

SUNSET ADVISORY COMMISSION

STAFF REPORT

Texas Medical Board



2016–2017

85TH LEGISLATURE

SUNSET ADVISORY COMMISSION

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HOW TO READ SUNSET REPORTS

Each Sunset report is issued *three times*, at each of the three key phases of the Sunset process, to compile all recommendations and action into one, up-to-date document. Only the most recent version is posted to the website. (**The version in bold is the version you are reading.**)

1. SUNSET STAFF EVALUATION PHASE

Sunset staff performs extensive research and analysis to evaluate the need for, performance of, and improvements to the agency under review.

FIRST VERSION: The *Sunset Staff Report* identifies problem areas and makes specific recommendations for positive change, either to the laws governing an agency or in the form of management directives to agency leadership.

2. SUNSET COMMISSION DELIBERATION PHASE

The Sunset Commission conducts a public hearing to take testimony on the staff report and the agency overall. Later, the commission meets again to vote on which changes to recommend to the full Legislature.

SECOND VERSION: The *Sunset Staff Report with Commission Decisions*, issued after the decision meeting, documents the Sunset Commission's decisions on the original staff recommendations and any new issues raised during the hearing, forming the basis of the Sunset bills.

3. LEGISLATIVE ACTION PHASE

The full Legislature considers bills containing the Sunset Commission's recommendations on each agency and makes final determinations.

THIRD VERSION: The *Sunset Staff Report with Final Results*, published after the end of the legislative session, documents the ultimate outcome of the Sunset process for each agency, including the actions taken by the Legislature on each Sunset recommendation and any new provisions added to the Sunset bill.

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**SUMMARY OF SUNSET STAFF
RECOMMENDATIONS**

SUMMARY

In the world of healthcare professionals, the physician reigns supreme. No other healthcare practitioner has greater autonomy or authority over patient care than a physician. Consequently, no other healthcare discipline poses a greater risk to patient and public safety than the practice of medicine — the regulation of which is under the purview of the Texas Medical Board. Given the enormous potential risk posed by physicians, the Medical Board is not an ordinary occupational licensing agency. Adding to the challenge of its mission to protect the public by ensuring quality health care for the citizens of Texas, the board oversees seven other healthcare professions, for a total of almost 132,000 licensees. Given the importance and scope of the board's duties, Sunset staff focused its review on ensuring the board is adequately protecting the public and targeting its resources in a streamlined and efficient way.

Because of longstanding legislative interest in the Medical Board stemming from the board's past struggles with major deficiencies in licensing and enforcement, Sunset staff closely examined the board's performance in these areas. While the last seven years of complaint and disciplinary data reveal fluctuations among the types of violations that received disciplinary actions, the Medical Board provided a consistent level of enforcement over those years. In addition, after conducting a more detailed analysis of various Medical Board datasets and multiple years of case files, Sunset staff did not detect any obvious indications of bias in favor or against any type of practitioner. In other words, the Medical Board has come a long way and generally is a solid model for licensure and enforcement of occupations. That does not mean that people do not have complaints about or disagree with decisions and actions of the board. However, Sunset cannot and does not re-evaluate individual decisions of a board.

One especially high-risk activity that physicians perform is prescribing highly addictive and dangerous drugs, particularly drugs designed for patients with chronic pain, as some of these drugs have contributed to an epidemic of addiction and overdose throughout the country. State law tasks the Medical Board with enforcing proper treatment of pain by monitoring prescribing activity of physicians and physician assistants and by regulating clinics designed specifically for treating patients for pain. Sunset staff obtained and analyzed previously unavailable data from the state's Prescription Monitoring Program. These data indicate that many pain management clinics, which are required to register with the board, pose a surprisingly low level of risk. The data also show that most physicians and physician assistants who prescribe controlled substances most frequently are not affiliated with pain management clinics. Accordingly, to better curb prescription drug abuse and misuse, the Medical Board's inspections of pain management clinics should be targeted toward

The Medical Board has come a long way and generally is a solid model for licensure and enforcement.

the highest prescribers and the board should more effectively monitor prescribing patterns through the newly enhanced Prescription Monitoring Program.

Another key way Texas aims to protect the public is through the state's peer assistance program for physicians and other board licensees that have physical or mental health conditions — the Texas Physician Health Program. Sunset staff found that the program is inhibited by its unclear arrangement with the Medical Board and limited funding sources. Requiring the Medical Board and the program to develop a memorandum of understanding covering services and operations; eliminating a statutory cap on the program's fee; and authorizing the program to accept gifts, grants, and donations would better set up the program to achieve its mission to help licensees return safely to practice.

Working closely with the Medical Board, Sunset staff identified administrative inefficiencies and redundancies in the board's newly acquired medical radiologic technology program and recommends streamlining this program. Sunset staff also made several recommendations to update board statutes and practices to reflect current standards, thereby increasing efficiency and better protecting the public, including authorizing the board to establish a risk-based approach to its office-based anesthesia inspections. In addition, Sunset staff concluded that Texas' joining of the Interstate Medical Licensure Compact would ease and improve the licensure of physicians wishing to practice in multiple states and could better facilitate future developments in telemedicine.

The following material summarizes Sunset staff recommendations on the Texas Medical Board.

Issues and Recommendations

Issue 1

Untargeted Inspections and Unclear Statutory Authority Limit the Effectiveness of Pain Management Clinic Regulation.

The Medical Board's pain management clinic inspection program does not follow best practices — such as effective use of Prescription Monitoring Program data, or consideration of past inspection reports or length of time since the last inspection — to maximize efficiency with limited investigatory resources. Inspecting all clinics every two years, even those that are high performing and have had no violations during previous inspections, takes focus away from other potentially harmful activities, while two years may be too long between inspections for problematic clinics. Data from the Prescription Monitoring Program suggest that prescribers practicing in PMCs pose a counterintuitively lower level of risk than prescribers not practicing in PMCs, making targeted inspections even more important. In addition, 10 of the board's more than 40 enforcement actions and lawsuits stemming from its pain management clinic inspections resulted in a judge questioning the board's statutory enforcement authority. Without certain tools clarified in statute, such as the ability to enforce its subpoenas and inspect unregistered clinics, the board is limited in its ability to regulate pain management clinics.

