrender	9	4
Suspension	11	3
Reprimand	20	24
Probation Only	0	3
Fine Only	8	4
Fine with Other Action	8	4
Cease and Desist Order	5	1
Advisory Letter	11	4
Denial of Reinstatement	2	0
Dismissal/Closure	3	2
Other	1	0

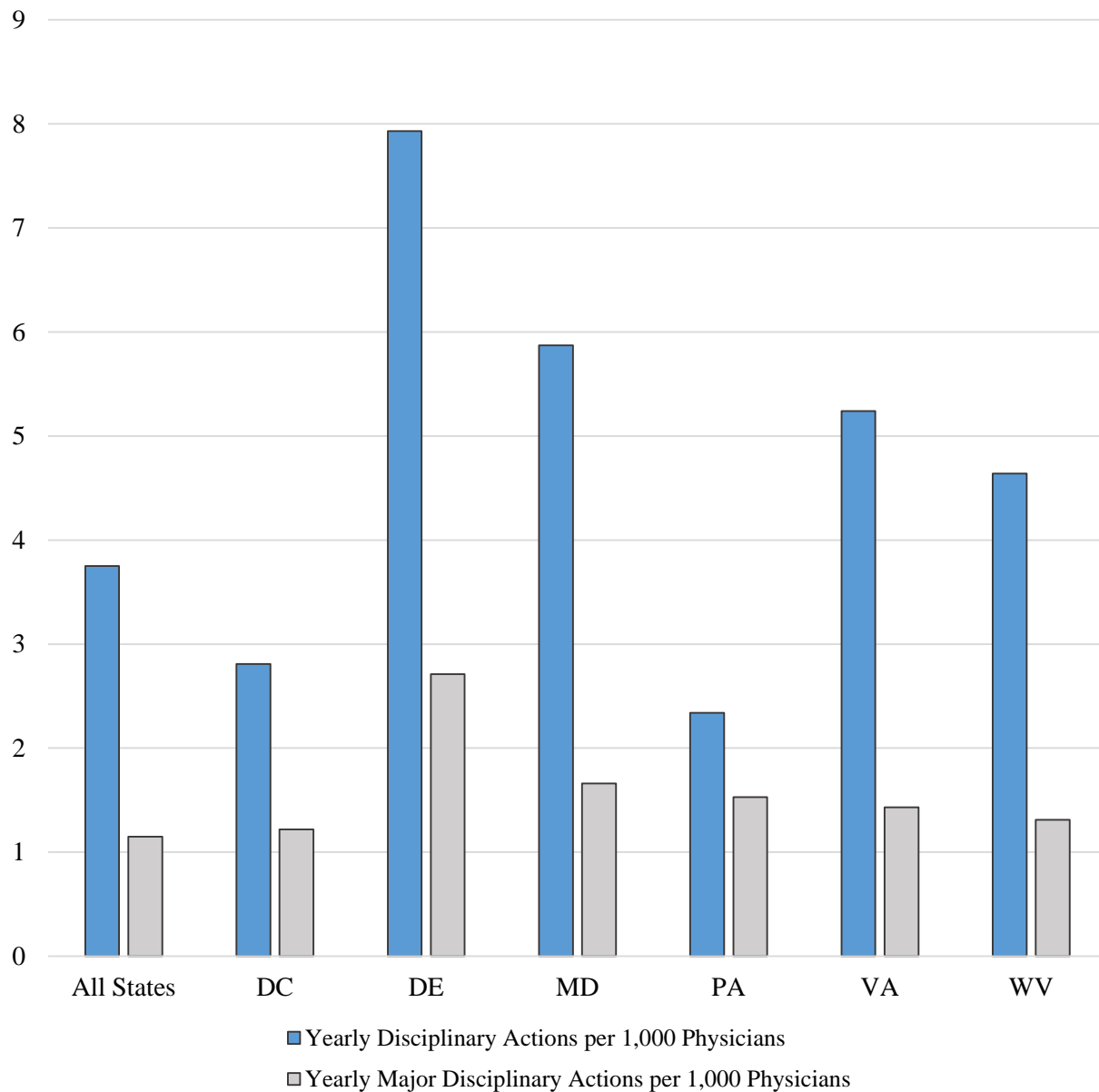
Note: Chart reflects final action taken by a panel either through a consent order or a final order.

Source: State Board of Physicians; Department of Legislative Services

Maryland Has Comparatively High Rate of Physician Disciplinary Action

As a measure of how well MBP may protect the public through the disciplinary process, data is available on the rates of physician disciplinary activity nationally. In February 2016, *BMJ Quality & Safety* published a study of state medical board physician disciplinary action rates across the United States between 2010 and 2014. The study found a fourfold variation in the annual rate of medical board disciplinary action by state, citing variations in resources and standards for judgment and disciplinary actions as possible contributing factors to the wide variation. According to this study, Maryland had the fifth highest rate of physician discipline (defined as yearly disciplinary actions per 1,000 physicians). Further, Maryland had the fourth highest rate of “major” physician disciplinary action (defined as yearly disciplinary actions involving the suspension, surrender, or revocation of a medical license per 1,000 physicians). As shown in **Exhibit 3.4**, among Maryland’s neighboring states, only Delaware had higher rates of disciplinary action.

Exhibit 3.4
Physician Disciplinary Actions by State Medical Boards
Calendar 2010-2014



Note: “Major” disciplinary actions are those involving the suspension, surrender, or revocation of a medical license.

Source: Harris, JA and Byhoff E., *Variations by State in Physician Disciplinary Actions by US Medical Licensure Boards*, BMJ Qual. Saf. (published online March 23, 2016)

Most Common Grounds for Discipline Remain Unchanged while Complaint Sources Continue to Shift

As noted in the 2011 sunset evaluation, immoral or unprofessional conduct and the failure to meet the standard of care continue to be the most common disciplinary grounds investigated by the board. As shown in **Exhibit 3.5**, from fiscal 2012 through 2016, the board investigated an average of 705 cases per fiscal year that involved immoral or unprofessional conduct and an average of 394 cases per fiscal year that involved the failure to meet the standard of care.

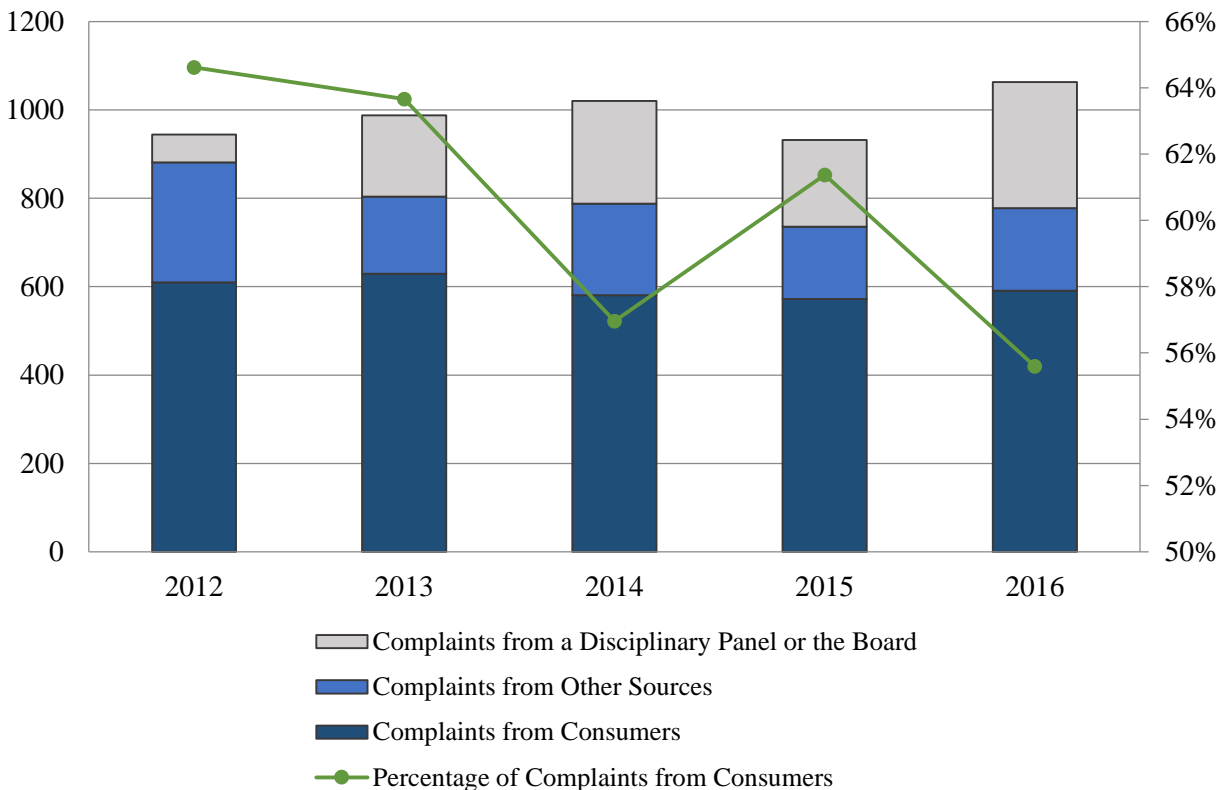
Exhibit 3.5
Number of Cases Investigated for Certain Grounds
Fiscal 2012-2016

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>Total</u>
Immoral or Unprofessional Conduct in the Practice of Medicine	663	1,012	679	570	601	3,525
Failure to Meet Standard of Care	468	611	257	286	248	1,970
Failure to Provide Medical Records to Another Physician or Hospital	67	80	55	46	51	299
Willfully Makes or Files a False Report or Record in the Practice of Medicine	26	42	11	3	12	94
Grossly Overutilizes Health Care Services	18	21	11	8	5	63
Patient Abandonment	11	12	11	13	8	55

Source: State Board of Physicians

The 2011 sunset evaluation found that complaints from consumers decreased from 73% of all complaints in fiscal 2007 to 64% in fiscal 2011. This trend has continued. As shown in **Exhibit 3.6**, complaints from consumers decreased from 65% in fiscal 2012 to 56% in fiscal 2016 while complaints from a disciplinary panel or the board increased from 7% in fiscal 2012 to 11% in fiscal 2016. The board attributes this increase to the reinstitution in 2013 of staff review of all “yes” answers to character and fitness questions on renewal applications, wherein staff determines if a preliminary investigation is required and presents such cases to a panel for review.

Exhibit 3.6
Maryland Board of Physicians Complaints by Source
Fiscal 2012-2016



Source: State Board of Physicians; Department of Legislative Services

Board Has Adopted and Generally Adheres to Sanctioning Guidelines

The 2011 sunset evaluation found that the board had not adopted sanctioning guidelines for physicians and allied health professionals (as required by Chapters 533 and 534 of 2010) and recommended withholding funds from MBP until the board promulgated such guidelines in regulations. Consequently, Chapter 148 of 2012 withheld \$1.0 million from MBP until the sanctioning guidelines were adopted.

The board adopted sanctioning guidelines regulations for physicians and allied health professionals in January 2013. The guidelines list the minimum and maximum disciplinary sanctions and fines that may be imposed for violations of each of the statutory grounds for discipline. A panel may impose a sanction that is outside of the guidelines if there are aggravating or mitigating factors, as set out in regulation; the panel must state its reasons for departing from

the sanctioning guidelines in its final decision and order. Additionally, a panel and licensee may agree to a surrender of license or a consent order with terms, sanctions, and fines agreed to by the panel, administrative prosecutor, and the licensee, notwithstanding the guidelines.

The guidelines list a wide range of permissible sanctions for each offense. For example, of the 43 disciplinary grounds for physicians, 22 of the grounds carry a reprimand as a minimum sanction and revocation as the maximum sanction; a panel may impose any sanction within this range, at the panel's discretion. When asked if they found the guidelines helpful, board members and staff commented on the broad nature of the guidelines and noted that, while the guidelines do provide some point of reference when considering appropriate sanctions, the guidelines do not ensure consistency between similar cases. However, board members and staff were reluctant to suggest stricter guidelines, citing the unique circumstances of each case and the need for flexibility. DLS reviewed the board's list of public disciplinary actions for physicians in fiscal 2015. The board adhered to the sanctioning guidelines in all but one instance: in that case, the board adopted the recommendations of the ALJ, whose order cited both aggravating and mitigating factors.

Board Should Increase Transparency in Sexual Misconduct Cases

National Interest in Sexual Misconduct Cases and the Transparency of State Medical Board Actions

In July 2016, the *Atlanta Journal-Constitution* (AJC) conducted a national investigation of disciplinary documents and records from state medical boards to identify cases involving doctors and sexual misconduct. The investigation identified more than 3,100 doctors who were publicly disciplined since January 1, 1999, for "sexual infractions." Of these, more than 2,400 doctors were publicly sanctioned for violations involving patients and the remainder were disciplined for sexual harassment of employees or for crimes like child pornography, public indecency, and sexual assault.

AJC noted that many sexual misconduct cases are handled "secretly" by state medical boards, such as through nonpublic action, and that there are often other barriers to board transparency like the failure of many state medical boards to post pending criminal charges, board orders, and underlying details about cases online or in physician profiles. Some states fail to maintain physician profiles with accurate information; others have physician profiles that are not easily accessible or understandable by the public.

As part of its investigation, AJC created a profile for each state with a "state report card" on how well each state protects patients against sexually abusive doctors. Maryland was ranked fifth overall. Further, AJC specifically scored states in the area of transparency, which included an assessment of whether the state provides complete and accurate information on physician discipline and how easily accessible this information is to the public. Maryland received the fourth-highest score in this category. AJC's profile for Maryland can be found at http://doctors.ajc.com/states/maryland_sex_abuse/.

Maryland Practitioner Profiles Accessible, but Sexual Misconduct Cases Difficult to Identify

AJC notes that MBP's practitioner profiles are accessible through the board's website. AJC also found that board orders often detail the complaints that led to disciplinary sanctions against a doctor. However, AJC noted that some profile information is limited to the most recent 10 years and that MBP issues nonpublic advisory letters, which are not included in profiles.

Statute requires the board to provide "appropriate and accessible" links to practitioner profiles from the board's website. The profiles must include certain information, including (1) a summary of charges filed against the licensee, including the charging document, until a disciplinary panel has taken action or has rescinded the charges and (2) a description of any disciplinary action taken by the board or a panel within the most recent 10-year period, including copies of public orders.

The 2011 sunset evaluation found that the board was not disclosing the filing of charges against licensees to the public, as required by statute. DLS recommended that statute be amended to require MBP to disclose the filing of charges on licensee profiles on the board's website with a disclaimer that charging documents do not indicate a final finding of guilt. Chapter 401 of 2013 enacted these recommendations.

While practitioner profiles generally contain the appropriate level of detail and the disclaimer regarding the filing of charges, as required by statute, DLS noted that cases involving sexual misconduct are not always easily identifiable based on the summaries of board orders. Cases involving physician sexual misconduct are usually charged as immoral conduct in the practice of medicine and/or unprofessional conduct in the practice of medicine. Licensees may also be charged with violating the board's sexual misconduct regulations.

DLS reviewed the board's disciplinary actions between October 2014 and September 2015 for cases that involved violations of these grounds, reviewed the corresponding practitioner profiles, and identified those that involved sexual misconduct. DLS found that order summaries on some licensee profiles do not reference the grounds the licensee violated; even if the grounds are referenced, the underlying sexual misconduct may not be mentioned. Some summaries specifically reference the board's sexual misconduct regulations, while others make no mention of these regulations even though the licensee was found to have violated the regulations.

Although the public may learn more about each case by clicking on the links to the board's orders and reviewing the orders themselves, these documents are often lengthy and complex. Therefore, a description of the underlying conduct in the order summaries would help the public understand the nature of the conduct for which the licensee was disciplined. This may be especially helpful for sexual misconduct cases, where the conduct is not always readily apparent based on the violated disciplinary grounds (*i.e.*, immoral or unprofessional conduct). In cases where the licensee was specifically found to have violated the board's sexual misconduct regulations, the board should ensure that these regulations are referenced in the order summaries.

Recommendation 7: The board should ensure that the sexual misconduct regulations are referenced in the order summaries in cases where the licensee was specifically found to have violated them. Additionally, the board should comment in a follow-up report on the feasibility of describing the underlying sexual misconduct in order summaries or other steps that the board can take to make it easier for the public to determine whether a case involved sexual misconduct.

Reporting Requirements Should Be Enhanced for MBP and All Other Health Occupations Boards as Current Reports Not Sufficiently Detailed

Sexual Misconduct Reporting

Section 1-212(e) of the Health Occupations Article requires each health occupations board to submit a statistical report to the Secretary of Health and Mental Hygiene with the number of sexual misconduct complaints received and the resolution of each complaint during the reporting period (October 1 through September 30). The Secretary must compile the information and submit an annual report to the General Assembly by December 31 of each year.

Other than “the number of complaints of sexual misconduct received and the resolution of each complaint,” statute does not mandate any specific reporting measures. Currently, DHMH includes the following information in its reports for each board during the reporting period:

- total number of sexual misconduct complaints received;
- number of individuals involved in the complaints;
- number of complaints still under investigation;
- number of complaints referred to OAG for prosecutorial action;
- number of complaints resulting in denials of licensure, reprimands, probations, and suspensions; and
- number of complaints resulting in other actions.

Exhibit 3.7 shows the number of sexual misconduct complaints received and the disposition of complaints by MBP during each reporting period between October 1, 2011, and September 30, 2015, as reported by DHMH. As shown in Exhibit 3.7, most sexual misconduct complaints received by MBP generally resulted in “other actions”; however, with the exception of the October 1, 2011 through September 30, 2012 reporting period, DHMH’s report did not provide any detail as to what “other actions” the board took in these cases. Such information was also lacking for other health occupations boards in certain reporting periods.

Exhibit 3.7
Receipt and Disposition of Sexual Misconduct Complaints
By the State Board of Physicians
October 1, 2011-September 30, 2015

	<u>2011-2012</u>	<u>2012-2013</u>	<u>2013-2014</u>	<u>2014-2015</u>
Complaints Received	19	30	22	20
Individuals Involved	20	34 ¹	30	27
Under Investigation	11	16	8	8
Denials of License	0	0	0	0
Reprimands	0	1	0	0
Probations	0	0	0	0
Suspensions	1	1	1	0
Referred to OAG	2	0	2	1
Other Actions ²	6	11	11	11
Advisory Letter	3	5	3	5
Dismissed	1	6	3	5
Letter of Surrender	2	0	2	0
Summary Suspension	0	0	3	0
Consent Agreement	0	0	0	1

¹ In one case, the total number of individuals was unknown.