Key Recommendations

- Direct the Medical Board to use Prescription Monitoring Program data, along with other factors, to establish a risk-based approach to scheduling pain management clinic inspections.
- Authorize the Medical Board to seek court enforcement of its administrative subpoenas.
- Clarify statute to authorize the Medical Board to inspect an unregistered pain management clinic.

Issue 2

Key Elements of the Texas Medical Board's Licensing and Regulatory Functions Do Not Conform to Common Licensing Standards.

Sunset staff found that various Medical Board licensing and enforcement statutes and processes do not match model standards or best practices observed through Sunset reviews of many regulatory agencies. Specifically, agencies whose licensees can prescribe controlled substances should have clear authority to monitor those licensees for inappropriate prescribing patterns. Clarifying the board's statutory authority to proactively monitor the state's Prescription Monitoring Program for improper prescribing of controlled substances by physicians or physician assistants would help Texas address the nationwide epidemic of prescription drug abuse. Agencies should also have processes in place to evaluate the risk level posed by entities and individuals subject to inspection. Authorizing the board to use a risk-based approach to its office-based anesthesia inspections would ensure the board avoids re-inspecting equipment and procedures already deemed safe and compliant, thereby targeting staff time and resources to the highest-risk areas.

Key Recommendations

- Clarify statute and provide direction for the Medical Board to monitor physician and physician assistant prescribing of controlled substances.
- Authorize the board to establish a risk-based approach to its office-based anesthesia inspection, focusing on the length of time since equipment and procedures were last inspected.
- Clarify statute to authorize the board to conduct fingerprint-based criminal background checks of all applicants.
- Remove the statutory limitations on the Medical Board's authority to set fees.

Issue 3

Streamlining the Medical Radiologic Technology Program Would Increase Fairness to Licensees and Administrative Efficiency.

State law establishes three different types of certification for medical radiologic technology professionals: general medical radiologic technologist, limited medical radiologic technologist (LMRT), and noncertified technician (NCT). The LMRT certification is unduly complicated and adds a needless administrative burden to an already busy agency. The types of procedures an LMRT certificate holder can legally perform vary by individual, complicating regulators' ability to detect and take enforcement action on violations. In fact, Texas' 625 LMRTs have 2,269 specialty certificates.

Statute requires NCTs under the supervision of physicians, chiropractors, and podiatrists to register with their respective regulatory boards — in addition to the main registry now under the authority of the Medical Radiologic Technology board and administered by Medical Board staff. This requirement is redundant, costly to licensees, and does not increase public safety.

Key Recommendations

- Abolish the limited medical radiologic technologist certification.
- Eliminate duplication by removing dual registry requirements for noncertified technicians.

Issue 4

The Current Process for Authorizing Qualified Physicians to Practice in Texas Does Not Maximize Mobility Within the Profession.

Licensure compacts are formal agreements among states with similar standards for a profession to recognize each other's licensees without requiring an application for a separate license in each state. The Interstate Medical Licensure Compact became active in May 2015, and 17 states have joined as of October 2016. The Texas Medical Board's current process for licensing physicians from other states can take up to 42 days and is cumbersome. In fact, the complexity of applying for licenses in additional states often warrants physicians hiring third-party companies to assist in completing medical licensure applications. The medical licensure compact would help expedite and simplify licensing for physicians seeking to practice medicine in multiple states and would facilitate the exchange of investigative and disciplinary information among member states. Increasing the administrative ease with which a physician can be authorized to practice in Texas could improve access to care in the state's critically underserved areas while also relieving the Medical Board's increasing administrative workload. The medical licensure compact would not supersede the Texas Medical Practice Act or any other state law; the Legislature would retain full authority over the Medical Board and the practice of medicine in Texas.

Key Recommendation

- Adopt the Interstate Medical Licensure Compact.

Issue 5

An Undefined Structure and Few Funding Sources Limit the Texas Physician Health Program's Success.

The Legislature established the Texas Physician Health Program in 2009 to provide monitored recovery services to physicians and other Medical Board licensees that have physical or mental health conditions, including substance use disorder. Sunset staff found that while the program is administratively attached to the board, the details of that attachment are unclear, contributing to the program's organizational instability. Staff also found that limited funding sources reduce the program's ability to reach more licensees that have potentially impairing conditions. Requiring the Medical Board and program to establish a memorandum of understanding and authorizing the program to accept gifts, grants, and donations would better position the program to help licensees safely return to practice.

Key Recommendations

- Require the Texas Medical Board and Texas Physician Health Program to develop a memorandum of understanding covering services and operations, including performance measures and auditing requirements.
- Authorize the Texas Physician Health Program to accept gifts, grants, and donations.

Issue 6

The State Has a Continuing Need to Regulate the Practice of Medicine and the Other Allied Health Professions at the Texas Medical Board.

Texas began regulating the practice of medicine in 1837. Today, the Texas Medical Board's mission is to protect and enhance the public's health, safety, and welfare by ensuring quality health care for the citizens of Texas through licensure, enforcement, and education. The Medical Board licenses and regulates about 78,600 physicians as well as seven other health professions for a total of roughly 132,000 licensees.

The state has a continuing need to regulate the practice of medicine and the allied health professions housed at the Medical Board. No other healthcare discipline poses a greater risk to patient and public safety than the practice of medicine. Likewise, as allied health professions have developed and grown, the state has seen the need to ensure they practice safely as well. All states license and regulate physicians and most do so either through an independent board or through a semi-autonomous board housed within an umbrella agency. The review of the Medical Board found that no substantial benefits would result from transferring the board's functions to another agency at this time, as regulatory consolidation has already occurred under the Medical Board. In addition, observations of multiple disciplinary proceedings and board and committee meetings, analysis of comprehensive board data, and scrutiny of certain disciplinary case files did not uncover any obvious suggestions of bias in favor or against any type of practitioner and instead indicate the board is successfully fulfilling its mission.

Key Recommendation

- Continue the Texas Medical Board for 12 years.

Fiscal Implication Summary

Overall, recommendations in this report would result in an annual loss to the General Revenue Fund of \$183,280 from eliminating the duplicative dual registration of noncertified technicians.

Issue 3 — Eliminating the requirement that the medical, chiropractic, and podiatry boards register noncertified technicians would result in an annual loss to general revenue of \$183,280 as the Texas Medical Board received \$179,177 in revenue from NCT permit fees in FY 2015, the Board of Chiropractic Examiners received \$3,963, and the Board of Podiatric Medical Examiners received just \$140. Because LMRTs would be likely to move towards MRT or NCT status, elimination of the LMRT license should not have a fiscal impact.

Texas Medical Board

Fiscal Year	Loss to the General Revenue Fund
2018	\$183,280
2019	\$183,280
2020	\$183,280
2021	\$183,280
2022	\$183,280

AGENCY AT A GLANCE

AGENCY AT A GLANCE

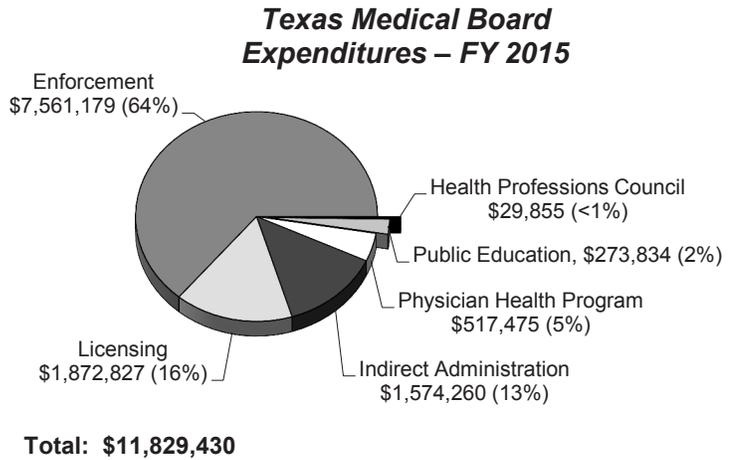
The Texas Medical Board licenses and regulates medical practitioners in the state to ensure that Texans receive safe and quality medical care. Texas first began regulating the practice of medicine in 1837, when the Legislature created the Board of Medical Censors. In 1907, the Legislature passed the Texas Medical Practice Act and established the Texas State Board of Medical Examiners to regulate physicians. In 1993, the Legislature created and housed under the board regulatory programs for physician assistants and acupuncturists, and did the same in 2001 for surgical assistants. The Legislature, in 2005, changed the board's name to the Texas Medical Board. In 2015, the Legislature transferred the regulation of medical physicists, medical radiologic technologists, perfusionists, and respiratory care practitioners from the Department of State Health Services to the Medical Board. To achieve its mission, the board carries out the following key activities:

- Licenses qualified physicians, physician assistants, acupuncturists, surgical assistants, medical physicists, medical radiologic technologists, perfusionists, and respiratory care practitioners.
- Registers and inspects pain management clinics and physicians who perform office-based anesthesia.
- Investigates and resolves complaints, and takes disciplinary action when necessary to enforce the board's statutes and rules.
- Monitors compliance with disciplinary orders.

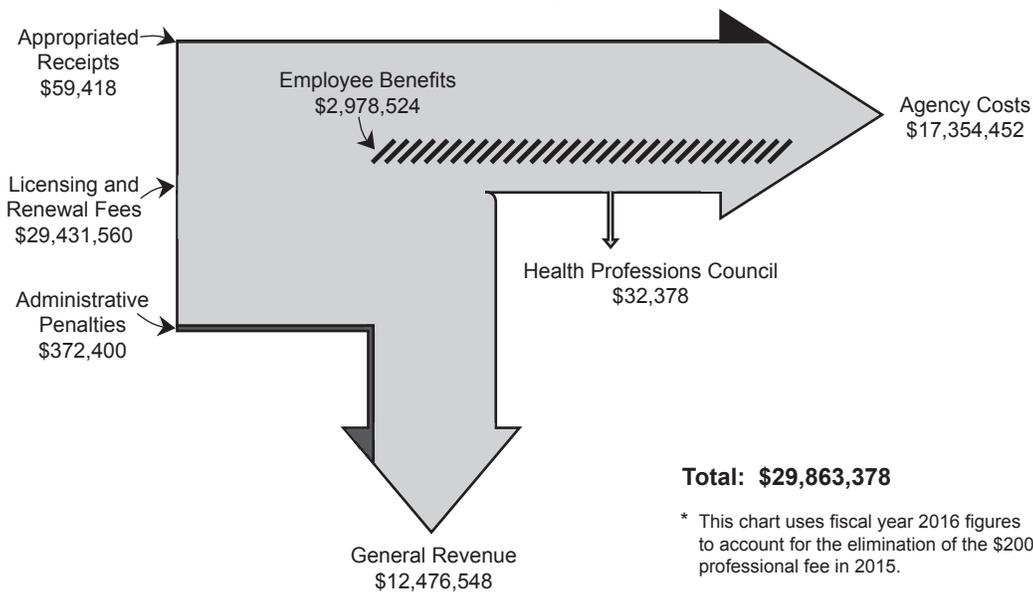
Key Facts

- **Boards and advisory committees.** Housed under the Texas Medical Board are four other boards and three advisory committees, with the Medical Board exercising policymaking for the board and oversight over the rulemaking of the associated boards and committees. The full Medical Board consists of 19 governor-appointed members: 12 Texas-licensed physicians, nine with a degree of doctor of medicine and three with a degree of doctor of osteopathic medicine, and seven members who represent the public. Additionally, the Board of Acupuncture Examiners, Board of Medical Radiologic Technology, and Board of Respiratory Care each consists of nine members appointed by the governor while the Physician Assistant Board has 13 governor-appointed members. These boards assist Medical Board staff by reviewing license applications and taking enforcement actions against their licensees. The advisory committees for perfusionists and medical physicists are both made up of seven members appointed by the Medical Board president, while the advisory committee for surgical assistants consists of six members also appointed by the Medical Board president. These committees do not have oversight of license applications or enforcement actions for their licensees.
- **Funding.** The Texas Medical Board operated on appropriations of about \$11.8 million in fiscal year 2015, almost all of which came from general revenue and a dedicated general revenue fund. The pie chart on the following page, *Texas Medical Board Expenditures*, breaks out the board's spending by major program areas. Appendix A, *Historically Underutilized Business Statistics*, describes the board's use of historically underutilized businesses in purchasing goods and services for fiscal years 2013–2015.