² Detail on other actions was provided only for the 2011-2012 reporting period; information for remaining years was provided by the State Board of Physicians.

Source: Department of Health and Mental Hygiene; State Board of Physicians; Department of Legislative Services

Reporting of Cases Referred to Law Enforcement

If MBP or a disciplinary panel determines that information contained in a record concerns possible criminal activity, the board or the panel must disclose the information to a law enforcement or prosecutorial official. AJC's profile on Maryland states that, while MBP is required to inform law enforcement of possible criminal sexual violations with a patient, the board must substantiate allegations first.

The reports submitted by DHMH do not include information on the number of sexual misconduct complaints forwarded to law enforcement for possible criminal prosecution. Upon further inquiry from DLS, MBP reported that there were three referrals to law enforcement in fiscal 2016. While cases have been forwarded to law enforcement in the past, the board advised that specific numbers for prior years are not available as such referrals were not previously tracked. The board created a specific tracking code for such referrals on August 1, 2016.

The board advises that it refers cases to law enforcement based on recommendations of the board's counsel and/or administrative prosecutors on whether the conduct could be considered criminal under the law.

Given the high interest in how state regulatory boards handle complaints of sexual misconduct, DHMH should include more detailed information in its annual reports on the health occupations boards' receipt and disposition of sexual misconduct complaints.

Recommendation 8: Statute should be amended to require that the sexual misconduct reports specify for each health occupations board (1) the total number of sexual misconduct complaints received; (2) the number of practitioners and complainants involved in the complaints; (3) the number of complaints still under investigation; (4) the number of complaints that were closed with no disciplinary action; (5) the number of complaints that resulted in informal or nonpublic action; (6) the number of complaints resulting in denials of licensure, reprimands, probations, suspensions, and revocations; (7) the number of complaints that were referred to OAG for prosecutorial action; (8) the number of complaints that were forwarded to law enforcement for possible criminal prosecution; and (9) if other actions were taken, a detailed breakdown of the types of action.

Board Has Improved Tracking of Sexual Misconduct Cases

The 2011 sunset evaluation recommended that the board institute a process for tracking sexual misconduct cases and that the board reopen all relevant cases using the original case number. The board advises that it declined to reopen all relevant cases using the original case number because it could potentially result in a case being left open beyond the 18-month benchmark for case completion. However, sexual misconduct cases are now tracked using the "immoral conduct in the practice of medicine" ground for discipline; when staff query the history of a licensee, these cases are flagged (with a summary of the conduct) to show that the licensee has a history of sexual misconduct complaints. Prior cases may be incorporated into new investigations. Cases are tracked based on the allegations in the complaint, regardless of the actual grounds charged or whether the case results in disciplinary action. As noted previously, the board now also tracks cases that are referred to law enforcement for possible criminal prosecution.

Other Issues

Disciplinary Matters Currently Handled by Full Board Could Shift to the Panels to Improve Efficiency

As discussed earlier in this report, the complaint resolution process for health care professionals licensed by the board was changed in 2013 to require two separate disciplinary panels, instead of the full board, to consider and act on most disciplinary matters. Proceedings involving the unauthorized practice of medicine, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders continue to require action by the full board.

Since the full board officially meets only four times per year, these proceedings typically are handled at the beginning of disciplinary panel meetings by having members of the *other* disciplinary panel call in to the meeting for the purpose of acting on these cases. DLS staff observed one disciplinary panel meeting at which an unlicensed practice of medicine case appeared on the wrong agenda, creating a delay in acting on the case. Members who call in to the panel meetings sometimes find it hard to hear and miss the opportunity for face-to-face discussion. Board staff advises that moving these proceedings from the full board to the disciplinary panels could avoid logistical delay and expedite case resolution.

As the effectiveness and efficiency of the two-panel system has not been adequately demonstrated, DLS finds it premature to recommend shifting remaining disciplinary matters from the full board to the panels. The next sunset review of the board should consider whether the shift is warranted.

Recommendation 9: The next sunset evaluation of MBP should examine the desirability of shifting proceedings involving the unauthorized practice of medicine, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders from the full board to the disciplinary panels.

Peer Review Requirements for Standard of Care Cases Should Be Clarified

After being assigned a complaint, statute requires a disciplinary panel to refer “any allegation in the complaint” based on standard of care for two peer reviews; other cases may be referred for peer review at the panel’s discretion. **Exhibit 3.8** shows the number of cases referred and the average number of days to complete peer review from fiscal 2012 through 2016.

Exhibit 3.8
Cases Referred and Average Number of Days to Complete Peer Review
Fiscal 2012-2016

	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>
Number of Cases	98	25	36	49	20
Average Number of Days	65	72	70	63	55

Source: State Board of Physicians; Department of Legislative Services

Given that standard of care cases are the second most frequent cases investigated by the board (see Exhibit 3.5) and the requirement that a disciplinary panel refer any standard of care complaint to the board’s peer review entity, DLS initially expected the number of cases referred for peer review to be much higher than what was ultimately reported. Upon further inquiry, board staff advised that only those cases in which allegations have been substantiated are referred for

peer review. Board counsel further noted that a complaint is assigned to a panel *after* the completion of the preliminary investigation. Although allegations might be characterized in the original complaint as involving standard of care, the preliminary investigation often shows that other grounds are more appropriate (*e.g.*, overutilization of health care services or unprofessional conduct) or that the claims have no factual basis. Thus, standard of care cases are referred to peer review after the panel reviews the preliminary investigation and orders a full investigation; this results in fewer cases sent to peer review.

Recommendation 10: Statute should be amended to clarify that the panel must refer a complaint for peer review if the panel decides, after reviewing the results of the preliminary investigation, that the licensee may have committed a standard of care violation.

Statute Should Be Amended to Require that Complaints Against Naturopathic Doctors Be Handled in the Same Manner as Those Against Other Allied Health Professionals

If a complaint is against an allied health professional, statute requires that the disciplinary panel consult with the chair of the appropriate allied health advisory committee, or the chair's designee, before taking disciplinary action against the allied health professional. Statute also specifies that complaints against allied health professionals be treated the same as complaints against physicians. For example, statute specifies that a disciplinary panel can enter into a consent order with an allied health professional, just as can be done with a physician.

However, when naturopathic doctors were added to the jurisdiction of the board, the definition of "allied health professional" was not amended to include them and neither were other changes made so that the board would be required to treat them the same with respect to the complaint process as other allied health professionals. As a result, the board could have different processes for handling complaints against naturopathic doctors than it has for handling all other complaints.

Recommendation 11: Statute should be amended to require that complaints against naturopathic doctors be handled in the same manner as complaints against other allied health professionals.

Board's Authority to Discipline Unlicensed Medical Practitioners Needs Clarification

Unlicensed medical practitioners (UMPs) are medical students completing clinical training and medical graduates completing postgraduate training in the State. Statute provides that, subject to the rules, regulations, and orders of the board, UMPs may practice medicine without a license. In 1995, the board adopted regulations governing UMPs that require the institutions at which the UMPs are training to register UMPs with the board. The regulations also authorize the board to take disciplinary action against an UMP in the same manner and for the same disciplinary grounds as if the UMP was a licensed physician. However, it is not clear that the board has statutory authority to take disciplinary action against UMPs.

Although the board has power to adopt regulations to carry out the Maryland Medical Practice Act, the statutory authority cited for the regulations that relate to the disciplinary authority of the board only authorize the board to take action against applicants for licenses to practice medicine and licensed physicians. Also, the regulations reference provisions of law that only apply to licensed individuals. For example, the regulations state that the board can take certain action against an UMP subject to the hearing provisions of § 14-405 of the Health Occupations Article. That section, however, only requires the board to provide an opportunity for a hearing before taking any action against applicants for licenses to practice medicine or respiratory care, licensed physicians, and licensed respiratory care practitioners. The regulations also require the board, under certain circumstances, to revoke the registration of an UMP for a crime involving moral turpitude “subject to the statutory mandate” of § 14-404(b)(2) of the Health Occupations Article. However, § 14-404(b)(2) only requires the board to revoke the license of a physician.

Even though the authority of the board is unclear, no known issues have arisen due to the board’s practice. According to the board and board documents, disciplinary action is rarely taken against UMPs. Statute should be amended to distinguish between individuals who are truly excepted from licensure and UMPs and explicitly allow the board to discipline UMPs in the same manner that applicants for licensure and licensees are disciplined.

Recommendation 12: Statute should be amended to (1) distinguish between individuals who are truly excepted from licensure and UMPs and (2) explicitly allow the board to discipline UMPs in the same manner that applicants for licensure and licensees are disciplined.

Reporting Requirements for Hospitals and Other Entities Need Updates

Under § 14-413 of the Health Occupations Article, each hospital and related institution must report every six months to MBP regarding denials of physician privileges or limitations on privileges and disciplinary actions taken against employed physicians or individuals in a postgraduate medical training program. Similar information is required to be reported regarding physicians by alternative health systems under § 14-414 of the Health Occupations Article. In addition to the six-month reports, the entities also must submit a report to MBP within 10 days of any action taken against a physician or individual in a postgraduate medical training program. Similar requirements apply to actions taken against allied health professionals and naturopathic doctors.

The 2011 sunset report noted that compliance with the statutory reporting requirements was poor, with only 49 reports received in total between fiscal 2007 and 2011. The report made several recommendations for board action to improve compliance, including conducting outreach to the reporting entities, exercising the board’s authority to issue civil fines against an entity that does not report, and posting on the board’s website a Report of Disciplinary Action form that may be used to report when a licensed allied health professional is disciplined or terminated. MBP has implemented or is in the process of implementing these recommendations, and compliance has improved markedly. As shown in **Exhibit 3.9**, over 400 reports have been received each year from reporting entities.

Exhibit 3.9
Mandatory Reporting for Hospitals, Related Institutions, and
Alternative Health Systems
2013-2016

	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>
Number of hospitals subject to the reporting requirement	62	63	63	63
Number of related institutions and alternative health systems subject to the reporting requirement	2,411	2,489	2897	Not yet available
Number of entities that made reports	410	424	424	326

Source: State Board of Physicians

New regulations that took effect in November 2016 strengthen the board's ability to enforce the statutory reporting requirement. The regulations specify the actions that entities must report to MBP and establish a process for MBP to impose civil penalties on entities that fail to report as required.

Although compliance with State-mandated reporting has improved since the last sunset review, a change in the reporting law is warranted. A report by a reporting entity submitted within 10 days of an action taken by the entity prompts the board to undertake an investigation. These "10-day reports" are helpful to the board in carrying out its mission to protect the public. However, the board has found that the cumulative reports that reporting entities are required to submit every six months have been confusing to the reporting entities and are not useful to the board.

Recommendation 13: Statute should be amended to repeal the six-month mandated reporting requirement.

Miscellaneous Statutory Requirements Regarding the Office of Administrative Hearings Should Be Modified

Chapter 539 of 2007 required the Chief Administrative Law Judge to designate a pool of ALJs to hear cases referred to OAH by MBP. The law also required MBP to provide training at least annually to OAH personnel on medical terminology, medical ethics, and, to the extent practicable, descriptions of basic medical and surgical procedures currently in use. The 2011 sunset report advised that a pool of judges had not been appointed and only three training sessions had occurred. The report suggested that MBP may wish to work with OAH to assess whether further actions should be taken related to adjudicating cases through OAH.

Only about 10 MBP cases each year are heard by OAH. The Chief Administrative Law Judge contends that appointing a pool of judges for MBP cases is not necessary because (1) all judges are cross-trained, (2) all judges hear every type of case, (3) MBP cases are not necessarily any more complex than other cases coming before OAH, (4) more experienced judges are appointed to hear any complex MBP cases as they are for any other complex cases, (5) requiring MBP cases to be heard only by certain judges could create scheduling problems for the total OAH caseload, (6) a pool of judges just for MBP would create an exception for one agency, and (7) the common practice nationally is not having expert judges.

MBP does provide training to OAH, most recently in March 2016. OAH personnel also participate in training for MBP members. Additionally, MBP has quarterly meetings with OAH to discuss any issues that arise. At these meetings, training needs are discussed and resources and educational materials are shared and then disseminated to the ALJs and/or board staff, prosecutors, or other counsel.

Recommendation 14: Chapter 539 of 2007 should be amended to repeal the requirement that the Chief Administrative Law Judge designate a pool of ALJs to hear cases referred by MBP. Conversely, the requirement in Chapter 539 that MBP provide annual training to OAH should be codified. Also, MBP and OAH should update each other, as necessary, regarding developments and changes in procedures that affect the other entity and the efficiency of the complaint process.

Chapter 4. Resource and Administrative Issues

Since the 2011 sunset evaluation, the State Board of Physicians (MBP) has undergone some significant fiscal and administrative changes. The Department of Legislative Services (DLS) found that the board continues to maintain a healthy fund balance but that the staff vacancy rate has increased. Additionally, beginning in fiscal 2017, the board will retain a significant portion of its revenues that was historically contributed toward scholarship funds. Given these savings, and the board's improved tracking of fiscal information for allied health professions, DLS concluded that the board should undertake another internal cost analysis and reassess fee levels for licensed professions. Further, while the board has taken steps to enhance transparency of its operations, the board could still improve its compliance with the Open Meetings Act. The board has also improved its information technology system; however, the status of the system's planned overhaul remains uncertain. Finally, DLS determined that statutory changes are needed to align the drug therapy management program with current practice.

Board Maintains a Healthy Fund Balance

MBP is special funded and derives its support from fees. License fee levels are supposed to approximate the cost of maintaining the board. On average, board fee revenues are \$10.1 million annually. However, due to the staggered, biennial license renewal cycle, revenues are approximately \$2.0 million higher in odd-numbered fiscal years than even-numbered fiscal years. As shown in **Exhibit 4.1**, revenues have increased 10% between fiscal 2012 and 2016, due to the addition of three new categories of allied health professionals: athletic trainers (fiscal 2012); perfusionists (fiscal 2014); and naturopathic doctors (fiscal 2016). The board's annual total expenditures generally align with annual revenues collected. Expenditures are projected to increase by approximately 23% between fiscal 2012 and 2017; the projected 19% increase in expenditures between fiscal 2016 and 2017 is primarily due to the board's expected attempts to improve its information technology (IT) system. Despite the increase in overall expenditures, the board continues to maintain a healthy fund balance (more than 20% of expenditures) – an indication that current fee levels are more than sufficient to cover the board's operating costs.

As noted in the 2005 and 2011 sunset evaluations, MBP began accruing a fund balance in 2001, and the board's fund balance consistently has remained above the recommended 20% threshold for health occupations boards of its size. The board's ending fund balance gradually became a smaller percentage of the board's expenditures, decreasing from 138% in fiscal 2007 to 66% in fiscal 2011, primarily due to the transfer of funds to the general fund through budget reconciliation and financing legislation. Funds were again transferred to the general fund in fiscal 2012, 2013, and 2015. Collectively, a total of \$2.3 million was transferred between fiscal 2012 and 2016 through budget reconciliation and financing legislation.

Exhibit 4.1
State Board of Physicians Fiscal History
Fiscal 2012-2017

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>	<u>Projected FY 2017</u>
Beginning Fund Balance	\$5,084,899	\$4,181,378	\$5,357,785	\$5,836,711	\$5,467,630	\$5,181,941
Revenues Collected ¹	8,669,880	10,724,385	9,115,349	11,115,607	9,576,129	11,337,919
Total Funds Available	13,754,779	14,905,763	14,473,134	16,952,318	15,043,759	16,519,860
Total Expenditures	8,398,239	7,964,843	7,543,134	8,327,631	8,695,846	10,305,528
Cash Transfer to Scholarship Fund ²	1,000,162	1,262,743	1,093,289	1,357,057	1,165,972	550,000
Cash Transfer to General Fund ³	175,000	320,392	0	1,800,000	0	0
Ending Fund Balance	4,181,378	5,357,785	5,836,711	5,467,630	5,181,941	5,664,332
Target Fund Balance	\$1,679,648	\$1,592,969	\$1,508,627	\$1,665,526	\$1,739,169	\$2,061,106
Balance as a % of Expenditures	49.8%	67.3%	77.4%	65.7%	59.6%	55.0%

¹ Excludes the Maryland Health Care Commission assessment collected by the board as a pass-through.

² Reflects statutorily mandated transfers to the Health Personnel Shortage Incentive Grant Program (HPSIG) and the Maryland Loan Assistance Repayment Program (MLARP). Chapter 178 of 2016 repealed the contribution to HPSIG and capped the board's MLARP contribution at \$550,000 in fiscal 2017 and 2018 and \$400,000 in each fiscal year thereafter.

³ Transfers to the general fund made by the Budget Reconciliation and Financing Acts of 2011, 2012, and 2015.

Source: State Board of Physicians; 2014-2017 Budget Books; Department of Legislative Services

Board Will Contribute Less to Scholarships and Retain More Fee Revenue

As required by statute, MBP has historically contributed 12% of its revenue to the Health Personnel Shortage Incentive Grant Program (HPSIG) and the Maryland Loan Assistance Repayment Program (MLARP). HPSIG provides grants to eligible institutions of higher education that have programs leading to licensure, certification, or registration in health personnel shortage areas. MLARP provides loan repayment assistance in exchange for certain service commitments to help ensure underserved areas of the State have sufficient numbers of primary care physicians and physician assistants. Between fiscal 2012 and 2016, MBP contributed an average of \$1.2 million per year for HPSIG and MLARP (funds were divided equally between the programs). However, Chapter 178 of 2016 repealed the statutory requirement that MBP contribute a portion of its fees to HPSIG and capped MBP's required contribution to MLARP at \$550,000 in fiscal 2017 and 2018 and at \$400,000 in each fiscal year thereafter. Therefore, beginning in fiscal 2017, MBP will retain more of its fee revenue each year.

Between fiscal 2012 and 2016, the board received an average of \$9.1 million in fee revenue in even-numbered fiscal years and an average of \$10.9 million in odd-numbered fiscal years. Pursuant to Chapter 178 of 2016, instead of 12% of its annual total fee revenue, the board must contribute only \$550,000 in fiscal 2017 and 2018 and only \$400,000 beginning in fiscal 2019 toward MLARP. **Exhibit 4.2** summarizes MBP's estimated retained revenue from fiscal 2017 through 2021 under Chapter 178.