The board collected \$43 million in revenue in fiscal year 2015, which is far in excess of what is needed to cover board expenditures. The majority of the revenue originated from licensing and renewal fees, totaling \$22.8 million, including more than \$16.3 million from the professional fee paid by physicians directly to the General Revenue Fund. Although the Legislature discontinued this professional fee in 2015, the board is still projected to bring in about \$12.5 million more from its fees in fiscal year 2016 than budgeted to run the board and pay for employee benefits. Funds collected and spent are shown in the following chart, *Flow of Texas Medical Board Revenue and Expenditures*.



**Flow of Texas Medical Board Revenue and Expenditures
FY 2016 (Budgeted)***



- Staffing.** The board’s cap on staff positions increased to 201 in fiscal year 2016, largely due to an additional 29 positions associated with a transfer of functions from the Department of State Health Services. About one-quarter of staff members work outside of Austin, with investigators and compliance officers located in five regions across the state. Appendix B, *Equal Employment Opportunity Statistics*, compares the board’s workforce composition to the statewide civilian labor force for the past three fiscal years. Additionally, the board is a member of the Health Professions Council. As a member of the council, the board helps support the council’s coordination efforts both financially and administratively. Appendix C, *Health Professions Council*, provides more information.

- **Licensing.** The board processes applications and renewals for its eight license programs. To be approved, an applicant must graduate from an educational institution approved by the appropriate board, pass a national exam corresponding with the applicant's intended practice, pass the Texas jurisprudence exam, and have not committed a disqualifying violation of law. On September 1, 2015, the board received from the Department of State Health Services oversight of more than 43,000 additional licensees. The table, *Texas Medical Board Licensees*, provides the number of licensees in each category.

Texas Medical Board Licensees – FY 2016

Type of License	Total Number of Licensees
Physicians	78,575
Physician Assistants	8,058
Acupuncturists	1,241
Surgical Assistants	452
Medical Physicists	671
Medical Radiologic Technologists	26,868
Perfusionists	397
Respiratory Care Practitioners	15,540
Total	131,802

- **Enforcement.** After receiving a complaint, the Medical Board determines if the complaint falls under its jurisdiction and if it violates the board's laws or rules. The Medical Board received 7,510 written complaints in fiscal year 2015 and opened 1,853 investigations during the same year. Of those investigations opened, 1,675 concerned physicians. The outcome of these investigations can be found in the table *Complaints Resolved Against Physicians*. For all license types the board approved 332 disciplinary actions and 261 remedial plans, which are corrective actions taken by the board and considered to be non-disciplinary. The table, *Enforcement Actions*, provides more information.

Complaints Resolved Against Physicians By Category – FY 2015

Complaint Type	Total Actions	Total Dismissed
Administrative	27	27
Violation of Law/Criminal Behavior	82	52
Medical Error	7	45
Mental or Physical Impairment	23	15
Quality of Care	149	586
Disciplinary Action by Peers	40	47
Substance Abuse	49	14
Unprofessional Conduct	102	389
Total	479	1,175*

* The number of cases does not total 1,675 because not every investigation is resolved in the same year it begins.

Enforcement Actions – FY 2015

Disciplinary Action Type	Physicians	Acupuncturists	Physician Assistants	Surgical Assistants
Temporary Suspension/Restriction	23	0	1	0
Revocation/Surrender	43	1	6	2
Suspension	22	0	2	0
Restriction	132	0	10	0
Reprimand	37	1	5	0
Administrative Penalty	3	0	0	0
Cease and Desist	16	0	0	0
Licensed With Conditions	23	0	4	0
Licensed Denied Following SOAH Hearing	1	0	0	0
Total Number of Disciplinary Actions	300	2	28	2

- **Texas Physician Health Program.** Administratively attached to the Medical Board, the Texas Physician Health Program serves physicians and other board licensees that have physical or mental health conditions, including substance use disorder, through a monitored recovery program. The president of the Medical Board appoints the 11-member governing board that oversees a staff of 8.5 employees that includes a medical director. The program had 377 participants at the end of fiscal year 2015.
- **Other registrations and inspections.** The Texas Medical Board registers pain management clinics, which are facilities where a majority of patients receive monthly prescriptions for opioids, benzodiazepines, barbiturates, carisoprodol, or other highly regulated drugs. The physician who is the owner and operator of a pain management clinic must register with the Medical Board, and clinic certificates are valid for two years. Currently, about 110 clinics are registered with the board which began routinely inspecting clinics in 2014.

The board also registers physicians who provide anesthesia services or perform procedures for which anesthesia services are provided in an outpatient setting. Registrations are valid for two years, and in August 2016, the board once again began performing inspections of registered office-based anesthesia service providers in the state after a year-and-a-half hiatus while the board revised the inspection process. The board currently registers 2,482 physicians who provide office-based anesthesia.

ISSUES

ISSUE 1

Untargeted Inspections and Unclear Statutory Authority Limit the Effectiveness of Pain Management Clinic Regulation.