Exhibit 4.2 Estimated Retained Revenue for the State Board of Physicians under Chapter 178 of 2016 Fiscal 2017-2021

	<u>FY 2017</u>	<u>FY 2018</u>	<u>FY 2019</u>	<u>FY 2020</u>	<u>FY 2021</u>
Total Revenue ¹	\$10,919,996	\$9,120,453	\$10,919,996	\$9,120,453	\$10,919,996
Prior Mandated Contribution ²	1,310,400	1,094,454	1,310,400	1,094,454	1,310,400
New Mandated Contribution ³	550,000	550,000	400,000	400,000	400,000
Estimated Retained Revenue⁴	\$760,400	\$544,454	\$910,400	\$694,454	\$910,400

¹ Based on average total collected revenue in even-numbered and odd-numbered fiscal years.

² Prior to Chapter 178 of 2016, the board's mandated contribution was 12% of total fee revenue.

³ Pursuant to Chapter 178 of 2016.

⁴ Figures differ from the fiscal and policy note for Senate Bill 217 of 2016 (Chapter 178), which assumed the State Board of Physicians' revenue remained relatively constant in subsequent fiscal years, as actual revenues are higher in odd-numbered fiscal years and lower in even-numbered fiscal years.

Source: Department of Legislative Services

Staff Vacancy Rate Has Increased

The 2011 sunset evaluation found that the board's vacancy rate decreased from 15% in fiscal 2007 to 9% in fiscal 2010, but that the vacancy rate was still at 6.54 positions (higher than its budgeted turnover rate of 3%) for fiscal 2010. As shown in **Exhibit 4.3**, the vacancy rate has since increased from 7.9% in fiscal 2012 to 11.3% in fiscal 2016. The vacancy rate reached a peak of 15.9% in fiscal 2014; this included key staff leadership positions of executive director and deputy director (both of which have since been filled). MBP planned to reclassify three vacant positions for criminal history records check implementation in fiscal 2017, but these positions were later abolished by the Department of Budget and Management.

Exhibit 4.3
Total Positions and Average Number of Vacancies
For the State Board of Physicians
Fiscal 2012-2016

	<u>FY 2012</u>	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>
Authorized Positions	67.10	70.10	70.10	70.10	71.10
Contractual Positions	2.48	3.40	1.85	2.97	5.30
Average Number of Vacancies	5.33	8.67	11.13	9.09	8.00
Vacancy Rate (%)	7.9%	12.3%	15.9%	13.0%	11.3%

Source: State Board of Physicians; Department of Legislative Services

Both in interviews with DLS and in board reports, the board has maintained that the current staffing level is inadequate to meet the board's workload. In addition to new allied health professions (athletic trainers, perfusionists, and naturopathic doctors), the board's responsibilities also now include implementation of criminal history records checks, which involves some manual data entry and processing. The board also reports that its Allied Health Unit is particularly understaffed for dealing with the current volume of physician assistant delegation agreements, and that additional personnel are also needed in the Communications, Education, and Policy Unit to timely handle external board inquiries (*e.g.*, Public Information Act requests) and to draft board regulations. As noted previously, DLS found that the board generally meets its licensing performance goals for physicians but that the licensing process could be improved for allied health professionals, and that criminal history records checks were delayed for initial applicants for licensure due in part to personnel shortages. DLS also found that the board generally processes complaints in a timely manner and seems to handle its complaint workload better than in previous years, but that the long-term effectiveness of the two-panel disciplinary system is unclear and may eventually be affected by staff workload.

Board Improved Tracking of Fiscal Information for Allied Health

To enable the board to better approximate the costs associated with allied health expenditures and whether fee levels were appropriate, the 2011 sunset evaluation recommended that the board budget allied health expenditures under a separate program code and report allied health revenues separately. In fiscal 2013, the board created a separate program cost code for allied health, allowing the board to report allied health expenditures and revenues separately from physicians. **Exhibit 4.4** shows the subset of revenues and expenditures associated with the allied health professions from fiscal 2013 through 2016. Beginning in fiscal 2017, the board will use specific budget codes to monitor the board's revenue by practitioner type and service provided.

Exhibit 4.4
Fiscal Condition of Allied Health Unit
Fiscal 2013-2016

	<u>FY 2013</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>FY 2016</u>
Allied Health Revenues	\$1,696,192	\$1,059,006	\$1,892,454	\$1,079,470
Allied Health Expenditures				
Salaries and Wages	397,473	451,432	544,057	604,247
Fixed Charges	0 ¹	52,161	59,686	51,982
Technical and Special Fees	12,936	11,372	33,550	37,911
Contractual Services	7,885	29,808	33,707	21,081
Travel	4,765	5,092	7,254	7,015
Total Expenditures ²	\$423,059	\$549,865	\$678,254	\$722,236
Difference Between Allied Health Revenues and Expenditures	\$1,273,133	\$509,141	\$1,214,200	\$357,234

¹ The board advises that the physicians program paid the Allied Health Unit's fixed charges in fiscal 2013.

² Total expenditures do not include communications costs of \$1 or \$0 each year.

Source: State Board of Physicians; Department of Legislative Services

Board Should Report More Detailed Fiscal Information and Reassess Fees

The 2011 sunset evaluation recommended that MBP assess its fee-charging practices, develop a long-term fiscal plan, and submit this information in follow-up reports to DLS. According to these follow-up reports, in fiscal 2012, MBP conducted an internal analysis to compare its fees for initial licensure, reinstatement, and renewal applications with other states. However, MBP did not ultimately alter its fee schedule. In fiscal 2014, MBP contracted with an

independent certified public accountant firm to conduct a long-term financial analysis, which included a cost allocation plan to match costs with revenues so as to create more equitable licensing fees among all of the board's licensed professions. The contracted report recommended options for altering the board's fee schedule, but noted that the cost analysis likely needed to be repeated once the board implements its new IT system. The board eventually decided not to alter the fee schedule, pending IT system implementation and other changes (*e.g.*, new accounting codes and legislative changes).

Since the 2011 sunset evaluation, the board has made several changes to its accounting practices, most notably a separate program cost code for allied health. Beginning in fiscal 2017, the board will also be able to report fiscal information by practitioner type. Such changes should enable the board to more closely assess and monitor the costs involved for each licensed profession. Further, while the board has made changes to its IT system, the development and improvement of its IT system is still an ongoing project; such changes may further improve board operations and reduce overall costs. Finally, beginning in fiscal 2017, the board will retain a significant portion of its fee revenue that will contribute to the board's already large fund balance. In light of these factors, the board would likely benefit from another cost analysis in the near future.

Recommendation 15: The board should report revenues and expenditures by practitioner type in its annual reports required under § 14-205 of the Health Occupations Article, beginning with the fiscal 2017 annual report. Further, in fiscal 2018, the board should conduct an internal fiscal analysis and reassess its fee schedules. The board should submit a follow-up report to DLS by October 1, 2018, with the results of the internal fiscal analysis, including any possible changes to the board's fee schedules for physicians and allied health professionals. The board should specifically comment on the board's fund balance in light of the additional retained revenue from the MLARP and HPSIG changes, as well as the ongoing issue of filling staff vacancies and the impact filling these vacancies would have on the board's expenditures and fund balance.

Board Should Continue to Improve Transparency

Board Can Further Enhance Compliance with Open Meetings Act

In the 2011 sunset evaluation, DLS noted that the board had violated the Open Meetings Act by discussing specific topics in the board's closed sessions, including the board's position on legislation and politically sensitive topics, when statute requires those topics to be heard in an open setting. DLS also noted that board counsel did not appear to be sufficiently active in determining whether agenda items were appropriate for closed meetings. While board counsel has become more active in reviewing agendas to prevent violations of the Open Meetings Act, DLS noted during the current evaluation that there are still occasions when violations have occurred.

When closing a meeting, the board is required under the Open Meetings Act to make a written statement of the reason for closing the meeting, including a citation of the authority, and a listing of topics to be discussed. DLS noted that the reason stated for closing board or disciplinary

panel meetings is that the board is prohibited from disclosing any information contained in a proceeding, record, or files of the board. This reason is given whether or not nondisciplinary items will be discussed so there is no notice to the public when the closed meeting agenda includes nondisciplinary items.

Recommendation 16: To enhance compliance with the Open Meetings Act, if the board or a disciplinary panel begins to discuss a matter in closed session that violates the Act, board counsel should advise the board or disciplinary panel that it is violating the Act and the board or disciplinary panel should cease discussion. Also, the board or disciplinary panel should state other statutory exceptions for closing a meeting in the written statement when nondisciplinary items are on the agenda.

Number of Full Board Meetings Needs to Be More Accurately Reported

MBP members and staff state that the full board only meets four times a year. Individuals outside the board who were interviewed by DLS also stated that there are only four full board meetings a year. Additionally, the information posted on the board's website, such as meeting notices and links to agendas and minutes, indicates that the full board only meets four times a year. While it is the case that the full board only meets together *in person* four times a year, full board meetings are conducted during the other months as well. This is accomplished by having the members of one disciplinary panel meet in person, while the members of the other disciplinary panel call in at the beginning so that business that needs to be acted on by the full board, such as approving delegation agreements, can be dealt with. As a result, the full board is actually meeting 20 times a year, rather than only 4.

Recommendation 17: To enhance public transparency, all documents and website information should clearly label all meetings in which the full board meets, either in person or through conference call, as meetings of the full board, rather than as meetings of a disciplinary panel.

Future of Proposed Information Technology System Remains Uncertain

Shortcomings of the board's outdated software systems were noted in the 2011 sunset evaluation, as well as in the University of Maryland, Baltimore report (the Perman Report), pointing to the need for the replacement of the board's existing systems. Since that time, efforts to replace the IT system have faltered due to staff turnover, differing assessments of the need for a custom-developed system versus an off-the-shelf system, hiring of a project manager, and a new approach to IT systems development at the Department of Information Technology (DoIT).

The 2011 sunset review found that the board's licensing and investigatory needs exceeded the board's software capabilities. The DLS analysis of the fiscal 2016 budget noted that the budget provided \$684,000 for planning a new IT system and that hiring of a project manager had stalled

for a year. In its response to the analysis, the board stated that its current IT system was 20 years old, had limitations such as extrapolating meaningful data, and was not equipped for an Internet platform. The board stated that its work required a modernized system that would allow conversion from a paper-based system to a paperless system. An additional goal was Internet capability to facilitate real-time information updates and exchanges. The board sought to hire a project manager to guide procurement of an IT system best suited to the board's needs.

The DLS analysis of the fiscal 2017 budget observed that a project manager was hired in June 2015 and a formal request for proposals was being prepared. The fiscal 2017 budget provided \$274,000 to continue planning, with the majority of the funding, \$1.1 million, planned for fiscal 2018 when the project was to be completed.

In the spring of 2016, DoIT determined that a shared services platform, in which the State Board of Pharmacy and State Board of Nursing, as well as MBP, would participate, would bring greater value to the IT project. DoIT requested the scope of work of the project be expanded to include the other boards.

In the course of the current sunset review, DLS found that the board provided information that was responsive to what was requested, though it sometimes took several weeks to obtain it and additional inquiries to reconcile the information with other information reported by the board. MBP staff advised DLS that the information requested was readily available, but that getting the right query and conducting quality assurance on the information sometimes took time. MBP staff asserts that the board's current IT system generally meets the board's needs. MBP staff no longer favors development of a new IT system and prefers to seek only an enhancement to the system to allow a web-based interface. As of September 2016, the status of the proposed new IT system was unclear.

Drug Therapy Management Program Statute Should Be Amended to Allow Current Practice

The Drug Therapy Management Program authorizes a physician and a pharmacist to enter into a therapy management contract that specifies treatment protocols that may be used to provide care to a patient. Therapy management contracts allow pharmacists to help manage a patient's medications in collaboration with a physician. A pharmacist may order laboratory tests and other patient care measures related to monitoring or improving the outcomes of drug or device therapy based on disease-specific, mutually agreed-upon protocols.

In the 2011 sunset report, DLS noted that participation in the program was low, with only nine physician-pharmacist agreements in effect at that time. DLS recommended that statute be amended to remove the requirement that physician-pharmacist agreements and protocols be approved by the State Board of Pharmacy and MBP. Instead, participating pharmacists and physicians should be required to submit copies of all agreements and protocols to their respective board and to promptly submit any modifications.

Chapter 658 of 2012 codified the recommended change to the statute. Chapter 658 also required the State Board of Pharmacy to report on the impact of the changes to the drug therapy management program. In October 2013, the State Board of Pharmacy reported that the boards had entered into a memorandum of agreement so that the process for establishing drug therapy management agreements would not be so onerous. The agreement required pharmacists and physicians that plan to engage in a drug therapy management agreement to submit the required documentation only to the State Board of Pharmacy. The State Board of Pharmacy then submits the documents to MBP for its records.

While MBP indicates the memorandum of agreement is working well, participation in the program remains low with only 25 new physician-pharmacist agreements approved in 2014 through September 2016.

Moreover, the procedure does not comply with the letter of the law, which requires a physician who has entered into a physician-pharmacist agreement to submit to MBP a copy of the agreement. The law does not provide for MBP to delegate the responsibility to the State Board of Pharmacy to receive the agreement on behalf of both boards. Since the memorandum of agreement between the boards is working well, statute should be modified to align with the current practice.

Recommendation 18: Statute should be amended to allow health occupations boards that have jurisdiction over authorized prescribers who have entered into a prescriber-pharmacist agreement to enter into an agreement with the State Board of Pharmacy to require that the authorized prescribers submit the agreement and any subsequent modifications to the agreement to the State Board of Pharmacy.

Chapter 5. Conclusion

Significant progress has been observed concerning the State Board of Physicians (MBP) and its related allied health advisory committees. MBP has implemented many of the recommendations included in the 2011 sunset evaluation or otherwise addressed most of the issues raised. Dedicated board and allied health advisory committee members continue to support MBP and its committees. The board has implemented changes to the licensing process to increase efficiency and is looking to implement further changes. Additionally, the complaint backlog has been eliminated, and the two-panel disciplinary process has been implemented. MBP plays a key role in protecting the public health and welfare, and there is no question that MBP and its allied health advisory committees should continue to exist.

The purpose of this report and its recommendations is to help MBP and its committees improve their ability to protect the public health and welfare and meet the challenges facing them. Because the two-panel system was implemented rather recently, the Department of Legislative Services (DLS) found that it could not evaluate the long-term efficacy of the new system. While there continues to be no complaint backlog, DLS, board staff, counsel, and members noted concerns regarding the new system, including staff workload, panel expertise, and consistency between panels. Although board staff and members, along with board counsel, work to address these concerns, it is unclear whether these efforts will adequately address the concerns on a long-term basis. Further evaluation of the new system is warranted. Additionally, due to the delayed implementation of criminal history records checks, DLS was unable to evaluate the effect that the requirement has on both the board and licensees. Finally, some of the issues raised in the 2011 sunset evaluation continue to linger, including issues with board licensing fees and the board's compliance with the Open Meetings Act.

Based on these findings, DLS recommends that the termination dates of MBP and its allied health advisory committees be extended for five years. The scope of the next sunset evaluation should be limited, as specified below. Any statutory changes recommended in this evaluation should be implemented through legislation adopted in the 2017 session. Uncodified language should be adopted in the 2017 session to require that the board include certain items in follow-up reports that are already required to be submitted on or before October 1, 2017, and October 1, 2018.

Recommendation 19: Statute should be amended to extend the termination date for the State Board of Physicians and the related allied health advisory committees until July 1, 2023. Further, uncodified language should be adopted to limit the scope of the next sunset evaluation to evaluating (1) the implementation of recommendations made in this report; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history records checks on the board and licensees. Uncodified language should be adopted to require that the board include in the follow-up report required to be submitted on or before October 1, 2017, under Chapter 401 of 2013, any issues specifically noted in this report for inclusion in a subsequent follow-up report, except for fiscal issues. Finally, uncodified language should be adopted in the 2017 session of the General Assembly to

require that the board include in the follow-up report required to be submitted on or before October 1, 2018, under Chapter 401 of 2013, any fiscal issues specifically noted in this report for inclusion in a subsequent follow-up report.

Appendix 1.

Draft Legislation

Bill No.: _____

Requested: _____

Committee: _____

Drafted by: Chilson

Typed by: Fran

Stored – 11/30/16

Proofread by _____

Checked by _____

By: **Leave Blank**

A BILL ENTITLED

1 AN ACT concerning

2 **State Board of Physicians and Allied Health Advisory Committees – Sunset**
 3 **Extension and Program Evaluation**

4 FOR the purpose of continuing the State Board of Physicians and the related allied health
 5 advisory committees in accordance with the provisions of the Maryland Program
 6 Evaluation Act (Sunset Law) by extending to a certain date the termination
 7 provisions relating to statutory and regulatory authority of the State Board of
 8 Physicians and the committees; altering the content of a certain statistical report
 9 regarding complaints of sexual misconduct; authorizing certain health occupations
 10 boards to enter into a certain agreement regarding prescriber–pharmacist
 11 agreements with the State Board of Pharmacy; altering the definition of “allied
 12 health professional” to include naturopathic doctors; requiring the State Board of
 13 Physicians to submit an annual report on or before a certain date each year to the
 14 Governor, the Secretary of Health and Mental Hygiene, and the General Assembly
 15 that includes certain data related to criminal history records checks; codifying the
 16 requirement that the State Board of Physicians provide certain training at least
 17 annually to the Office of Administrative Hearings; authorizing the State Board of
 18 Physicians to discipline individuals exempt from licensure under a certain provision
 19 of this Act in a certain manner and for certain grounds; authorizing a physician who
 20 fails to renew a license before the license expires to renew the license under certain
 21 circumstances; requiring the State Board of Physicians to consider certain factors in
 22 determining whether to take disciplinary action based on criminal history record

 EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



information against certain physicians or allied health professionals, rather than in determining whether to renew or reinstate the license; altering the circumstances under which a disciplinary panel is required to refer an allegation to peer review; repealing certain provisions of law rendered obsolete by certain provisions of this Act; repealing the requirement that hospitals, related institutions, and alternative health systems report certain information to the State Board of Physicians at certain intervals; making conforming changes; requiring that the State Board of Physicians include certain information in certain reports; limiting the scope of a certain full evaluation to certain matters; and generally relating to the State Board of Physicians and the related allied health advisory committees.

BY repealing and reenacting, with amendments,

Article – Health Occupations

Section 1–212(e), 12–6A–03(b), 14–101(a–1), 14–302(a), 14–316(a) and (g), 14–317, 14–401.1(a)(5)(i), (c)(1) and (2), (k), and (l), 14–411.1(b)(6)(iv), 14–413(a)(1) and (2), 14–414(a)(1) and (2), 14–5A–13(g), 14–5A–25, 14–5B–12(g), 14–5B–21, 14–5C–14(g), 14–5C–25, 14–5D–12(h), 14–5D–20, 14–5E–13(g), 14–5E–25, 14–5F–15(d), 14–5F–32, 14–602(c), 14–606(a)(5), 14–702, 15–307(g), and 15–502

Annotated Code of Maryland

(2014 Replacement Volume and 2016 Supplement)

BY adding to

Article – Health Occupations

Section 14–205.1, 14–205.2, and 14–302.2

Annotated Code of Maryland

(2014 Replacement Volume and 2016 Supplement)

BY repealing and reenacting, without amendments,

Article – Health Occupations

Section 14–316(c) and 14–606(a)(4)

Annotated Code of Maryland

(2014 Replacement Volume and 2016 Supplement)

BY repealing

Article – Health Occupations

Section 14–401.1(j)

Annotated Code of Maryland

- 1 (2014 Replacement Volume and 2016 Supplement)
- 2 BY repealing and reenacting, without amendments,
- 3 Article – Insurance
- 4 Section 24–201(a)
- 5 Annotated Code of Maryland
- 6 (2011 Replacement Volume and 2016 Supplement)
- 7 BY repealing and reenacting, with amendments,
- 8 Article – Insurance
- 9 Section 24–201(d)
- 10 Annotated Code of Maryland
- 11 (2011 Replacement Volume and 2016 Supplement)
- 12 BY repealing and reenacting, without amendments,
- 13 Article – State Government
- 14 Section 8–405(a)
- 15 Annotated Code of Maryland
- 16 (2014 Replacement Volume and 2016 Supplement)
- 17 BY repealing and reenacting, with amendments,
- 18 Article – State Government
- 19 Section 8–405(b)(5)
- 20 Annotated Code of Maryland
- 21 (2014 Replacement Volume and 2016 Supplement)
- 22 BY repealing
- 23 Chapter 539 of the Acts of the General Assembly of 2007
- 24 Section 4 and 5
- 25 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
- 26 That the Laws of Maryland read as follows:
- 27 **Article – Health Occupations**
- 28 1–212.

(e) (1) (i) Each year, each health occupations board shall submit a statistical report to the Secretary, indicating:

1. [the] **THE** number of complaints of sexual misconduct received [and the resolution of each complaint];

2. **THE NUMBER OF LICENSEES, CERTIFICATE HOLDERS, AND COMPLAINANTS INVOLVED IN THE COMPLAINTS OF SEXUAL MISCONDUCT LISTED SEPARATELY BY CATEGORY;**

3. **THE NUMBER OF COMPLAINTS OF SEXUAL MISCONDUCT STILL UNDER INVESTIGATION;**

4. **THE NUMBER OF COMPLAINTS OF SEXUAL MISCONDUCT THAT WERE CLOSED WITH NO DISCIPLINARY ACTION;**

5. **THE NUMBER OF COMPLAINTS OF SEXUAL MISCONDUCT THAT RESULTED IN INFORMAL OR NONPUBLIC ACTION;**

6. **THE NUMBER OF COMPLAINTS OF SEXUAL MISCONDUCT THAT WERE REFERRED TO THE OFFICE OF THE ATTORNEY GENERAL FOR PROSECUTORIAL ACTION;**

7. **THE NUMBER OF COMPLAINTS OF SEXUAL MISCONDUCT THAT RESULTED IN EACH OF THE FOLLOWING:**

A. **LICENSE REVOCATION;**

B. **SUSPENSION;**

C. **PROBATION;**

D. **REPRIMAND; AND**

E. **DENIAL OF LICENSURE;**

1 **8. THE NUMBER OF COMPLAINTS OF SEXUAL**
 2 **MISCONDUCT THAT WERE FORWARDED TO LAW ENFORCEMENT FOR POSSIBLE**
 3 **CRIMINAL PROSECUTION; AND**

4 **9. FOR ANY OTHER ACTIONS TAKEN REGARDING**
 5 **COMPLAINTS OF SEXUAL MISCONDUCT, A DETAILED BREAKDOWN OF THE TYPES OF**
 6 **ACTIONS TAKEN.**

7 (ii) The report shall cover the period beginning October 1 and ending
 8 the following September 30 and shall be submitted by the board not later than the
 9 November 15 following the reporting period.

10 (2) The Secretary shall compile the information received from the health
 11 occupations boards and submit an annual report to the General Assembly, in accordance
 12 with § 2–1246 of the State Government Article, not later than December 31 of each year.

13 12–6A–03.

14 (b) (1) **(I) [An] EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS**
 15 **PARAGRAPH, AN** authorized prescriber who has entered into a prescriber–pharmacist
 16 agreement shall submit to the health occupations board that regulates the authorized
 17 prescriber a copy of the prescriber–pharmacist agreement and any subsequent
 18 modifications made to the prescriber–pharmacist agreement or the protocols specified in
 19 the prescriber–pharmacist agreement.

20 **(II) A HEALTH OCCUPATIONS BOARD MAY ENTER INTO AN**
 21 **AGREEMENT WITH THE BOARD OF PHARMACY THAT REQUIRES AUTHORIZED**
 22 **PRESCRIBERS REGULATED BY THE HEALTH OCCUPATIONS BOARD TO SUBMIT TO**
 23 **THE BOARD OF PHARMACY DOCUMENTATION THAT OTHERWISE WOULD BE**
 24 **REQUIRED TO BE SUBMITTED TO THE HEALTH OCCUPATIONS BOARD UNDER**
 25 **SUBPARAGRAPH (I) OF THIS PARAGRAPH.**

26 (2) A licensed pharmacist who has entered into a prescriber–pharmacist
 27 agreement shall submit to the Board of Pharmacy a copy of the prescriber–pharmacist
 28 agreement and any subsequent modifications made to the prescriber–pharmacist
 29 agreement or the protocols specified in the prescriber–pharmacist agreement.

30 14–101.

(a-1) “Allied health professional” means an individual licensed by the Board under Subtitle 5A, 5B, 5C, 5D, [or] 5E, **OR 5F** of this title or Title 15 of this article.

14-205.1.

ON OR BEFORE DECEMBER 1 EACH YEAR, THE BOARD SHALL SUBMIT TO THE GOVERNOR, THE SECRETARY, AND, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY AN ANNUAL REPORT THAT INCLUDES THE FOLLOWING DATA FOR BOTH PHYSICIANS AND ALLIED HEALTH PROFESSIONALS CALCULATED ON A FISCAL YEAR BASIS:

(1) THE NUMBER OF INITIAL AND RENEWAL LICENSES ISSUED;

(2) THE NUMBER OF POSITIVE AND NEGATIVE CRIMINAL HISTORY RECORDS CHECKS RESULTS RECEIVED;

(3) THE NUMBER OF INDIVIDUALS DENIED INITIAL OR RENEWAL LICENSE DUE TO POSITIVE CRIMINAL HISTORY RECORDS CHECKS RESULTS; AND

(4) THE NUMBER OF INDIVIDUALS DENIED INITIAL OR RENEWAL LICENSE DUE TO REASONS OTHER THAN A POSITIVE CRIMINAL HISTORY RECORDS CHECK.

14-205.2.

(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, THE BOARD SHALL PROVIDE TRAINING AT LEAST ANNUALLY TO THE PERSONNEL OF THE OFFICE OF ADMINISTRATIVE HEARINGS IN ORDER TO IMPROVE THE QUALITY AND EFFICIENCY OF THE HEARINGS IN PHYSICIAN DISCIPLINE CASES.

(B) THE TRAINING PROVIDED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE MEDICAL TERMINOLOGY, MEDICAL ETHICS, AND, TO THE EXTENT POSSIBLE, DESCRIPTIONS OF BASIC MEDICAL AND SURGICAL PROCEDURES CURRENTLY IN USE.

14-302.

1 (a) Subject to the rules, regulations, and orders of the Board, the following
2 individuals may practice medicine without a license if the individuals submit to a criminal
3 history records check in accordance with § 14–308.1 of this subtitle:

4 [(1) A medical student or an individual in a postgraduate medical training
5 program that is approved by the Board, while doing the assigned duties at any office of a
6 licensed physician, hospital, clinic, or similar facility;]

7 [(2)] (1) A physician licensed by and residing in another jurisdiction, if
8 the physician:

9 (i) Is engaged in consultation with a physician licensed in the State
10 about a particular patient and does not direct patient care; or

11 (ii) Meets the requirements of § 14–302.1 of this subtitle;

12 [(3)] (2) A physician employed in the service of the federal government
13 while performing the duties incident to that employment;

14 [(4)] (3) A physician who resides in and is authorized to practice medicine
15 by any state adjoining this State and whose practice extends into this State, if:

16 (i) The physician does not have an office or other regularly
17 appointed place in this State to meet patients; and

18 (ii) The same privileges are extended to licensed physicians of this
19 State by the adjoining state; and

20 [(5)] (4) An individual while under the supervision of a licensed physician
21 who has specialty training in psychiatry, and whose specialty training in psychiatry has
22 been approved by the Board, if the individual submits an application to the Board on or
23 before October 1, 1993, and either:

24 (i) 1. Has a master's degree from an accredited college or
25 university; and

2. Has completed a graduate program accepted by the Board in a behavioral science that includes 1,000 hours of supervised clinical psychotherapy experience; or

(ii) 1. Has a baccalaureate degree from an accredited college or university; and

2. Has 4,000 hours of supervised clinical experience that is approved by the Board.

14-302.2.

(A) SUBJECT TO THE RULES, REGULATIONS, AND ORDERS OF THE BOARD, A MEDICAL STUDENT OR AN INDIVIDUAL IN A POSTGRADUATE MEDICAL TRAINING PROGRAM THAT IS APPROVED BY THE BOARD, WHILE DOING ASSIGNED DUTIES AT ANY OFFICE OF A LICENSED PHYSICIAN, HOSPITAL, CLINIC, OR SIMILAR FACILITY, MAY PRACTICE MEDICINE WITHOUT A LICENSE IF THE INDIVIDUAL SUBMITS TO A CRIMINAL HISTORY RECORDS CHECK IN ACCORDANCE WITH § 14-308.1 OF THIS SUBTITLE.

(B) THE BOARD MAY DISCIPLINE AN INDIVIDUAL WHO IS EXEMPT FROM LICENSURE UNDER SUBSECTION (A) OF THIS SECTION IN THE SAME MANNER AND BASED ON THE SAME GROUNDS AS IF THE INDIVIDUAL WERE A LICENSED PHYSICIAN.

14-316.

(a) (1) The Board shall provide for the term and renewal of licenses under this section.

(2) The term of a license may not be more than 3 years.

(3) A license expires at the end of its term, unless the license is renewed for a term as provided by the Board.

(4) A PHYSICIAN WHO FAILS TO RENEW A LICENSE BEFORE THE LICENSE EXPIRES MAY RENEW THE LICENSE IF:

1 **(I) LESS THAN 60 DAYS HAVE ELAPSED SINCE THE EXPIRATION**
2 **OF THE LICENSE; AND**

3 **(II) THE PHYSICIAN MEETS THE RENEWAL REQUIREMENTS OF**
4 **SUBSECTION (C) OF THIS SECTION.**

5 (c) Before the license expires, the licensee periodically may renew it for an
6 additional term, if the licensee:

7 (1) Otherwise is entitled to be licensed;

8 (2) Pays to the Board a renewal fee set by the Board; and

9 (3) Submits to the Board:

10 (i) A renewal application on the form that the Board requires; and

11 (ii) Satisfactory evidence of compliance with any continuing
12 education requirements set under this section for license renewal.

13 (g) (1) Beginning October 1, 2016, the Board shall require a criminal history
14 records check in accordance with § 14–308.1 of this subtitle for:

15 (i) Annual renewal applicants as determined by regulations
16 adopted by the Board; and

17 (ii) Each former licensee who files for reinstatement under § 14–317
18 of this subtitle after failing to renew the license for a period of 1 year or more.

19 (2) On receipt of the criminal history record information of a licensee
20 forwarded to the Board in accordance with § 14–308.1 of this subtitle, in determining
21 whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN,**
22 **BASED ON THE CRIMINAL RECORD INFORMATION, AGAINST A LICENSEE WHO**
23 **RENEWED OR REINSTATED A LICENSE,** the Board shall consider:

24 (i) The age at which the crime was committed;

25 (ii) The nature of the crime;

- (iii) The circumstances surrounding the crime;
- (iv) The length of time that has passed since the crime;
- (v) Subsequent work history;
- (vi) Employment and character references; and
- (vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this subtitle has not been received.

14–317.

The Board shall reinstate the license of a physician who has failed to renew the license **BEFORE THE END OF THE 60–DAY PERIOD IMMEDIATELY FOLLOWING THE LICENSE EXPIRATION** for any reason if the physician:

- (1) Meets the renewal requirements of § 14–316 of this subtitle;
- (2) Pays to the Board a reinstatement fee set by the Board; and
- (3) Submits to the Board satisfactory evidence of compliance with the qualifications and requirements established under this title for license reinstatements.

14–401.1.

(a) (5) (i) If a complaint proceeds to a hearing under § 14–405 of this subtitle, § 14–5A–17, § 14–5B–14, § 14–5C–17, § 14–5D–15, [or] § 14–5E–16, **OR § 14–5F–21** of this title, or § 15–315 of this article, the chair of the disciplinary panel that was assigned the complaint under paragraph (2)(i) of this subsection shall refer the complaint to the other disciplinary panel.

(c) (1) Except as otherwise provided in this subsection, after being assigned a complaint under subsection (a) of this section, the disciplinary panel may:

(i) Refer an allegation for further investigation to the entity that has contracted with the Board under subsection (e) of this section;

(ii) Take any appropriate and immediate action as necessary; or

(iii) Come to an agreement for corrective action with a licensee pursuant to paragraph (4) of this subsection.

(2) (i) **[After] IF, AFTER** being assigned a complaint **AND COMPLETING THE PRELIMINARY INVESTIGATION**, the disciplinary panel **FINDS THAT THE LICENSEE MAY HAVE VIOLATED § 14-404(A)(22) OF THIS SUBTITLE, THE DISCIPLINARY PANEL** shall refer **[any] THE** allegation **[in the complaint based on § 14-404(a)(22) of this subtitle]** to the entity or entities that have contracted with the Board under subsection (e) of this section for further investigation and physician peer review within the involved medical specialty or specialties.

(ii) A disciplinary panel shall obtain two peer review reports from the entity or individual with whom the Board contracted under subsection (e) of this section for each allegation the disciplinary panel refers for peer review.

[(j)] Those individuals not licensed under this title but covered under § 14-413(a)(1)(ii)3 and 4 of this subtitle are subject to the hearing provisions of § 14-405 of this subtitle.]

[(k)] (J) (1) It is the intent of this section that the disposition of every complaint against a licensee that sets forth allegations of grounds for disciplinary action filed with the Board shall be completed as expeditiously as possible and, in any event, within 18 months after the complaint was received by the Board.

(2) If a disciplinary panel is unable to complete the disposition of a complaint within 1 year, the Board shall include in the record of that complaint a detailed explanation of the reason for the delay.

[(l)] (K) A disciplinary panel, in conducting a meeting with a physician or allied health professional to discuss the proposed disposition of a complaint, shall provide an opportunity to appear before the disciplinary panel to both the licensee who has been

charged and the individual who has filed the complaint against the licensee giving rise to the charge.

14–411.1.

(b) The Board shall create and maintain a public individual profile on each licensee that includes the following information:

(6) Medical education and practice information about the licensee including:

(iv) The name of any hospital where the licensee has medical privileges [as reported] **IF KNOWN** to the Board [under § 14–413 of this subtitle];

14–413.

(a) (1) [Every 6 months, each] **EACH** hospital and related institution shall [file with] **SUBMIT TO** the Board a report [that:

(i) Contains the name of each licensed physician who, during the 6 months preceding the report:

1. Is employed by the hospital or related institution;
2. Has privileges with the hospital or related institution; and
3. Has applied for privileges with the hospital or related institution; and

(ii) States whether, as to each licensed physician, during the 6 months preceding the report] **WITHIN 10 DAYS AFTER:**

[1.] **(I)** The hospital or related institution denied the application of a physician for staff privileges or limited, reduced, otherwise changed, or terminated the staff privileges of a physician, or the physician resigned whether or not under formal accusation, if the denial, limitation, reduction, change, termination, or resignation is for reasons that might be grounds for disciplinary action under § 14–404 of this subtitle;

[2.] (II) The hospital or related institution took any disciplinary action against a salaried, licensed physician without staff privileges, including termination of employment, suspension, or probation, for reasons that might be grounds for disciplinary action under § 14–404 of this subtitle;

[3.] (III) The hospital or related institution took any disciplinary action against an individual in a postgraduate medical training program, including removal from the training program, suspension, or probation for reasons that might be grounds for disciplinary action under § 14–404 of this subtitle;

[4.] (IV) A licensed physician or an individual in a postgraduate training program voluntarily resigned from the staff, employ, or training program of the hospital or related institution for reasons that might be grounds for disciplinary action under § 14–404 of this subtitle; or

[5.] (V) The hospital or related institution placed any other restrictions or conditions on any of the licensed physicians **OR INDIVIDUALS IN A POSTGRADUATE TRAINING PROGRAM** as listed in items [1 through 4 of this item] **(I) THROUGH (IV) OF THIS PARAGRAPH** for any reasons that might be grounds for disciplinary action under § 14–404 of this subtitle.

(2) The hospital or related institution shall:

(i) Submit the report within 10 days of any action described in paragraph (1)(ii) of this subsection; and

(ii) State] **STATE** in the report the reasons for its action or the nature of the formal accusation pending when the physician resigned.

14–414.

(a) (1) [Every 6 months, each] **EACH** alternative health system as defined in § 1–401 of this article shall [file with] **SUBMIT TO** the Board a report [that:

(i) Contains the name of each licensed physician who, during the 6 months preceding the report:

1. Is employed by the alternative health system;
2. Is under contract with the alternative health system; and
3. Has completed a formal application process to become under contract with the alternative health system; and

(ii) States whether, as to each licensed physician, during the 6 months preceding the report] **WITHIN 10 DAYS AFTER:**

[1.] **(I)** The alternative health system denied the formal application of a physician to contract with the alternative health system or limited, reduced, otherwise changed, or terminated the contract of a physician, or the physician resigned whether or not under formal accusation, if the denial, limitation, reduction, change, termination, or resignation is for reasons that might be grounds for disciplinary action under § 14–404 of this subtitle; or

[2.] **(II)** The alternative health system placed any other restrictions or conditions on any licensed physician for any reasons that might be grounds for disciplinary action under § 14–404 of this subtitle.

(2) The alternative health system shall[:

(i) Submit the report within 10 days of any action described in paragraph (1)(ii) of this subsection; and

(ii) State] **STATE** in the report the reasons for its action or the nature of the formal accusation pending when the physician resigned.