Background

The Texas Medical Board enforces the Medical Practice Act which prohibits, among other things, the prescribing of drugs for nontherapeutic purposes. If a doctor prescribes a drug to a patient that the doctor knows or should know the patient does not medically need, the doctor has engaged in nontherapeutic prescribing. Among other drugs, physicians can prescribe what are legally designated as “dangerous drugs,” like antibiotics, and “controlled substances,” like hydrocodone. The textbox, *Controlled Substances*, provides more information on this class of drugs. In 2015, Texas patients filled 38.6 million controlled substance prescriptions.¹

Nontherapeutic prescribing of controlled substances, especially opioids, is of particular concern as these drugs carry a significant risk of abuse and can lead to serious negative medical outcomes including addiction and death. In 2014, the Medical Board began inspecting pain management clinics (PMCs) to help combat nontherapeutic prescribing. Pain management clinics primarily prescribe controlled substances, such as opioids and muscle relaxers, and therefore warrant additional state oversight to ensure proper prescribing of these dangerous, highly addictive drugs. A facility is only required to register as a PMC with the Medical Board if the majority of its patients are prescribed on a monthly basis a prescription for opioids, benzodiazepines, barbiturates, or carisoprodol and are not offered another form of treatment such as surgery or injections.²

Statute requires a person seeking to register a PMC to have no criminal history or previous administrative violations related to controlled substances, and requires that the owner or operator of the clinic, who must be a physician, be on the premises at least 33 percent of the time and review at least 33 percent of the patient files.³ By rule, the Medical Board places additional requirements on physicians such as 10 hours of continuing medical education in pain management and considering whether to check the Prescription Monitoring Program (PMP) — a statewide database that collects information on every controlled substance dispensed in Texas — to review a patient’s prescription history.⁴ In addition,

Controlled Substances

What are controlled substances?

- Highly addictive medications with increased potential for abuse — addiction can occur from taking just one valid prescription
- Commonly prescribed for pain relief or sedation
- Examples include opioid drugs such as Vicodin (hydrocodone) and OxyContin (oxycodone) and benzodiazepine drugs such as Xanax (alprazolam)

What additional regulations govern controlled substances?

- The federal Drug Enforcement Agency registers and monitors prescribers, pharmacists, and drug distributors of controlled substances
- In Texas, prescriptions for particularly addictive controlled substances must be written on registered, secure prescription pads
- The Texas Medical Practice Act defines four classes of controlled substances carrying higher risk and places additional requirements on pain management clinics that prescribe these drugs (opioids, benzodiazepines, barbiturates, and carisoprodol)
- The state’s Prescription Monitoring Program requires all Texas pharmacies to enter information about controlled substance prescriptions into a statewide database within seven days of dispensing

PMCs must submit to board inspections to ensure compliance with the statute and board rules.⁵ The board conducts inspections on a biennial basis, prior to renewal of a PMC's registration. The Medical Board currently employs 31 investigators located throughout the state who inspect about 110 PMCs in addition to conducting complaint investigations and office-based anesthesia inspections.

Findings

The Medical Board's pain management clinic inspection program does not follow best practices to make efficient use of the board's limited investigatory resources.

The board's current inspection method does not use available data to help target inspection efforts. After already scheduling an inspection, the board queries the PMP to look at the owner's prescribing history, looking for telltale signs of nontherapeutic prescribing. However, the board does not use this data or other information — such as past inspection reports or length of time since the last inspection — to prioritize which clinics need inspecting. Inspections can take an entire day for two investigators, who also conduct office-based anesthesia inspections and investigate the more than 1,800 valid, jurisdictional complaints that the board receives each year. Sunset staff observed an inspection of a PMC that had two clean inspections yet would still be subject to another inspection in two years despite showing no signs of any problem behavior. Having to re-inspect well performing PMCs every two years takes an inspector's focus away from other potentially harmful activities. Similarly, for especially problematic clinics, two years may be too long between inspections.

The board does not use data to prioritize which clinics need inspecting.

Many pain management clinics do not pose sufficient risk to warrant biennial inspections. Sunset staff requested prescriber data from the Prescription Monitoring Program for the top 300 prescribers of controlled substances for all licensees authorized to prescribe controlled substances, which includes physicians, physician assistants, nurse practitioners, podiatrists, dentists, optometrists, and veterinarians. The request targeted the four categories of controlled substances whose prescribing is governed by the pain management statute — opioids, benzodiazepines, barbiturates, and carisoprodol.⁶ The data indicate that the majority of physicians and physician assistants who prescribe controlled substances the most frequently are not affiliated with pain management clinics. In fiscal year 2015, the board registered 140 PMCs, whose physicians and physician assistants would be expected to be among the top prescribers of these classes of drugs. However, as detailed in the table on the following page, *Physicians and Physician Assistants Among the Top 300 Prescribers*, those licensees who are unaffiliated with registered PMCs did the most prescribing of these drugs.

Non-PMC prescribers are more likely to prescribe components of the "Houston cocktail."

In fact, when looking at the data for trends in prescribing patterns, non-PMC prescribers are more likely than PMC-affiliated prescribers to prescribe the components of the "Houston cocktail" — a closely monitored mix of drugs designed to mimic the high of heroin. Based on PMP data, 17 prescribers appeared on the list of the 300 top prescribers of these drugs, but only three of them were affiliated with a PMC. These data do not automatically prove

Physicians and Physician Assistants Among the Top 300 Prescribers

Category of Controlled Substance	Number of Physicians and Physician Assistants Out of Top 300	PMC Prescribers	Non-PMC Prescribers
Barbiturates	166 out of 300	0	166
Benzodiazepines	280 out of 300	4	276
Carisoprodal	249 out of 300	41	208
Opioids	287 out of 300	61	226

these physicians and physician assistants are engaging in nontherapeutic prescribing, but the data may indicate that prescribers practicing in PMCs pose a counterintuitively lower level of risk than prescribers not practicing in PMCs, making targeted inspections of PMCs even more important.

Unclear statutory authority limits the board's ability to effectively regulate pain management clinics.

The board has been involved in more than 40 enforcement actions and lawsuits stemming from its inspections of pain management clinics. In 10 of these cases, either an administrative law judge at the State Office of Administrative Hearings (SOAH) or a federal or state district judge has called into question the board's statutory enforcement authority. Without certain tools clarified in statute, the board is limited in its ability to regulate pain management clinics.