14–5A–13.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) Annual renewal applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section after failing to renew the license for a period of 1 year or more.

(2) On receipt of the criminal history record information of a licensee forwarded to the Board in accordance with § 14–308.1 of this title, in determining whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

(i) The age at which the crime was committed;

(ii) The nature of the crime;

(iii) The circumstances surrounding the crime;

(iv) The length of time that has passed since the crime;

(v) Subsequent work history;

(vi) Employment and character references; and

(vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this title has not been received.

14–5A–25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2018] **2023**.

14–5B–12.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) Annual renewal applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section after failing to renew the license for a period of 1 year or more.

(2) On receipt of the criminal history record information of a licensee forwarded to the Board in accordance with § 14–308.1 of this title, in determining whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

(i) The age at which the crime was committed;

(ii) The nature of the crime;

(iii) The circumstances surrounding the crime;

(iv) The length of time that has passed since the crime;

(v) Subsequent work history;

(vi) Employment and character references; and

(vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this title has not been received.

14–5B–21.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act, and subject to the termination of this title under § 14–702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2018] **2023**.

1 14-5C-14.

2 (g) (1) Beginning October 1, 2016, the Board shall require a criminal history
3 records check in accordance with § 14-308.1 of this title for:

4 (i) Annual renewal applicants as determined by regulations
5 adopted by the Board; and

6 (ii) Each former licensee who files for reinstatement under
7 subsection (f) of this section after failing to renew the license for a period of 1 year or more.

8 (2) On receipt of the criminal history record information of a licensee
9 forwarded to the Board in accordance with § 14-308.1 of this title, in determining whether
10 [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON**
11 **THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO**
12 **RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

13 (i) The age at which the crime was committed;

14 (ii) The nature of the crime;

15 (iii) The circumstances surrounding the crime;

16 (iv) The length of time that has passed since the crime;

17 (v) Subsequent work history;

18 (vi) Employment and character references; and

19 (vii) Other evidence that demonstrates whether the licensee poses a
20 threat to the public health or safety.

21 (3) The Board may not renew or reinstate a license if the criminal history
22 record information required under § 14-308.1 of this title has not been received.

23 14-5C-25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2018] **2023**.

14–5D–12.

(h) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) Annual renewal applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section after failing to renew the license for a period of 1 year or more.

(2) On receipt of the criminal history record information of a licensee forwarded to the Board in accordance with § 14–308.1 of this title, in determining whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

(i) The age at which the crime was committed;

(ii) The nature of the crime;

(iii) The circumstances surrounding the crime;

(iv) The length of time that has passed since the crime;

(v) Subsequent work history;

(vi) Employment and character references; and

(vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this title has not been received.

14–5D–20.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2018] **2023**.

14–5E–13.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) Annual renewal applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under subsection (f) of this section after failing to renew the license for a period of 1 year or more.

(2) On receipt of the criminal history record information of a licensee forwarded to the Board in accordance with § 14–308.1 of this title, in determining whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

(i) The age at which the crime was committed;

(ii) The nature of the crime;

(iii) The circumstances surrounding the crime;

(iv) The length of time that has passed since the crime;

(v) Subsequent work history;

(vi) Employment and character references; and

(vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this title has not been received.

14–5E–25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14–702 of this title, this subtitle and all regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2018] **2023**.

14–5F–15.

(d) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this title for:

(i) Annual renewal applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under § 14–5F–16(b) of this subtitle after failing to renew the license for a period of 1 year or more.

(2) On receipt of the criminal history record information of a licensee forwarded to the Board in accordance with § 14–308.1 of this title, in determining whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

(i) The age at which the crime was committed;

(ii) The nature of the crime;

(iii) The circumstances surrounding the crime;

(iv) The length of time that has passed since the crime;

(v) Subsequent work history;

(vi) Employment and character references; and

(vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this title has not been received.

14–5F–32.

Subject to the evaluation and reestablishment provisions of the Program Evaluation Act, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2018] **2023**.

14–602.

(c) An unlicensed individual who acts under § 14–302, **§ 14–302.2**, or § 14–306 of this title may use the word “physician” together with another word to describe the occupation of the individual as in phrases such as “physician’s assistant” or “physician’s aide”.

14–606.

(a) (4) Except as provided in paragraph (5) of this subsection, a person who violates § 14–601 or § 14–602 of this subtitle is:

(i) Guilty of a felony and on conviction is subject to a fine not exceeding \$10,000 or imprisonment not exceeding 5 years or both; and

(ii) Subject to a civil fine of not more than \$50,000 to be levied by the Board.

(5) The provisions of paragraph (4) of this subsection do not apply to a [licensee] **PHYSICIAN** who has failed to renew a license under § 14–316 of this title if:

(i) Less than 60 days have elapsed since the expiration of the license; and

(ii) The [licensee] **PHYSICIAN** has applied for license renewal, including payment of the renewal fee.

14–702.

Subject to the evaluation and reestablishment provisions of the Program Evaluation Act, this title and all rules and regulations adopted under this title shall terminate and be of no effect after July 1, [2018] **2023**.

15–307.

(g) (1) Beginning October 1, 2016, the Board shall require a criminal history records check in accordance with § 14–308.1 of this article for:

(i) Annual renewal applicants as determined by regulations adopted by the Board; and

(ii) Each former licensee who files for reinstatement under this title after failing to renew the license for a period of 1 year or more.

(2) On receipt of the criminal history record information of a licensee forwarded to the Board in accordance with § 14–308.1 of this article, in determining whether [to renew or reinstate a license] **DISCIPLINARY ACTION SHOULD BE TAKEN, BASED ON THE CRIMINAL HISTORY RECORD INFORMATION, AGAINST A LICENSEE WHO RENEWED OR REINSTATED A LICENSE**, the Board shall consider:

(i) The age at which the crime was committed;

(ii) The nature of the crime;

(iii) The circumstances surrounding the crime;

(iv) The length of time that has passed since the crime;

(v) Subsequent work history;

(vi) Employment and character references; and

(vii) Other evidence that demonstrates whether the licensee poses a threat to the public health or safety.

(3) The Board may not renew or reinstate a license if the criminal history record information required under § 14–308.1 of this article has not been received.

15–502.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act, this title and all regulations adopted under this title shall terminate and be of no effect after July 1, [2018] **2023**.

Article – Insurance

24–201.

(a) In this subtitle the following words have the meanings indicated.

(d) “Physician” means an individual who:

(1) is licensed to practice medicine in the State; or

(2) lawfully practices medicine without a license under [§ 14–302(1) through (4)] **§ 14–302(1) THROUGH (3) OR § 14–302.2** of the Health Occupations Article.

Article – State Government

8–405.

(a) The Department shall:

(1) conduct a full evaluation of each governmental activity or unit to be evaluated under this section; and

(2) prepare a report on each full evaluation conducted.

(b) Each of the following governmental activities or units and the statutes and regulations that relate to the governmental activities or units are subject to full evaluation, in the evaluation year specified, without the need for a preliminary evaluation:

(5) Physicians, State Board of (§ 14–201 of the Health Occupations Article: [2016] **2021**), including:

(i) Athletic Training Advisory Committee (§ 14–5D–04 of the Health Occupations Article: [2016] **2021**);

(ii) Naturopathic Medicine Advisory Committee (§ 14–5F–04 of the Health Occupations Article: [2016] **2021**);

(iii) Perfusion Advisory Committee (§ 14–5E–05 of the Health Occupations Article: [2016] **2021**);

(iv) Physician Assistant Advisory Committee (§ 15–201 of the Health Occupations Article: [2016] **2021**);

(v) Polysomnography Professional Standards Committee (§ 14–5C–05 of the Health Occupations Article: [2016] **2021**);

(vi) Radiation Therapy, Radiography, Nuclear Medicine Technology Advisory, and Radiology Assistance Committee (§ 14–5B–05 of the Health Occupations Article: [2016] **2021**); and

(vii) Respiratory Care Professional Standards Committee (§ 14–5A–05 of the Health Occupations Article: [2016] **2021**).

Chapter 539 of the Acts of 2007

[SECTION 4. AND BE IT FURTHER ENACTED, That the Chief Administrative Law Judge shall designate a pool of administrative law judges in the Office of Administrative Hearings to hear cases referred to it by the State Board of Physicians.]

[SECTION 5. AND BE IT FURTHER ENACTED, That the State Board of Physicians shall provide training at least annually to the personnel of the Office of

1 Administrative Hearings in order to improve the quality and efficiency of the hearings in
2 physician discipline cases. The training shall include medical terminology, medical ethics,
3 and, to the extent practicable, descriptions of basic medical and surgical procedures
4 currently in use.]

5 SECTION 2. AND BE IT FURTHER ENACTED, That, in the report the State Board
6 of Physicians is required to submit under Section 2 of Chapter 401 of the Acts of the General
7 Assembly of 2013 on or before October 1, 2017, the Board shall include:

8 (1) a description of the efforts the Board has taken to meet the goal of
9 issuing licenses within 10 days after the receipt of the last qualifying document, especially
10 for the allied health professionals;

11 (2) the findings and recommendations of the Board and the Physician
12 Assistant Advisory Committee regarding ways to expedite the process for physician
13 assistants to assume the duties under a delegation agreement; and

14 (3) whether it is feasible to describe any underlying sexual misconduct in
15 order summaries and, if it is not feasible, a description of other steps that the Board can
16 take to make it easier for the public to determine whether a case involved sexual
17 misconduct.

18 SECTION 3. AND BE IT FURTHER ENACTED, That, in the report the State Board
19 of Physicians is required to submit under Section 2 of Chapter 401 of the Acts of the General
20 Assembly of 2013 on or before October 1, 2018, the Board shall include:

21 (1) the results of the internal fiscal analysis and reassessment of fees that
22 was recommended by the Department of Legislative Services in the December 2016
23 publication "Sunset Review: Evaluation of the State Board of Physicians and the Related
24 Allied Health Advisory Committees", including any possible changes to the fee schedules
25 for physicians and allied health professionals;

26 (2) comments on the Board's fund balance in light of the additional
27 retained revenue that resulted from Chapter 178 of the Acts of the General Assembly of
28 2016; and

(3) steps the Board has taken to address ongoing issues with filling staff vacancies and the impact that filling vacancies will have on Board expenditures and the Board's fund balance.

SECTION 4. AND BE IT FURTHER ENACTED, That, in the report the State Board of Physicians is required to submit under § 14–205.1 of the Health Occupations Article on or before December 1, 2019, as enacted by Section 1 of this Act, the Board shall report:

(1) whether criminal history records checks are causing delays in licensure;

(2) whether existing Board staff are able to manage the criminal history records checks workload; and

(3) any other concerns the Board has regarding the criminal history records checks requirement.

SECTION 5. AND BE IT FURTHER ENACTED, That, notwithstanding § 8–405(e) of the State Government Article, the full evaluation required to be conducted by the Department of Legislative Services on or before December 1, 2021, shall be limited to evaluating:

(1) the implementation of recommendations made by the Department in the December 2016 publication “Sunset Review: Evaluation of the State Board of Physicians and the Related Allied Health Advisory Committees”;

(2) the efficacy of the two–panel disciplinary system; and

(3) the impact of the criminal history records checks on the State Board of Physicians and its licensees.

SECTION 6. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017.

Appendix 2.

State Board of Physicians Sunset Evaluation: Documents and Files Reviewed

<u>Material Reviewed</u>	<u>Period Under Review</u>	<u>Purpose of Review</u>
Board Minutes	All open and closed meeting minutes: 2012-2016 year-to-date	History of MBP action; assessment of procedures established by the board to carry out its administrative and disciplinary functions; and accuracy of minutes
Complaint and Discipline Material	Fiscal 2012-2016	Timeliness of processing of complaints; efficiency of disciplinary procedures; criteria for discipline; and identification of bottlenecks in complaint/disciplinary process
Board Financial Records	Budget submissions: fiscal 2012-2017	Adequacy of budget; assessment of budget prioritization; and assessment of financial planning and resource availability
Board Annual Reports	Fiscal 2012-2016	MBP history and background data

Source: Department of Legislative Services

Appendix 3.

Allied Health Advisory Committees

<u>Committee</u>	<u>Membership Composition</u>	<u>Duties</u>
Physician Assistant Advisory Committee	<ul style="list-style-type: none"> • 3 physicians, including 1 who is a board member • 3 physician assistants • 1 consumer member 	Make recommendations to the board concerning physician assistant licenses and delegation agreements, as well as regulations governing physician assistants
Radiation Therapy, Radiography, Nuclear Medicine Technology, and Radiology Assistance Advisory Committee	<ul style="list-style-type: none"> • 4 physicians • 1 radiation therapist • 1 radiographer • 1 radiologist assistant • 1 nuclear medicine technologist • 1 consumer • 1 board member 	Make recommendations to the board concerning regulations, a code of ethics, standards of care, and requirements for licensure for the practice of radiation therapy, radiography, nuclear medicine technology, and radiology assistance; on request, review applications for licensure and make recommendations to the board
Respiratory Care Professional Standards Committee	<ul style="list-style-type: none"> • 3 physicians • 3 respiratory care practitioners • 1 consumer member 	Make recommendations to the board concerning regulations, a code of ethics, requirements for licensure, applications for a license to practice respiratory care, continuing education requirements for license renewal, the practice of respiratory care, and if requested, standards of care
Polysomnography Professional Standards Committee	<ul style="list-style-type: none"> • 3 physicians • 3 polysomnographic technologists • 1 consumer member 	Make recommendations to the board concerning regulations, a code of ethics, standards of care, requirements for licensure, criteria for licensees in other states to practice in Maryland, continuing education requirements for license renewal, licensure of applicants, the practice of polysomnography, and criteria for the direction of students in clinical education programs

Athletic Trainer Advisory Committee	<ul style="list-style-type: none"> • 3 athletic trainers • 3 physicians • 1 chiropractor • 1 physical therapist • 1 occupational therapist • 2 consumer members 	Make recommendations to the board concerning regulations, continuing education requirements for license renewal, the practice of athletic training, and, when requested, individual evaluation and treatment protocols; also, develop and recommend an evaluation and treatment protocol for use by an athletic trainer and a supervising physician
Perfusion Advisory Committee	<ul style="list-style-type: none"> • 3 perfusionists • 3 physicians • 1 consumer member. 	Make recommendations to the board concerning regulations, a code of ethics, the practice of perfusion, including standards of care, and continuing education requirements for license renewal
Naturopathic Medicine Advisory Committee	<ul style="list-style-type: none"> • 2 naturopaths • 2 physicians, including 1 who is a board member • 1 consumer member 	Make recommendations to the board concerning regulations, procedures for the issuance of licenses by reciprocity, examination standards and times, a code of ethics, and continuing education requirements for license renewal

Source: Department of Legislative Services

Appendix 4.
Summary of Recommendations and Outcomes from the
2011 Sunset Review: Evaluation of the State Board of Physicians
and the Related Allied Health Advisory Committees

	<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
	1. The State Board of Physicians (MBP) should develop Managing for Results (MFR) goals for allied health professionals to report on consumer satisfaction and licensure processing goals.	Administrative	Adopted	MBP began reporting MFR goals for allied health in fiscal 2012.
	2. To expedite the audit process and optimize board resources, MBP should notify a licensee who has been selected for the continuing medical education (CME) audit in the renewal notice. MBP should advise such licensees who have been selected for the CME audit that they are required to send documentation of their CME to the board by December 31 of the renewal year.	Administrative	Modified	MBP notifies a licensee that the licensee has been selected for an audit at the time the licensee begins the online renewal application process. The licensee has 15 days from the notification to submit CME documentation to MBP.
8	3. MBP should amend its regulations to reflect current fee levels.	Regulatory	Rejected	Board regulations continue to have a separate fee for the physician and the physician assistant rehabilitation programs. Certain fees in the regulations and the fees listed on the board's website for various allied health professions do not match.
	4. Statute should be amended to repeal the requirement that the board assess physician assistants a fee to fund the rehabilitation program for the physicians and certain allied health professionals.	Statutory	Adopted	Chapter 401 of 2013

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
5. Uncodified language should be adopted requiring the board to recommend measures to increase the involvement of allied health advisory committees in complaint resolution and licensee discipline. Uncodified language should require that the recommendations be submitted by MBP to the Department of Legislative Services (DLS) in a subsequent follow-up report.	Statutory	Modified	Chapter 401 requires (1) a disciplinary panel to consult with the chair of the appropriate allied health advisory committee, or the chair's designee, before taking disciplinary action against an allied health professional and (2) MBP to provide to each allied health committee an annual report on the disciplinary matters involving the committee's licensees.
6. MBP should report complaint data for allied health professionals in board annual reports and MFR data in the same manner as reported for physicians.	Administrative	Adopted	MBP began reporting most complaint data for allied health professionals in annual reports and MFR data in fiscal 2012 and started reporting the grounds for discipline of allied health professionals in fiscal 2015.
7. MBP should revise the expedited complaint process for CME cases to include (1) a ratification of the consent agreement or consent order by MBP prior to the sanctions included in the agreement or order becoming effective and (2) a mechanism for board review of more egregious cases before a consent agreement or consent order is offered to the licensee. MBP should also adopt regulations governing all expedited case resolution procedures. The amount of fines levied for failure to complete CME requirements should be reported in the board's annual report.	Administrative/ Regulatory	Modified	<p>The board recently adopted a revised CME process. Ratification of each consent order is not required. If a licensee declines the board's offer of a pre-charge consent order, the case is then presented to a panel for a vote to charge.</p> <p>MBP has not adopted regulations governing all expedited case resolution procedures.</p> <p>MBP began reporting the amount of CME fines in its fiscal 2012 annual report.</p>

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
8. MBP should review and adjust the expedited process for ground 21 and 24 disciplinary cases to address (1) the lack of involvement of the board; (2) the involvement of the executive director in determining appropriate sanctions; (3) the lack of a determination regarding legal sufficiency; and (4) the lack of clarity regarding the board's role in the expedited processing letter.	Administrative	Modified	The board has delegated proceeding with reciprocal action cases to board staff. If a licensee declines the board's offer of a pre-charge consent order, the case is presented to a panel for a vote to charge. Board counsel advises board staff if there is a question regarding legal sufficiency.
9. Uncodified language should be adopted requiring MBP and the Department of Health and Mental Hygiene (DHMH) to jointly develop and implement a strategy for reducing the backlog of complaint cases by December 31, 2012. MBP should be required to include the strategy, as well as information regarding the effect of the strategy on the backlog and complaint resolution time, in a subsequent follow-up report submitted to DLS.	Statutory	Modified	Chapter 401 of 2013 implemented a two disciplinary panel system in an effort to reduce the backlog and required MBP to report on the status of the backlog in follow-up reports.
10. MBP should (1) expand the complaint database to track the sanctions imposed in cases; (2) track the date the board votes to charge in a way that can be more easily accessed; and (3) institute steps that ensure that information recorded in the database is complete and accurate, including listing cases under all grounds for which the licensee was charged and fully tracking the grounds for allied health cases.	Administrative	Adopted	

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
11. MBP should treat violations of probation and violations of orders as distinct, board-generated complaints and assign new complaint case numbers in these situations when the board learns of subsequent violations.	Administrative	Modified	MBP is now using a “77” prefix in case numbers to indicate that the case is a probation case that is being monitored. Violations of probation are tracked using a code in the board’s information technology system.
12. Budget bill language should be adopted during the 2012 legislative session to withhold funds from MBP until the board promulgates sanctioning guideline regulations for physicians and allied health professionals, as required by Chapters 533 and 534 of 2010. In the meantime, board staff should update sanctioning information provided in board books and include information related to allied health professionals.	Statutory/ Administrative	Adopted	Chapter 148 of 2012 withheld \$1,000,000 from MBP until the sanctioning guidelines were promulgated. The sanctioning guidelines were adopted, and the funds were released.
13. If unable to resolve a complaint within one year, MBP should comply with statute and include in the record of the complaint a detailed explanation of the reason for the delay.	Administrative	Adopted	
14. MBP should comply with statute and disclose the filing of charges and notice of initial denial of a license application to the public. Statute should be amended to require MBP to disclose the information on the licensee profile with a disclaimer stating that the charging document does not indicate a final finding of guilty by the board.	Administrative/ Statutory	Adopted	Chapter 401 of 2013

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
15. Statute should be amended to require MBP to disclose the filing of charges against an allied health licensee and notice of initial denial of an allied health license application to the public, with a disclaimer stating that the charging document does not indicate a final finding of guilty by the board.	Statutory	Adopted	Chapter 401 of 2013
16. Statute should be amended to codify the requirement that MBP give the complainant in a case the opportunity to appear before the board during a case resolution conference. Board regulations should be updated to reflect this requirement.	Statutory/ Regulatory	Adopted	Chapter 401 of 2013 codified the requirement, and the regulations have been updated.
17. MBP should (1) adopt guidelines for reopening cases, especially sexual misconduct cases; (2) revise the advisory letter sent to licensees after an initial complaint involving sexual misconduct to include a statement notifying the licensee that the case may be reopened and charges may be issued if a pattern of behavior emerges; (3) institute a process for tracking sexual misconduct cases; and (4) reopen all relevant cases using the original case number.	Administrative	Modified	MBP has implemented most of the recommendation; however, MBP declined to reopen all relevant cases using the original case number.