- **Enforcement of subpoenas.** The PMC statute authorizes the Medical Board to inspect a PMC, including the clinic's records.⁷ The board needs records to establish the number of patients being seen, which allows for the determination of overall prescribing patterns, and to check for compliance with board rules on patient care. Records review forms the core of the board's inspection process. To get copies of the records for inspection, the board must use its general subpoena authority.⁸ However, the Medical Board's statutory subpoena authority does not provide for a mechanism to enforce its subpoena if a clinic should refuse to comply, which effectively shuts down the board's inspection process. This issue has come up in seven separate federal and state district court cases since 2015. Other licensing boards like the State Board of Dental Examiners and the Texas Department of Licensing and Regulation have the ability to request that the attorney general seek a court order for compliance with a subpoena.⁹
- **Definition of inappropriate prescribing.** The PMC statute prohibits the owner or operator of a PMC from having been the subject of disciplinary action by any licensing entity for conduct that was the result of inappropriate prescribing.¹⁰ However, the statute does not define inappropriate prescribing. Furthermore, the board's general enforcement authority uses the term "nontherapeutic prescribing," which is the more common term in statute.^{11,12} In three cases before SOAH, administrative law judges have ruled that the Medical Board's proof of previous nontherapeutic prescribing did not

PMC prescribers may pose a lower level of risk than non-PMC prescribers.

In 10 cases, judges have questioned the board's statutory enforcement authority regarding pain management clinics.

fall under the pain management statute's prohibition on inappropriate prescribing, drawing a distinction between the two terms. Without clearly defining a term for the act of prescribing to patients drugs that are not medically necessary, the board may not be able to prevent potentially unqualified individuals from owning or controlling a pain management clinic.

- **Inspections of unregistered clinics.** The PMC statute authorizes the Medical Board to inspect pain management clinics to ensure compliance with the pain management statute but does not state whether those pain management clinics must have already registered with the board.¹³ A federal district judge recently ruled that the statute does not authorize the Medical Board to inspect an unregistered clinic.¹⁴ This ruling limits the board's ability to enforce the statute, because only by inspecting a clinic and reviewing its records could the board tell if the pain management clinic is required to register and, if so, is complying with the law.

Recommendations

Change in Statute

1.1 Authorize the Medical Board to seek court enforcement of its administrative subpoenas.

This recommendation would authorize the Medical Board to seek, through the attorney general, a court order for compliance with its subpoena upon a showing that good cause exists to issue the subpoena. By ensuring eventual compliance with the Medical Board's subpoena for critical patient records, which will remain confidential, the board will better be able to regulate pain management clinics.

1.2 Amend the pain management clinic statute to clarify the definition of "inappropriate prescribing."

The ambiguity of the term "inappropriate prescribing" in the pain management clinic statute as it relates to the more commonly used term "nontherapeutic prescribing" creates confusion over whether these are separate offenses. This recommendation would clarify the pain management clinic statute's definition of the term "inappropriate prescribing" to include the offense of "nontherapeutic prescribing." Under this recommendation, the Medical Board would be authorized to adopt rules that specify the type of conduct that would constitute inappropriate prescribing. This clarity would allow the board to enforce the statutory prohibition on allowing an owner or operator to register a pain management clinic if they have been subject to disciplinary action for inappropriate prescribing.

1.3 Clarify statute to authorize the Medical Board to inspect an unregistered pain management clinic.

This recommendation would clarify the Medical Board's authority to inspect an unregistered PMC to ensure compliance with the pain management statute's registration requirement. By clearly authorizing the inspection of unregistered pain management clinics, the board would be able to verify that all PMCs required to register have done so, rather than having to rely on voluntary compliance.

This recommendation would not make all facilities in which physicians and physician assistants practice subject to inspection. Rather, the recommendation would apply to facilities holding themselves out as pain management clinics, regardless of whether they are registered, and to facilities that the Medical Board has reason to believe are operating as pain management clinics — even if they present themselves as a wellness, family, or other type of clinic — based on their level of prescribing activity as indicated by the PMP. As part of this recommendation, the board would be required to adopt rules clearly establishing the grounds for inspecting a clinic that potentially should be registered with the board.

Management Action

1.4 Direct the Medical Board to use Prescription Monitoring Program data, along with other factors, to establish a risk-based approach to scheduling pain management clinic inspections.

This recommendation would direct the Medical Board to establish a risk-based approach to pain management clinic inspections. The board should consider factors like the clinic's prior inspection history, current PMP report, length of time since the clinic's last inspection, and any other factors the board considers relevant. By targeting inspections to PMCs that pose the greatest risk, the board can focus its limited resources on clinics most likely engaged in nontherapeutic or inappropriate prescribing and free up investigative resources from redundant inspections of low-risk clinics.

Fiscal Implication

This recommendation should have no fiscal impact to the state. Better targeting pain management clinic inspections would reduce some of the workload for Medical Board investigators, allowing them to redirect their time to complaint investigations and office-based anesthesia inspections. While better use of the Prescription Monitoring Program may enable the Medical Board to identify additional improper prescribing of controlled substances, the board should be able to handle these cases with existing board resources. Finally, clarifying the Medical Board's statutory authority regarding pain management clinics may result in fewer contested cases which would reduce board staff workload, but staff could redirect their time to other areas of the board's enforcement process.

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¹ Based on Texas Department of Public Safety data.

² All citations to Texas statutes are as they appear on <http://www.statutes.legis.texas.gov/>. Sections 168.001(1), 168.002(7), and 168.002(8), Texas Government Code.

³ Sections 168.102(a), 168.201(a), 168.201(b), and 168.201(c), Texas Government Code.

⁴ 22 T.A.C. Sections 195.4(f)(A) and 170.3(5)(v).

⁵ Section 168.052, Texas Occupations Code.

⁶ Section 168.001(1), Texas Occupations Code.

⁷ Section 168.052, Texas Occupations Code.

⁸ Section 153.007, Texas Occupations Code.

⁹ Section 263.008 and Section 51.3512, Texas Occupations Code.

¹⁰ Section 168.201(a)(3), Texas Occupations Code.

¹¹ Section 164.053(a)(5), Texas Occupations Code.

¹² Section 483.003(a), Texas Health and Safety Code; Section 107.052, Texas Occupations Code; and Section 204.304, Texas Occupations Code.

¹³ Section 168.052, Texas Occupations Code.

¹⁴ *Joseph A. Zadeh, DO and Patient Jane Doe, Plaintiffs v. Mari Robinson (in her individual capacity and in her official capacity), Sharon Pease (in her individual capacity) and Kara Kirby (in her individual capacity), Defendants; Cause No. 1:15-cv-00598-RP* (United States District Court for the Western District of Texas).

ISSUE 2

Key Elements of the Texas Medical Board's Licensing and Regulatory Functions Do Not Conform to Common Licensing Standards.

Background

The Texas Medical Board licenses and regulates medical practitioners in the state to ensure that Texans receive safe and quality medical care. To achieve its mission, the board licenses physicians and oversees the regulatory programs for physician assistants, acupuncturists, surgical assistants, medical physicists, medical radiologic technologists, perfusionists, and respiratory care practitioners. The Medical Board seeks to protect the public by ensuring that their licensees are qualified, competent, and adhere to established professional standards. The Medical Board provides staff and assistance to the other regulatory boards and committees that oversee the various licensee populations and, in fiscal year 2016, oversaw a total of almost 132,000 licensees. In addition, the Medical Board adopts rules for all the other boards and committees and takes enforcement action for the committees.

The Sunset Advisory Commission has a long history evaluating licensing agencies, as the increase of occupational licensing programs served as an impetus behind the creation of the Commission in 1977. Since then, the Sunset Commission has completed more than 100 licensing agency reviews. Sunset staff has documented standards in reviewing licensing programs to guide future reviews of licensing agencies. While these standards provide a guide for evaluating a licensing program's structure, they are not intended for blanket application. The following material highlights areas where the statutes and rules under the Medical Board's jurisdiction differ from these model standards and describes the potential benefits of conforming to standard practices.

Findings

Statutory licensing provisions and board procedures do not follow model licensing practices, presenting unnecessary hurdles to applicants and reducing the efficiency of Medical Board operations.

- **Subjective qualification for licensure.** Qualifications for licensure should not overburden applicants or unreasonably restrict entry into practice. Currently, statute requires surgical assistant, medical physicist, and physician assistant applicants for licensure to be of "good moral character." Good moral character is a subjective, vague requirement that may be determined inconsistently. In reviewing applications, the Medical Board relies on several provisions in statute and rule, which set out guidelines for denying a license based on criminal history.¹ Removing the statutory requirement that applicants be of good moral character would be in line with the board's current practice of reviewing an applicant's criminal history and denying licenses based on criminal history that is related to the profession.
- **Unnecessary and cumbersome application requirements.** Application forms should be simple, straightforward, and only require information

Good moral character is a subjective, vague requirement that may be determined inconsistently.

Changing to biennial renewal for physician assistants and acupuncturists would ease administrative tasks for board staff.

necessary for the agency to determine the applicant's eligibility for a license. Statute requires that perfusionist applications for licensure be sworn to, an unnecessary requirement on the applicant that adds no value to the process.² State law already prohibits a person from knowingly making a false entry in a government record.³ Further, the Medical Board does not have this requirement for any of its other applicant types and, in practice, does not actually require the affidavit of perfusionists. Removing the requirement that applicants for perfusionist licensure provide a sworn affidavit with their application would be in line with the Medical Board's current practice without reducing the board's ability to determine an applicant's eligibility for licensure.

- **Burdensome license renewal process.** A regulatory agency should have a renewal process that helps ensure adequate oversight of regulated persons or activities. Statute requires physician assistants and acupuncturists to renew their licenses annually, which needlessly adds to the Medical Board's administrative burden, as the board already uses a two-year timeframe for all other licensees. Changing the physician assistant and acupuncturist renewal period to every two years would ease the administrative tasks of Medical Board staff, and allow the board to synchronize license renewal requirements without compromising oversight of the licensees.
- **Restrictive fee authority.** The Legislature has established a practice in many licensing programs of eliminating capped fee amounts in statute and allowing agencies to set fees by rule. This practice allows for greater administrative flexibility and is consistent with a provision in the General Appropriations

Licensing and Administrative Fee Caps – FY 2016

Fee Type	Statutory Cap	Current Fee
Medical License	\$900	\$817
Initial Registration Permit	\$400	\$370
Renewal Registration Permit	\$400	\$370
Temporary Physician License	\$200	\$107
Initial Physician-in-Training Permit	\$200	\$212
Outpatient Anesthesia Registration	\$600	\$210
Endorsement to Other State Medical Boards	\$200	No Fee in Rule
Duplicate License	\$200	No Fee in Rule
Reinstated License After Cancellation for Cause	\$700	\$817 ⁶
Annual Participation Fee for Texas Physician Health Program	\$1,200	\$1,200

Act that requires agencies to set fee amounts necessary to recover the cost of regulation.⁴ Limiting agency expenditures through the appropriations process discourages agencies from setting fees too high. The public has the opportunity to comment on proposed fees since the agency sets them in rule. Contrary to this approach, many of the Medical Board's licensing and administrative fees are capped by statute, limiting the board's flexibility to set fees as needs change.⁵ In fact, two of the board's fees exceed the statutory cap. The table, *Licensing and Administrative Fee Caps*, lists fees that the Medical Board charges and their statutory caps.

- **No statutory authority to deny renewal applications for noncompliant licensees.** The authority to deny license renewals based on the applicant's failure to comply with previous board orders bolsters agencies' enforcement efforts and ensures that disciplined licensees have fulfilled their responsibilities

regarding safe practices. Without the authority to deny renewals for noncompliance, the board must instead open another enforcement case. Having to pursue a new case in these instances requires additional resources and time, allowing noncompliant licensees to continue to work and possibly putting the public at risk.

- **Unnecessary limitations on jurisprudence exam.** Licensing agencies should require applicants to complete a jurisprudence exam to ensure their knowledge of the profession's scope of practice and board rules and laws within the state. Many licensing agencies grant applicants unlimited attempts to take and pass the exam, as the point of a jurisprudence exam is not to limit entrance into the profession, but for practitioners to demonstrate a working understanding of law and rule. Currently, statute allows physician licensure applicants to take the jurisprudence exam just three times and the board, by rule, has extended this requirement to its other licensees.⁷ Even though an applicant would have already completed appropriate training, if an applicant is unable to pass the jurisprudence exam in the three allotted attempts, the applicant would not be eligible for licensure. Limiting the number of times an applicant can take the jurisprudence exam is unnecessarily restrictive.
- **Insufficient authority to conduct fingerprint background checks.** An agency's enabling statute should be consistent with the agency's actual operations. To help protect the public's safety, licensing agencies commonly conduct background checks using the Department of Public Safety's fingerprint system, which accurately identifies the individual, provides automatic updates, and uncovers criminal history on applicants and licensees nationwide. While the board requires fingerprint-based background checks on all applicants for licensure, it lacks explicit statutory authority to do so for surgical assistant, acupuncturist, and physician assistant applicants. Authorizing the Medical Board to perform fingerprint-based background checks for all applicants would ensure consistency between statutory authority and board practices.