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
18. When referring individuals to the Maryland Physician Rehabilitation Program, the board should no longer specify licensees are required to participate in the program for a specified time period. Instead, the length of participation should be based on clinical need and whether the individual is still licensed in Maryland.	Administrative	Adopted	MBP requires that a licensee remain on probation for a specified period of time, but defers to the rehabilitation program for the length of time the licensee should be monitored.
19. Statute should be amended to authorize MBP to seek a warrant for entry into private premises for the purpose of investigating formal complaints that allege a person is practicing, attempting to practice, or offering to practice medicine without a license and to require that MBP have a warrant before entering into private premises for those purposes.	Statutory	Adopted	Chapter 401 of 2013
20. MBP should be required to assess its fee-charging practices, develop a long-term fiscal plan, and submit a report to DLS by December 31, 2012.	Statutory	Modified	Chapter 401 of 2013 requires MBP to provide updates on a long-term financial plan and financial data in follow-up reports.

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
21. MBP should budget allied health expenditures under a separate program code and report licensure revenues for physician assistants and radiographers with revenues derived from other allied health professionals. The board should monitor the revenues and expenditures to determine if additional personnel is needed to support the licensure of athletic trainers and perfusionists.	Administrative	Adopted	
22. The board should examine the schedule of fees for allied health professionals and, if necessary, adjust licensure fees to more accurately reflect the ongoing cost of licensure amongst the various allied health professionals. The board should determine the percentage of board activities dedicated to each allied health profession and adjust application and renewal fees accordingly. When making fee changes, the board should balance the need to maintain the current, reasonable surplus attributable to the Allied Health Unit, while considering new anticipated revenues from athletic trainers and perfusionists.	Administrative	Adopted	
23. MBP should not use contractual employees to perform ongoing functions of the board or to perform functions that could be done by existing employees.	Administrative	Adopted	

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
24. Board counsel, in conjunction with the executive director of the board, should establish clear guidance for board staff participation and attendance at closed meetings. The board should no longer require applicants for reinstatement who meet the requirements for reinstatement after a suspension to appear before the Reinstatement Inquiry Panel.	Administrative	Modified	<p>Guidance for participation and attendance of MBP staff at closed meetings was adopted.</p> <p>MBP still requires applicants for reinstatement after a suspension to appear.</p>
25. Statute should be amended to clarify that the board is required to provide online profiles on allied health licensees and require that allied health licensee profiles, to the extent possible, contain the same information that is provided on physician profiles.	Statutory	Adopted	Chapter 401 of 2013 implemented this recommendation for each of the allied health professions under the jurisdiction of MBP at the time the law was passed. This requirement, however, was not included in the Maryland Naturopathic Medicine Act (Chapters 153 and 399 of 2014).
26. MBP should improve the quality of its website for consumers and licensees so it is more user friendly and improve its transparency to the public by posting all required disciplinary action on its website, as well as posting open meeting agendas, open meeting minutes, board staff names, meeting cancellations, and contact information through which a person can receive information from the board regarding medical malpractice settlements.	Administrative	Modified	<p>MBP has improved its website and included more information on it.</p> <p>For medical malpractice information, the board website directs individuals to the Health Care Alternative Dispute Resolution Office and states that the board does not have this information.</p>

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
27. Board staff should standardize information and documents that are kept in the hard copy files and establish a system to ensure that the files are organized and information is readily accessible. Hard copy complaint files should contain a checklist for documents included in the file, as well as dates corresponding with the steps in the complaint resolution process.	Administrative	Adopted	
28. Board staff should ensure that information included in the board's annual reports is consistent with information reported in its MFR submission and the board's complaint database. When board staff prepares closed session minutes, staff should verify that case and licensure numbers are accurate and correspond to the appropriate licensee.	Administrative	Adopted	
29. MBP should ensure that its members and staff receive training in the requirements of the Open Meetings Act from the Office of Attorney General (OAG) and DHMH. Board counsel should review and approve the closed and open meeting agendas prior to monthly board meetings to maintain compliance with the act. If the board begins to discuss a matter in closed session that violates the act, board counsel should advise the board that it is violating the act and the board should cease discussion.	Administrative	Adopted	

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
30. MBP should continue to improve board member training by developing training in conjunction with DHMH, OAG, and the Office of Administrative Hearings on board procedures, including parliamentary procedures to expedite the disciplinary process.	Administrative	Adopted	
31. Statute for each allied health advisory committee should include a requirement that the advisory committee submit an annual report to the board; the chair serve in an advisory capacity to the board as a representative of the committee; the board consider all recommendations of the advisory committee and provide a written explanation of the board's reasons for rejecting or modifying the committee's recommendation; the chair report to the board on a biannual basis and present to the board the committee's annual report; and the board provide to the advisory committee chair on a biannual basis a report on disciplinary matters involving allied health professionals. Board staff should ensure that these reporting requirements are met.	Statutory/ Administrative	Modified	Chapter 401 of 2013 requires (1) each allied health advisory committee to submit an annual report to MBP; (2) the chair of each committee to serve in an advisory capacity to MBP as a representative of the committee; (3) MBP to consider all recommendations of the advisory committee; and (4) MBP to provide to the committee an annual report on disciplinary matters involving allied health professionals.

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
32. Uncodified language should be adopted requiring the board to develop and implement a plan by December 31, 2012, to improve the recruitment of allied health advisory committee members. The board should also be required to provide an update on implementation of that recruitment plan as well as study and report to DLS on several issues related to advisory committee membership.	Statutory	Modified	Uncodified language was not adopted, but MBP took steps to fill vacancies on the allied health advisory committees.
33. As the board assumes responsibility to license new allied health professions, the board should appoint members, convene advisory committees, and develop and adopt regulations in a timely manner.	Administrative	Adopted	MBP has taken steps to implement this recommendation. There were delays regarding the adoption of the naturopathic doctor regulations that were out of the control of MBP.
34. Statute should be amended to prohibit the appointment of an individual to an advisory committee or the board if the individual is providing or has provided services to the board for remuneration. Any individual currently serving on MBP or an advisory committee who has provided services to the board for remuneration should be replaced.	Statutory	Rejected	
35. The board should adopt and implement meeting procedures to ensure that nonmembers are clearly identified before addressing an allied health advisory committee or the board.	Administrative	Adopted	

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
<p>36. MBP should adopt regulations by December 31, 2012, that govern (1) exceptions to licensure for the purpose of consultation; (2) exemptions from licensure fees; and (3) mental health record subpoenas. If the board fails to adopt regulations as required, budget bill language should be adopted in the 2013 legislative session to withhold funds from MBP until the regulations are adopted.</p>	Administrative/ Statutory	Modified	<p>Chapters 582 and 583 of 2013 altered exceptions from licensure for the purpose of consultation. Regulations have not been adopted on this issue.</p> <p>Regulations have not been adopted regarding exemptions from licensure fees.</p> <p>Regulations regarding mental health record subpoenas have been adopted.</p> <p>Budget bill language withholding funds was not adopted.</p>
<p>37. The board should institute a process for updating regulations when the board changes its practices. Uncodified language should be adopted requiring the board to amend its regulations to conform to current practice by December 31, 2012. If the board fails to update regulations as required, budget bill language should be adopted during the 2013 legislative session to withhold funds from MBP until the regulations are adopted.</p>	Administrative/ Statutory	Modified	<p>The uncodified language and budget bill language were not adopted; however, the board did institute a process for updating regulations when the board changes its practices.</p>

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
38. Statute should be amended to allow for current MBP practice regarding the requirement of postgraduate medical training for licensure and in cases of the failure to pass the required examination to be consistent with the Maryland Medical Practice Act.	Statutory	Modified	Statute was not amended to allow for the MBP practice regarding the requirement of postgraduate training for licensure; however, the practice is still in regulations. The regulations no longer include the former MBP practice regarding the failure to pass the required examination.
39. Statute should be amended to remove the requirement that physician-pharmacist agreements and protocols be approved by the State Board of Pharmacy and MBP. Participating pharmacists and physicians should be required to submit copies of all agreements and protocols to their respective board and to promptly submit any modifications. MBP should collaborate with the State Board of Pharmacy to submit a follow-up report to the Senate Education, Health, and Environmental Affairs and House Health and Government Operations committees by October 1, 2013, on the impact of these modifications to the drug therapy management program.	Statutory/ Administrative	Adopted	Chapter 658 of 2012

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
40. Uncodified language should be adopted requiring the board to work with the Maryland Insurance Administration, OAG, and DHMH's Office of the Inspector General to determine the appropriate entity for investigating and enforcing Maryland's Self-referral Law. MBP should be required to report the findings to DLS in a subsequent follow-up report.	Statutory	Rejected	
41. Statute should be amended to authorize MBP, rather than requiring the circuit courts, to impose civil fines against alternative health systems that fail to report as required to that the civil fine provisions related to reporting by hospitals and related institutions and alternative health systems are the same. Statute should be amended to clarify how the court reporting requirement is to be enforced and place the requirement in a separate statutory section.	Statutory	Adopted	Chapter 401 of 2013

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
<p>42. Statute should be amended to clarify that all entities required to report to the board under §§ 14-413 and 14-414 of the Health Occupations Article are to report every six months even if the institution has not taken disciplinary action against a licensee or denied privileges to a licensee. The board should simplify its reporting form and conduct outreach with the facilities on this issue. The board should (1) exercise its authority to assess civil fines against an entity that does not report as required under § 14-413 and (2) create and post on the board's website a Report of Disciplinary Action form that may be used to report when a licensed allied health professional is disciplined or terminated.</p>	Statutory/ Administrative	Modified	<p>Chapter 401 of 2013 authorized MBP, in consultation with all interested parties, to adopt regulations to define (1) changes in employment or privileges that require reporting under § 14-413 or § 4-414 of the Health Occupations Article and (2) actions by licensees that are grounds for discipline and that require reporting.</p> <p>The reporting form was simplified. MBP conducted outreach to interested parties and developed regulations regarding the reporting requirement.</p>
<p>43. To accommodate the conventional practice of athletic training, statute should be amended to (1) clarify that a supervising physician may authorize, in an evaluation and treatment protocol, an athletic trainer to accept an outside referral from a nonsupervising physician or licensed health care practitioner; (2) specify the licensed health care practitioners from whom an athletic trainer may accept referrals; and (3) clarify the acceptable mechanisms that a physician may use to supervise an athletic trainer.</p>	Statutory	Adopted	Chapters 314 and 315 of 2012

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
<p>44. Uncodified language should be adopted requiring the board, with considerable input from the Physician Assistant Advisory Committee (PAAC), physician assistants, and supervising physicians from a variety of practice settings, to adopt regulations by December 31, 2012, for determining (1) what constitutes an advanced duty and (2) how many successful procedures a physician assistant must perform to be deemed able to safely perform a delegated medical act. PAAC should (1) complete its work in refining the list of advanced duties the board has approved in the past; (2) post the list of advanced duties on the board's website; and (3) include the list as an attachment to both the addendum application and delegation agreement application to perform core duties. If there is a question as to whether a medical act in a delegation agreement filed with the board constitutes an advanced duty, PAAC as a whole should make the determination.</p>	Statutory/ Administrative	Modified	Regulations were not adopted for determining what constitutes an advanced duty and the required number of successful procedures. The list of advanced duties is on the MBP website and is attached to both the addendum application and the delegation agreement application to perform core duties.
<p>45. Uncodified language should be adopted that requires the board to license individuals who were enrolled in an unaccredited radiation therapy, radiography, or nuclear medicine technology program on October 1, 2010, and who graduate by June 30 2014, provided that the individuals meet all other requirements for licensure.</p>	Statutory	Rejected	The unaccredited programs that were at issue are now accredited.

<u>Recommendation</u>	<u>Change Type</u>	<u>Status</u>	<u>Comment</u>
46. Extend the termination date for MBP and the related allied health advisory committees to July 1, 2014. Adopt uncodified language to (1) require MBP to submit a follow-up report to DLS by June 1, 2013, that addresses the implementation of the recommendations made in the evaluation report and (2) require DLS by October 1, 2013, to make a recommendation to specified committees of the General Assembly regarding further extension of the termination dates based on the progress of MBP in complying with the recommendation of the evaluation report and the submission of the follow-up report by MBP.	Statutory	Modified	Chapter 401 of 2013 extended the board's termination date to July 1, 2018, and required that an evaluation of the board and the allied health committees be done in 2016. Chapter 401 also required MBP to submit a report by October 1, 2013, and annually for the next five years to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee. The report must provide an update on (1) any changes to the board's disciplinary process and the effect of those changes on the complaint backlog and complaint resolution times; (2) the progress of the board in procuring and implementing a new information technology system to improve data management; (3) a long-term financial plan; (4) financial data for the preceding fiscal year; and (5) the progress of the board in implementing the recommendations made by DLS in the 2011 sunset evaluation.

Source: Department of Legislative Services; State Board of Physicians

Appendix 5.
Major Legislative Changes Affecting the State Board of Physicians and
Allied Health Professionals
Since the 2011 Full Sunset Review

Physicians

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2012	267	Requires the boards of dental examiners, physicians, and podiatric medical examiners to report certain information to the Division of Drug Control (DDC) regarding licensees that personally prepare and dispense prescription drugs. Requires the boards to charge a fee to a dentist, physician, or podiatrist who holds a dispensing permit in an amount that will produce funds to approximate the documented costs to DDC for inspections of dispensing permit holders.
2012	295/296	Require MBP to disclose its proceedings, records, and files to the Maryland Health Care Commission (MHCC) for the purpose of investigating quality or utilization of care in any entity regulated by the Office of Health Care Quality or the Health Services Cost Review Commission.
2012	681	Requires the Governor to appoint the chair of MBP and specifies that the term of the chair is two years.
2013	154/155	Require each health occupations board to take certain action to expedite licensing, certification, and registration of active military, veterans, and their spouses.
2013	401	Extends the termination date of the board from July 1, 2013, to July 1, 2018, and makes substantial changes to the board.
2013	404	Authorizes each health occupations board to develop a secure electronic system for the distribution of a renewed license, permit, certification, or registration.

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2013	596/597	<p>Authorize MBP to issue a cease and desist order or obtain injunctive relief against an individual for taking any action (1) for which MBP determines there is a preponderance of the evidence of grounds for discipline; and (2) that poses a serious risk to the health, safety, and welfare of a patient.</p> <p>Require MBP to adopt regulations to carry out its judicial powers, including hearing procedures and sanctions for noncompliance with a cease and desist order.</p> <p>Repeal the authority of certain persons aggrieved by MBP in a contested case to appeal to the Board of Review and then take any further appeal allowed by the Administrative Procedures Act.</p>
2015	34	Requires applicants and licensees of MBP to submit to a criminal history records check as a qualification of licensure. Creates new grounds for disciplinary action if a licensee fails to submit to a criminal history records check as required.
2016	94	Authorizes physicians with athletic and sports teams to practice medicine in the State without a license under certain circumstances.
2016	99	Prohibits MBP from establishing a continuing education requirement that every licensed physician complete a specific course or program as a condition to the renewal of a license.
2016	178	Alters the distribution of fees from the State Board of Physicians Fund.
2016	460/461	Requires MBP to license physicians licensed or certified in another jurisdiction under requirements that MBP determines are substantially equivalent to the requirements to be licensed in Maryland if the other jurisdiction offers similar reciprocal licensing process for individuals licensed to practice medicine by MBP. Requires MBP to adopt regulations to carry out the licensing provision.

Allied Health Professionals

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2012	241/242	Repeal the requirement that certain patients being treated by a physician assistant (PA) be seen by the PA's supervising physician according to a specified frequency. Require instead that a delegation agreement between a PA and a supervising physician include a certain attestation regarding care by and access to the supervising physician.

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2012	314/315	Alter the educational requirements for licensure as an athletic trainer, authorize athletic trainers to accept an “outside referral” from specified licensed health care practitioners, clarify the acceptable mechanisms that a physician may use to supervise an athletic trainer, prohibit certain entities and employers from employing an athletic trainer without a license or an approved evaluation and treatment protocol, and make various other changes.
2013	585/586	Alter reinstatement provisions for polysomnographic technologists, add failure to cooperate with a lawful investigation conducted by the board as a new ground for disciplinary action, prohibit a licensed physician and specified entities from employing an individual practicing polysomnography without a license, and authorize MBP to impose a civil penalty of not more than \$5,000 for a violation.
2014	153/399	<p>Require individuals, by March 1, 2016, to be licensed to practice “naturopathic medicine” by MBP; establish a Naturopathic Medicine Advisory Committee within MBP; require MBP to adopt regulations for the licensure and practice of naturopathic medicine; establish the scope of practice authorized by a license, requirements for disciplinary action, and penalties for practicing without a license or representing to the public that the individual is licensed to practice naturopathic medicine.</p> <p>Require MBP to convene a workgroup to study the development of a naturopathic formulary and the routes of administration that may be used when administering natural medicines. The workgroup is required to report its findings and recommendations by July 1, 2015.</p>
2016	411/412	Require the Athletic Trainer Advisory Committee (ATAC) to recommend approval, modification, or disapproval of individual athletic trainer evaluation and treatment protocols to MBP. An athletic trainer may assume the duties under an evaluation and treatment protocol after receiving a written recommendation of approval from ATAC under specified circumstances. MBP may disapprove an evaluation and treatment protocol or a specialized task included in the evaluation and treatment protocol under specified circumstances.
2016	700	Establishes a Naturopathic Doctors Formulary Council within MBP to develop and make recommendations to MBP regarding a formulary for licensed naturopathic doctors. MBP is required to adopt a formulary based on the council’s recommendations.

Source: Laws of Maryland

Appendix 6.
Written Comments of the State Board of Physicians



STATE OF MARYLAND

DHMH Board of Physicians

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

November 28, 2016

Mr. Warren G. Deschenaux, Director
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, MD 21401-1991

Dear Mr. Deschenaux:

The Maryland Board of Physicians ("Board") appreciates the diligent work of the Sunset analysts. They are to be commended for their detailed examination and review of the Board's operations and processes. The Board thanks Ms. Jodie Chilson, Ms. Sasika Subramaniam, Ms. Linda Stahr and Ms. Jennifer B. Chasse, for their thorough analysis and professional interactions with Board staff. Sunset review is an important process that assists the Board in fulfilling its mission of protecting Maryland citizens through efficient licensure and effective discipline.

Board members, leadership and staff have worked diligently and collaboratively to address the issues related to the 2011 Sunset Review and the requirements of the 2013 Sunset legislation. The Board continuously assesses the disciplinary process, improvements in communication and innovative ideas regarding its operations. All of these efforts continue to advance and refine the work of the Board.

Thank you for the opportunity to review and provide comments to the "Exposure Draft" developed as a result of the Sunset Review process. The Board appreciates the opportunity to be involved in the development of the report before it is finalized and provide responses to the recommendations contained in this update.

Enclosed please find the preliminary response from the Board. While we agree with many, we disagree with a few of the recommendations and believe that it is important to provide more elaboration overall. The Board is committed to its mission of public protection, has made significant progress and recognizes that sustaining improvement is an ongoing process.

We look forward to continued interaction during this process. Thank you.

Sincerely,

Damean W. E. Freas, D.O.
Board Chair

Christine A. Farrelly
Executive Director

Enclosure

cc: Van T. Mitchell, Secretary, DHMH
Shawn Cain, DHMH
Jennifer B. Chasse, Office of Policy Analysis, DLS
Yemisi Koya, MBP

Maryland Board of Physicians Responses to Sunset Exposure Draft

Recommendation 1: The Board should work to improve the administrative process for issuing licenses promptly, especially for allied health professionals, and report on efforts to meet the 10-day goal in a follow-up report to the General Assembly.

Board Response: The Board agrees with this recommendation but requests to include the information in the Board's Annual Report instead of in an additional report.

Recommendation 2: MBP should amend its regulations and update its website to accurately reflect current fees.

Board Response: The Board agrees with the recommendation and updated its website on November 18, 2016 to reflect the breakdown of the fees for physician initial licensure, reinstatement and renewal (http://www.mbp.state.md.us/pages/physician_fees.html).

Additionally, the Board will amend its regulations regarding fees. It should be noted that the statute authorizes and requires that the Board charge physicians and physician assistants for the rehabilitation program. (See Health Occupations Article, §§15-206 (a)(2) and 14-207(b)(2)).

The Board had been only listing the total physician initial application fee of \$790 on the application and on the Board's website, rather than the breakdown of fees, to avoid confusion for applicants. When the breakdown of fees was listed, there was confusion about what fees were required and applicants routinely submitted an incorrect amount for the application which caused a delay in the processing of the licensure application. The regulations currently specify the component fees rather than the total fee.

The Board is authorized by statute and regulation to collect a total of \$790 for an initial physician licensure application. The \$790 consists of a \$260 application fee plus a \$50 rehabilitation program fee and the \$480 license fee (\$20 per month for 24 months). If an individual licensee will not be licensed for the entire 24 months, the Board issues a refund of \$20 per month which is deducted from the \$480 license fee. This results in more than 93% of applicants for initial licensure receiving refunds. For example, in FY 2016, 1831 of 1964 applicants for initial physician licensure received refunds totaling \$444,600.

Exhibit 2.4 in the Sunset Exposure Draft incorrectly identifies that the Board's regulations do not reflect the current fees charged by the Board and the fees reflected in the exhibit are not calculated correctly. For example, the rehabilitation fee by regulation is collected for initial, renewal and reinstatement applications for physicians. When added to the fees in Exhibit 2.4 for renewal and reinstatement, the fee collected by the Board accurately reflects the fees authorized by both statute and regulation. Refer to the Board's alternative Exhibit 2.4 below which shows selected fee levels authorized by regulation and are required to be charged by the Board.

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Alternative Exhibit 2.4 Board of Physicians Selected Fee Levels for Physicians

Initial Physician Licensure Fees

COMAR Citation	Fee	Amount
10.32.01.12 B. (1)	Initial Application	\$260
10.32.01.12 B. (5)	Physician License Fee per month of \$20 until expiration of initial license	\$480
10.32.01.12 B. (6)	Initial Physician Rehabilitation Fee	\$50
	Total Fee authorized by COMAR	\$790
	Fee Charged by Board	\$790

Physician Renewal Fees

COMAR Citation	Fee	Amount
10.32.01.12 C. (1)	Biennial License Renewal	\$436
10.32.01.12 C. (2)	Physician Rehabilitation Program Fee	\$50
	MHCC Fee	\$36
	Total Fee authorized by COMAR	\$522
	Fee Charged by Board	\$522

Physician Reinstatement (if eligible for renewal in previous year)

COMAR Citation	Fee	Amount
10.32.01.12 D. (1)	Reinstatement	\$650
10.32.01.12 D. (3)	Physician Rehabilitation Program Fee	\$50
	Total Fee authorized by COMAR	\$700
	Fee Charged by Board	\$700

Physician Reinstatement (if not eligible for renewal in previous year)

COMAR Citation	Fee	Amount
10.32.01.12 D. (2)	Reinstatement	\$550
10.32.01.12 D. (3)	Physician Rehabilitation Program Fee	\$50
	Total Fee authorized by COMAR	\$600
	Fee Charged by Board	\$600

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For clarification purposes, the correct fee for the polysomnographic technologists' initial and reinstatement application is \$200, not \$236. The MHCC fee of \$36 was inadvertently added to the initial and reinstatement application fee in the regulations. The Board does not charge applicants the additional \$36 fee. The MHCC fee is deducted from the \$200 fee. The Board will correct this in regulations.

The Board has made ongoing efforts to update fees to accurately reflect the costs associated with physicians and each allied health profession in accordance with the statute. Unfortunately, not all revision attempts to the regulations made it through the promulgation process. For example, the Board proposed revisions to COMAR 10.32.20.13, which required certain fees for Perfusionists to be updated on a certain date, but the proposed regulations were not approved. The Board is, however, authorized by statute to set reasonable fees for Perfusionist licensure (H.O. 14-5E-04(a)(1)).

Recommendation 3: The Board should establish a late renewal process that would be available to physicians for a 60-day period after the license expiration date. Statute should be amended to clarify that a physician has 60 days after the license expiration date in order to renew the license.

Board Response: The Board strongly disagrees with this recommendation. The implementation of a 60 day late renewal period was proposed during the 2016 legislative session. The legislation, SB 482/HB 1114, was fully vetted by the House and Senate and did not pass. The Board opposed the legislation based on several fiscal and operational negative impacts. The Board has serious concerns, in addition to any fiscal and operational impacts, about implementing a late renewal period, which are discussed below.

Issue # 1 – Permitting Unlicensed Practice: A late renewal period would permit physicians to practice with an expired license for up to 60 days. This contravenes statutory law, which requires an individual to be licensed in order to practice a profession regulated by the Board. Md. Code Ann., Health Occ. § 14-301. The late renewal process also contradicts Md. Code Ann., Health Occ. § 14-317, which requires the Board to reinstate the license of a physician who has failed to renew his or her license. The statutory provisions of Md. Code Ann., Health Occ. § 14-606(a)(5), which prohibit sanctioning individuals that have an expired license for less than 60 days, are very different from authorizing the unlicensed practice of medicine. The Board cannot support any legislation or recommendations that would legalize the unlicensed practice of medicine.

Issue # 2 – No jurisdiction over expired licensees: A medical license expires on September 30. Under Md. Code Ann., Health Occ. § 14-316(c), a licensee may renew before a license expires – i.e., on or before September 30. Section 14-317 requires the Board to reinstate the license of a

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physician who has failed to renew for any reason if they meet certain requirements. If an individual's license is expired, the Board loses jurisdiction to charge or discipline the individual for violations of the Medical Practice Act. The Board only retains jurisdiction over a license that has lapsed if the individual is under investigation or charges are pending on or before September 30. *See* Health Occ. § 14-403(a) and *Salerian v. Bd of Physicians*, 176 Md. App. 231, 247 (2007). A late renewal period does not change the fact of expiration on September 30 and would create a gap in licensure.

Issue # 3 – No demonstrated need: The vast majority of physicians renew on time prior to the expiration of their license. In the most recent renewal period, only 7 physicians out of 15,733 failed to timely renew before the expiration of the license. The license expires on the same date every two years and the Board provides multiple notifications to licensees about renewal, including reminder notices sent by mail, e-mails, newsletters, and announcements on the Board's Website. The Board has an online renewal process that is open to licensees for a period of approximately twelve weeks, twenty-four hours a day, seven days a week.

Under current law, if an individual does not renew the license before the license expires, the individual is required to reinstate the license before he or she may resume practicing medicine. The individual must meet the same requirements for reinstatement that are required for renewal. Reinstatement applications (if all documents are complete and the applicant meets the minimum requirements for licensure) are generally processed within a short time-frame.

Issue # 4 – Status of Licensees/Licensee Profiles: The Licensee Practitioner Profile System was developed to provide valuable information to Maryland citizens. The Board maintains and updates more than 101,000 individual practitioner profiles. Each profile includes the status of the licensee. A licensure status that is reflected as "late renewal" or "pending" will create confusion, rather than providing clear information to the public, and will be of no value to the citizens of Maryland. Public trust and safety will be compromised if patients and stakeholders are unable to determine the current licensure status of licensees.

Recommendation 4: Statute should be amended to require MBP to submit an annual report on the results of CHRCs and related implementation. Specifically, MBP should be required to report the following information for physicians and allied health professionals:

- (1) The number of initial and renewal licenses issued;**
- (2) The number of positive and negative CHRC results received;**
- (3) The number of individuals denied initial or renewal licensure due to positive CHRC results; and**
- (4) The number of individuals denied licensure due to reasons other than a positive CHRC.**

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Further, MBP should include in the fiscal 2019 CHRC report information regarding whether CHRCs are causing licensure delays, whether existing staff are able to manage the CHRC workload, and any other concerns with the CHRC process.

Board Response: The Board agrees with this recommendation, but requests to include the information in the Board's Annual report instead of in an additional report.

The implementation of the CHRC requirement was delayed until October 1, 2016 for the reasons mentioned in the Sunset Report, but also due to several additional factors that were outside of the Board's control. The Board began the implementation process in June of 2015 by holding an implementation meeting with CJIS. The Board, however, was unable to begin CHRCs until the FBI granted access to national criminal history information, which would then allow CJIS to issue a state-level authorization to move forward. The FBI required a legal sufficiency review of the final legislation and would not begin to review the CHRC legislation until it was signed by the Governor on April 14, 2015. The Board received an approval letter from CJIS granting FBI access at the end of October 2015. In April of 2016, the Board received the approval from CJIS for state-level CHRC information. The delay in obtaining the required FBI and CJIS approvals contributed significantly to the delay in implementation.

The Board would also like to clarify the CHRC implementation timeline. The 2005 sunset evaluation did not include any recommendation related to CHRCs. The first mention of a CHRC was in a 2007 update to the 2005 sunset evaluation. Recommendation 6 in the 2007 update suggested a requirement for the Board to require CHRCs. At that time the Board and Med Chi opposed the recommendation. Subsequently, the 2007 Sunset legislation struck all language related to CHRCs. In 2011, DLS advised that there was no need for CHRCs. Then, in 2014, a CHRC proposal was developed for the 2015 session as a direct response to a case that highlighted the need. Legislation was introduced and passed in the 2015 legislative session.

Recommendation 5: Given MBP's concerns about the timing of receipt and investigation of CHRC results on the renewal process, statute should be amended to clarify that the listed factors are to be considered by the Board when determining whether to take disciplinary action based on the results of CHRCs against a licensee who renewed or reinstated the license.

Board Response: The Board agrees with this recommendation.

Recommendation 6: The Board, in consultation with the Physician Assistant Advisory Committee, should study the desirability of modifying the law to require delegation agreements to be kept at the practice level only but be available for Board inspection on request and report their findings and recommendations in a follow-up report.

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Board Response: The Board's Physician Assistant Advisory Committee (PAAC) has already studied the desirability of modifying the law to require delegation agreements to be kept only at the practice level. The PAAC has considered the possibility of maintaining delegation agreements at the practice location only and does not support a modification in the law. The full Board will consider the PAAC's recommendation to oppose the modification in the law at the Board meeting on November 30, 2016.

The Maryland Academy of Physician Assistants (MAPA) sent a letter to Dr. Freas dated October 27, 2016 that suggested several changes to the law to expedite the processing of delegation agreements. The letter outlined concerns about delays in the physician assistant (PA) delegation agreement approval process, and suggested changes similar to this recommendation--maintaining delegation agreements only at the practice level for delegation agreements that do not include advanced duties and delegation agreements that contain advanced duties previously approved by the Board. Specifically related to advanced duty delegation agreements, it was urged that if a practice setting had an approved credentialing process, Board review was duplicative and unnecessary and also should be kept on file at the practice setting. Under MAPA's proposal, both types of agreements would, however, be available for Board inspection at any time and delegation agreements for practice settings with no credentialing body would still be subject to PAAC and Board review.

This information was presented to the PAAC on Wednesday, November 2, 2016 to obtain the PAAC's recommendation for the Board. In evaluating MAPA's proposals, the PAAC recognized the importance for the Board to have a record of the contract between the supervising physician and the PA. The PAAC also identified the need for delegation agreements to be submitted to the Board for processing. Board staff informed the PAAC that there are a significant number of delegation agreements that are incomplete and/or do not meet all requirements for approval when they are received by the Board, which further justifies the need for Board oversight.

Recent changes have improved and sped up the approval process and the Board has recently hired two additional analysts assigned to the Physician Assistant licensure program, which will increase efficiency in processing delegation agreements. The PAAC recommended that the Board implement additional measures to expedite the approval process, such as creating an electronic process for the PA and supervising physician to complete and submit delegation agreements. In light of the ongoing efforts to expedite the approval process, the PAAC did not believe that statutory change was necessary and has recommended that the Board not support MAPA's proposed changes to the statute. There was general support from the PAAC to continue to work with MAPA to improve the efficiency of the current process for submission of delegation agreements.

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Accordingly, the Board is already in the process of complying with this recommendation and will have fulfilled this recommendation as of the November 30, 2016 full Board meeting when it considers the advice of the PAAC, therefore a follow up report on this item is not necessary.

Recommendation 7: The Board should ensure that sexual misconduct regulations are referenced in the order summaries in cases where the licensee was specifically found to have violated them. Additionally, the Board should comment in a follow-up report on the feasibility of describing the underlying sexual misconduct in order summaries or other steps that the Board can take to make it easier for the public to determine whether a case involved sexual misconduct.

Board Response: The Board agrees with this recommendation and does cite the sexual misconduct regulations when there is a *conclusion of law* in a Board Order that these regulations have been violated. The Board is committed to transparency on sexual misconduct cases as evidenced by the Board's 5th place ranking out of all State Medical Boards in the Atlanta Journal Constitution survey (<http://doctors.ajc.com/states/>). The Board has commenced evaluating the feasibility of describing underlying sexual misconduct in summaries and options to make it easier for the public to determine whether a case involved sexual misconduct. The Board requests to include the information required in the follow-up report in the Board's annual report, instead of in an additional report.

Recommendation 8: Statute should be amended to require that the sexual misconduct reports specify for each health occupation Board

- (1) The number of sexual misconduct complaints that were closed with no disciplinary action;**
- (2) The number of sexual misconduct complaints that resulted in informal or nonpublic action;**
- (3) The number of sexual misconduct complaints that resulted in license revocation;**
- (4) The number of sexual misconduct complaints that were forwarded to law enforcement for possible criminal prosecution; and**
- (5) If other actions were taken, a detailed breakdown of the types of action.**

Board Response: The Board agrees with this recommendation, but wishes to clarify that this statutory change applies to all Health Occupation Boards. The Board complies with the current reporting requirements provided below.

Md. Code Ann., Health Occ., §1-212(e) requires each health occupations Board to "submit a statistical report to the Secretary, indicating the number of complaints of sexual misconduct received and the resolution of each complaint. The report shall cover the reporting period beginning October 1 and ending the following September 30 and shall be submitted by the Board not later than the November 15 following the reporting period. The Secretary shall compile the

Maryland Board of Physicians Responses to Sunset Exposure Draft

information received from the health occupations Board's and submit an annual report to the General Assembly, in accordance with 2-1246 of the State Government Article, not later than December 31 of each year."

Recommendation 9: The next sunset evaluation of MBP should examine the desirability of shifting proceedings involving the unauthorized practice of medicine, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders from the full Board to the disciplinary panels.

Board Response: The Board disagrees with this recommendation. In implementing one of the key recommendations of the 2011 sunset evaluation and the 2012 Perman Report, Chapter 401 of 2013 amended the Medical Practice Act to establish two separate disciplinary panels, each having the authority to make a final determination in contested cases under the Administrative Procedure Act ("APA"). Board members are not aware of any practical or legal rationale for requiring resolution of the four types of proceedings listed in the above recommendation by the full Board, as opposed to resolution by a disciplinary panel.

The goals of the two-panel system were to improve Board efficiency by expediting its review of disciplinary cases and to provide greater due process protections to health occupations providers. These goals were based on concerns about a backlog of Board disciplinary cases and the potential for unfair bias if the same Board members participated in the investigative and charging process and in the subsequent hearing and sanctioning phases. It remains unclear why the same efficiency and fairness considerations would not be desirable in proceedings involving the unauthorized practice of medicine and misrepresentation, denials of initial licenses, certain denials of renewals or reinstatements, and cease and desist orders. Similar to two-panel disciplinary cases under §14-404, these proceedings are governed by the APA, relate directly or indirectly to complaint resolution and involve the efficiency of Board processes. In the absence of in-person discussion and clear telephone communications, the call-in arrangement by the other disciplinary panel to act on these cases at the beginning of a meeting can impede a streamlined process and result in a cumbersome and frustrating experience for Board members and be a poor use of their time. From a practical and fairness standpoint, the Board suggests that the disciplinary panels be empowered to act on these cases before 2023.

Recommendation 10: Statute should be amended to clarify that the panel must refer a complaint for peer review if the panel decides, after reviewing the results of the preliminary investigation, that the licensee may have committed a standard of care violation.

Board Response: The Board agrees with this recommendation.

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Recommendation 11: Statute should be amended to require that complaints against naturopathic doctors be handled in the same manner as complaints against allied health professionals.

Board Response: The Board agrees with this recommendation and has identified that there are several other provisions of the Naturopath statute that should be amended to make them consistent with other provisions in the allied health statutes. As an example, the existing language in H.O. §14-5F-29(b) is inconsistent with other allied health statutes (see H.O. §14-5B-19) and could be interpreted to require a felony conviction before a civil fine for unlicensed practice can be imposed.

The following additional changes should also be considered to conform the Naturopath statute to the other allied health statutes, for example, adding change of address language (see H.O. §14-5A-14), language regarding the civil penalty and requirements for failure to report (see H.O. §14-5A-18), and language regarding the civil penalty for violations of the subtitle (see H.O. §14-5A-23).

Recommendation 12: Statute should be amended to (1) distinguish between individuals who are truly exempt from licensure and UMPs and (2) explicitly allow the Board to discipline UMPs in the same manner that applicants for licensure and licensees are disciplined.

Board Response: The Board agrees with this recommendation. In May of 2016, pursuant to the DHMH legislative approval process, the Board submitted a pre-proposal concept paper seeking to obtain approval to submit legislation, which would create an Unlicensed Medical Practitioner (UMP) training license. The legislative proposal was not approved.

The pre-proposal concept paper outlined the current law and regulations that allow an UMP in an accredited postgraduate clinical training program to practice medicine without a license while performing the assigned duties at any office of a licensed physician, hospital, clinic or similar facility, as long as they are registered with the Board by the program where they are being trained. Each institution providing the training program is responsible to register the UMP within 30 days of the contract start date. The registration period is generally one year. Frequently, programs fail to timely register the UMPs, resulting in UMPs practicing medicine without a registration. These individuals are essentially “unknown” to the Board or the public. Also, as UMPs rotate to different institutions, each facility must re-register the UMP with the Board. Because UMPs are not licensed, there is no requirement for the Board to create and maintain a public profile on UMPs.

The proposal created a portable training license that would allow the UMP to practice medicine in any approved residency training program for a longer period. The UMP would apply for and

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possess the license, and each institution would no longer be required to register the residents with the Board. The UMP training license would be portable and would be able to automatically transfer with the UMP to any approved program in the State upon notice to the Board. Once licensed, the Board would be able to post the current training program assignment of each UMP on the Board's website.

The training program's role as bureaucratic middleman would be eliminated and the proposal would not place a significant burden on the UMPs. As an example, the majority of residency programs are for three years, which requires an initial registration (current fee is \$100 annually), and then at least two additional registrations for a total fee of \$300 over the course of a three year residency. Currently, re-registration is required even for programs as short as 30 days so the cost for three years can be much greater than \$300. As a result of increased efficiency of the process, portability, and longer term of the training license, *the Board would be able to decrease the fees.*

This concept would improve the status quo by removing an administrative burden from the training programs and allowing the Board to streamline its own process to improve tracking of UMPs. It would not unduly burden UMPs, because most of the information training programs now submit in order to register their UMPs is obtained from the UMPs themselves.

Creation of a training license would clarify and create more consistent oversight for UMPs in a framework that is aligned with that of a licensed physician. Although the current provisions are substantially similar to licensed physician provisions, the statutory language would need revising and updating to eliminate ambiguity.

A draft of proposed amendments to H.O. §14-302 and the new proposed §14-303 are available for review.

Recommendation 13: Statute should be amended to repeal the six-month mandated reporting requirement.

Board Response: The Board agrees with this recommendation.

Recommendation 14: Chapter 539 of 2007 should be amended to repeal the requirement that the Chief Administrative Law Judge designate a pool of ALJs to hear cases referred by MBP. Conversely, the requirement in Chapter 539 that MBP provide annual training to OAH should be codified. Also, MBP and OAH should update each other, as necessary, regarding developments and changes in procedures that affect the other entity and the efficiency of the complaint process.

Board Response: The Board agrees with repealing the requirement that the Chief Administrative Law Judge designate a pool of ALJs to hear cases referred by the Board and

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would like to clarify that in addition to providing training to OAH, as necessary, it meets with OAH on a quarterly basis to discuss pertinent matters. After consultation with OAH, the Board would like to recommend that the statute be amended to require the Board to conduct training when it is deemed necessary by the Board and OAH.

Recommendation 15: The Board should report revenues and expenditures by practitioner type in its annual reports, beginning with the fiscal 2017 annual report. Further, in fiscal 2018, the Board should conduct an internal fiscal analysis and reassess its fee schedules. The board should submit a follow-up report to DLS by October 1, 2018, with the results of the internal fiscal analysis, including any possible changes to the Board's fee schedules for physicians and allied health professionals. The Board should specifically comment on the Board's fund balance in light of the additional retained revenue from the MLARP and HPSIG changes, as well as the ongoing issue of filling staff vacancies and the impact filling these vacancies would have on the Board's expenditures and fund balance.

Board Response: The Board agrees with this recommendation, however, the Board respectfully requests that the Board be permitted to include the information requested in the FY 2019 annual report, rather than submitting a separate report by October 1, 2018. The Board should have the necessary fiscal data on July 1, 2018, however, the Board will need more than 90 days to analyze the data, conduct an accurate internal fiscal audit and determine whether any changes to the fee schedules will be recommended.

The Board has attached alternate Exhibits 4.1 through 4.4 that more accurately reflect the Board's fiscal data.

Recommendation 16: To enhance compliance with the Open Meetings Act, if the Board or a disciplinary panel begins to discuss a matter in closed session that violates the Act, Board counsel should advise the Board or disciplinary panel that it is violating the Act and the Board or disciplinary panel should cease discussion. Also, the Board or disciplinary panel should state other statutory exceptions for closing a meeting in the written statement when nondisciplinary items are on the agenda.

Board Response: The Board agrees with this recommendation.

Recommendation 17: To enhance public transparency, all documents and website information should clearly label all meetings in which the full Board meets, either in person or through conference call, as meetings of the full Board, rather than as meetings of disciplinary panel.

Board Response: The Board agrees with this recommendation.

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Recommendation 18: Statute should be modified to allow health occupations boards that have jurisdiction over authorized prescribers who have entered into a prescriber-pharmacist agreement to enter into an agreement with the State Board of Pharmacy to require that the authorized prescribers submit the agreement and any subsequent modifications to the agreement to the State Board of Pharmacy.

Board Response: The Board agrees with this recommendation but would like to clarify that the Drug Therapy Management Program is a Pharmacy Board Statute, specifically Md. Code Ann., Health Occ. §§12-6A-01 through 12-6A-10.

Recommendation 19: Statute should be amended to extend the termination date for the State Board of Physicians and the related allied health advisory committees until July 1, 2023. Further, uncodified language should be adopted to limit the scope of the next sunset evaluation to evaluating (1) the implementation of recommendations made in this report; (2) the efficacy of the two-panel disciplinary system; and (3) the impact of criminal history record checks on the Board and licensees. Uncodified language should be adopted to require that the Board include in the follow-up report required to be submitted on or before October 1, 2017, under Chapter 401 of 2013, any issues specifically noted in this report for inclusion in a subsequent follow-up report, except for fiscal issues. Finally, uncodified language should be adopted in the 2017 session of the General Assembly to require that the Board include in the follow-up report required to be submitted on or before October 1, 2018, under Chapter 401 of 2013, any fiscal issues specifically noted in this report for inclusion in a subsequent follow-up report.

Board Response: The Board agrees with this recommendation, however, the Board respectfully requests that the Board be permitted to include the information in the follow-up reports in the Board's Annual Report to the legislature, for efficiency purposes, rather than in separate reports.

The 2011 Sunset Review included a recommendation that the Board submit a Sunset compliance update, on an annual basis through 2018. The Board respectfully requests that this report requirement, which was based on a recommendation in the 2011 sunset review, be repealed.

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**Alternative* 2016 Sunset Report Exhibits
Chapter Four Attachments**

* Please refer to Recommendation 15.

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Exhibit 4.1 in the Sunset Exposure Draft attempts to summarize the Board's six year fiscal history by presenting the number of positions, showing the cumulative fund balance calculation, and comparing the target cumulative and actual cumulative fund balances. This exhibit includes employment statistics in a chart specifically intended to summarize fiscal statistics and summarizes several calculations in a single chart.

The Board has created an alternative chart that presents the calculation of the cumulative fund balance alone in one chart as shown in Exhibit 4.1 (A) and displays each component of the cumulative fund balance calculation. Also, the notes in Exhibit 4.1 (A) provide the cumulative fund balance equation and the bold text and use of underlining assist with depicting the breakdown of a calculation.

Exhibit 4.1 (A)
State Board of Physicians Fiscal History: Cumulative Fund Balance
Fiscal Years 2012 through 2017

	<u>Actual FY2012</u>	<u>Actual FY2013</u>	<u>Actual FY2014</u>	<u>Actual FY2015</u>	<u>Actual FY2016</u>	<u>Projected FY2017</u>
Beginning Fund Balance	\$5,084,899	\$4,181,378	\$5,357,785	\$5,836,711	\$5,467,630	\$5,181,941
Sum of Total Revenues	\$8,669,880	\$10,724,384	\$9,115,349	\$11,115,607	\$9,576,129	\$11,337,919
Sum of Total Expenditures	\$8,398,239	\$7,964,842	\$7,543,134	\$8,327,631	\$8,695,846	\$10,305,528
<i>Cash Transfers to Scholarship Program (MHEC)*</i>	\$1,000,162	\$1,262,743	\$1,093,289	\$1,357,057	\$1,165,972	\$550,000
<i>Cash Transfers to State's General Fund (BRFA)**</i>	\$175,000	\$320,392	\$0	\$1,800,000	\$0	\$0
Sum of Total Cash Transfers	\$1,175,162	\$1,583,135	\$1,093,289	\$3,157,057	\$1,165,972	\$550,000
Total Cumulative Fund Balance***	\$4,181,378	\$5,357,785	\$5,836,711	\$5,467,630	\$5,181,941	\$5,664,332

*Reflects statutorily mandated transfers to the Health Personnel Shortage Incentive Grant Program (HPSIG) and the Maryland Loan Assistance Repayment Program (MLARP) equal to 12% of annual revenues. Chapter 178 of 2016 repealed the contribution to HPSIG and capped the Board's MLARP contribution at \$550,000 in FY2017.

** Transfers to the State's General Fund as mandated by the annual Budget Reconciliation and Financing Act.

*** Total Cumulative Fund Balance = Beginning Fund Balance + Sum of Total Revenues - Sum of Total Expenditures - Sum of Total Cash Transfers

Source: State Board of Physicians; 2014-2017 Budget Books; Department of Legislative Services

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The Board recommends that the comparison of the target cumulative fund balance and the actual cumulative fund balance be presented in a separate chart as shown in Exhibit 4.1 (B). The Board's alternate chart displays fiscal data rather than a calculation.

Exhibit 4.1 (B)
State Board of Physicians Fiscal History: Target Cumulative Fund Balance vs Actual Cumulative Fund Balance
Fiscal Years 2012 through 2017

	<u>Actual FY2012</u>	<u>Actual FY2013</u>	<u>Actual FY2014</u>	<u>Actual FY2015</u>	<u>Actual FY2016</u>	<u>Projected FY2017</u>
Target Cumulative Fund Balance as a Percentage of the Sum of Expenditures	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%
Target Cumulative Fund Balance (Sum of Total Expenditures X 20%)	\$1,679,648	\$1,592,968	\$1,508,627	\$1,665,526	\$1,739,169	\$2,061,106
Actual Cumulative Fund Balance as a Percentage of the Sum of Total Expenditures*	49.8%	67.3%	77.4%	65.7%	59.6%	55.0%
Actual Cumulative Fund Balance	\$4,181,378	\$5,357,785	\$5,836,711	\$5,467,630	\$5,181,941	\$5,664,332

*MBP is considered a large board. As a general rule, large boards strive to maintain a cumulative fund balance that is at least 20% of the sum of expenditures for individual fiscal years. This amount is referred to as the target cumulative fund balance. Maintaining a target cumulative fund balance that is at least 20% of the sum of expenditures for individual fiscal years lessens MBP's exposure to financial devastation during periods of high, unanticipated costs. A portion of MBP's fund balance that exceeds the target cumulative fund balance is reserved for information technology system.

Source: State Board of Physicians; 2014-2017 Budget Books; Department of Legislative Services

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Exhibit 4.2 in the Sunset Exposure Draft attempts to compare the Board's retained revenues using the old MHEC contribution mandate to the Board's retained revenues using the new MHEC contribution mandate. The Board's alternative chart, as presented in Exhibit 4.2 below, shows more data in the chart to assist with the analysis of the information including the revenue, the old contribution amount, the new contribution amount, and the difference between the contributions.

Exhibit 4.2
Retained Revenues for the
State Board of Physicians Under Chapter 178 of 2016
Fiscal Years 2017 through 2021

	<u>FY2017</u>	<u>FY2018</u>	<u>FY2019</u>	<u>FY2020</u>	<u>FY2021</u>
Projected Revenues	\$10,920,000	\$9,120,450	\$10,920,000	\$9,120,450	\$10,920,000
Former Mandated HPSIG and MLARP Contribution (\$)*	\$1,310,400	\$1,094,454	\$1,310,400	\$1,094,454	\$1,310,400
MLARP Contribution as Mandated by Chapter 178 of 2016	\$550,000	\$550,000	\$400,000	\$400,000	\$400,000
Retained Revenues under Chapter 178 of 2016	\$760,400	\$544,454	\$910,400	\$694,454	\$910,400

*Pursuant to Chapter 178 of 2016, instead of 12% of its annual total fee revenues, the Board must contribute only \$550,000 in FY2017 and FY2018 then only \$400,000 beginning in FY2019 toward MLARP.
Source: Department of Legislative Services

Exhibit 4.1 in the Sunset Exposure Draft is titled "State Board of Physicians Fiscal History" but includes employment statistics combined with the Board's fiscal information.

The Board's alternative chart (Exhibit 4.3 below) combines employment statistics from Exhibits 4.1 and 4.3 to include all employment data in one chart.

Exhibit 4.3
Average Number of Vacancies for the State Board of Physicians
Fiscal Years 2012 through 2016

	<u>FY2012</u>	<u>FY2013</u>	<u>FY2014</u>	<u>FY2015</u>	<u>FY2016</u>
Number of Authorized Positions	67.10	70.10	70.10	70.10	71.10
Number of Contractual Positions	2.48	3.40	1.85	2.97	5.30
Average Number of Vacancies	5.33	8.67	11.13	9.09	8.00
Vacancy Rate (%)	7.9%	12.3%	15.9%	13.0%	11.3%

Source: State Board of Physicians; Department of Legislative Services

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Exhibit 4.4 in the Sunset Exposure Draft was introduced as a chart displaying only the revenues and expenditures for Allied Health, but then attempted to calculate the fund balance for Allied Health. Unfortunately, revenues and expenditures are just two of the three components of the fund balance equation. Because the Board does not currently report cash transfers at the program level, it is not possible to effectively calculate Allied Health's fund balance. The Board is a fund and Allied Health is a program and at a lower level than the fund level.

The Sunset Exposure Draft narrative represents the exhibit as showing the "subset of revenues and expenditures associated with the allied health professions from fiscal 2013 through 2016." The alternative exhibit shown below with only the Allied Health revenues and expenditures aligns the fiscal information with the description in the narrative. To assist with reviewing the information presented, the Board's alternative Exhibit 4.4 includes the breakdown of the expenditures for Allied Health.

Exhibit 4.4 Fiscal Condition of Allied Health Unit Fiscal Years 2013 through 2016

	<u>FY2013</u>	<u>FY2014</u>	<u>FY2015</u>	<u>FY2016</u>
Sum of Total Allied Health Revenues	\$1,696,192	\$1,059,006	\$1,892,454	\$1,079,470
<i>Salaries and Wages</i>	<i>\$397,473</i>	<i>\$451,432</i>	<i>\$544,057</i>	<i>\$604,247</i>
<i>Technical and Special Fees</i>	<i>\$12,936</i>	<i>\$11,372</i>	<i>\$33,550</i>	<i>\$37,911</i>
<i>Communications</i>	<i>\$1</i>	<i>\$1</i>	<i>\$1</i>	<i>\$0</i>
<i>Travel</i>	<i>\$4,765</i>	<i>\$5,092</i>	<i>\$7,254</i>	<i>\$7,015</i>
<i>Contractual Services</i>	<i>\$7,885</i>	<i>\$29,808</i>	<i>\$33,707</i>	<i>\$21,081</i>
<i>Fixed Charges*</i>	<i>\$0</i>	<i>\$52,161</i>	<i>\$59,686</i>	<i>\$51,982</i>
Sum of Total Allied Health Expenditures	\$423,060	\$549,865	\$678,255	\$722,237

**The Board's Physicians program paid Allied Health's fixed charges in FY2013.*

Source: State Board of Physicians; Department of Legislative Services