The board lacks explicit statutory authority to conduct fingerprint background checks for all licensees.

Nonstandard enforcement practices could reduce the Medical Board's effectiveness in protecting the public.

- **Need to strengthen drug enforcement through inspections.** An agency whose licensees can prescribe controlled substances should have clear authority to monitor licensees for inappropriate prescribing patterns and take action as necessary. A nationwide epidemic of prescription drug abuse, including drug diversion, has raised awareness of medical professionals improperly prescribing controlled substances with serious consequences to patients and the public, including addiction, overdoses, and diversion of drugs for illegal sale on the street. The Medical Board currently responds to drug-related complaints against physicians and physician assistants.

Research has shown proactive monitoring of prescribing patterns has a positive effect on curbing prescription drug abuse and misuse.

Research has shown proactive monitoring of prescribing patterns has a positive effect on curbing prescription drug abuse and misuse.⁸ The board actively monitors licensees' prescribing history through the state's Prescription Monitoring Program by performing quarterly searches of the top 20 opioid prescribers. As of September 1, 2016, improvements in the program should allow the board to review more detailed trend data and dangerous drug combinations, such as prescribing benzodiazepines or carisoprodol along with opioids. Such improvements will strengthen the board's ability to use more targeted searches to investigate and potentially discipline practitioners who improperly prescribe controlled substances. The Medical Board should establish a process to efficiently use this tool to identify practitioners who may be improperly prescribing controlled substances. If a review of the database uncovers a physician or a physician assistant engaging in potentially harmful prescribing patterns, the Medical Board should investigate and take any necessary enforcement action. By actively monitoring the prescribing patterns of its licensees in a targeted approach, the board could further protect the public by helping address the prescription drug abuse epidemic.

The board's current process may result in the same office-based anesthesia equipment and procedures being inspected multiple times.

- **Inefficient inspection procedures.** An agency should have processes in place to evaluate the risk level posed by entities and individuals subject to inspection and target staff time and resources to the highest-risk areas. The Medical Board's current process for inspecting providers of office-based anesthesia is to inspect each registered physician's equipment and procedures at least once every four years. However, because the board has designed its process so that each physician who registers as an office-based anesthesia provider undergoes an inspection, this process may result in the same equipment and procedures being inspected multiple times, as many physicians share the same facility and equipment. While the board acknowledges this potential problem and is working to address it, the current process cannot prevent possible re-inspection of equipment within the four-year period, resulting in equipment and procedures already deemed safe and compliant being inspected again, unnecessarily disrupting the physician's practice and wasting the board's limited time and resources.
- **Difficult complaint filing.** The public, the licensing agency, or a licensee should be able to file a written complaint against a licensee on a simple form provided on the licensing agency's website, through email, or through regular mail. The form should not have to be notarized or sworn to. Statute requires that a formal complaint filed by the Medical Board with the State Office of Administrative Hearings, which is filed by the board's legal staff to initiate an enforcement action after the complaint has been substantiated, must be made by a credible person under oath.⁹ This additional requirement on formal complaints filed by board staff is unnecessary as state law already prohibits a person from knowingly making a false entry in a government record.¹⁰ Removing the affidavit requirement from statute would make filing the complaint easier while maintaining the prohibition on filing a false complaint.

A nonstandard administrative practice reduces the Medical Board's ability to inform the public about the professions the board regulates.

- **Availability of public information.** Regulatory agencies exist to protect the public, and the public should have access to general information about an agency's operation as well as the professions under the agency's jurisdiction. While the Medical Board's website provides easy access to complaint forms and past administrative actions, the website's overall focus is on providing information to licensees and does not include basic information for the public regarding the professions the Medical Board regulates.

Recommendations

Change in Statute

2.1 Remove unnecessary provisions requiring applicants to be of good moral character.

This recommendation would remove the requirement that applicants for surgical assistant, medical physicist, and physician assistant licensure be of "good moral character," a standard that is unclear, subjective, and difficult to enforce. The Medical Board would continue to receive and review criminal history information to determine an applicant's eligibility for licensure according to requirements in Occupations Code Chapter 53 and the Medical Board's current rules.

2.2 Remove affidavit requirement for individuals applying for licensure.

This recommendation would remove the statutory requirement for perfusionist licensure applicants to verify by affidavit the information in the license application. Current provisions of the Penal Code that make falsifying a government record a crime would continue to apply to these applications.

2.3 Authorize the Medical Board to provide biennial license renewal for all license types.

This recommendation would allow the Medical Board to establish biennial renewal for physician assistant and acupuncturist licensees. The Medical Board would determine when to start and how to implement biennial renewals. This recommendation would reduce staff time spent on renewals and allow the Medical Board to streamline licensing and continuing medical education processes, without compromising board oversight of licensees.

2.4 Remove the statutory limitations on the Medical Board's authority to set fees.

This recommendation would eliminate statutory language that sets and caps fees and give the Medical Board greater discretion to set its own fees at the level necessary to recover costs as conditions change. The Medical Board would establish all fees by rule, allowing for public comment on any fee adjustments. The Legislature would maintain control over fees by setting spending levels in the General Appropriations Act.

2.5 Authorize the board to deny renewal applications from noncompliant applicants.

Under this recommendation, the board would have the discretion to determine whether noncompliant applicants can safely perform their job or if their renewal application should be denied. Authority to

deny renewals would help the board better protect consumers from potentially unsafe practitioners and provide greater incentive for licensees to comply with board orders.

2.6 Remove the limitation on the number of times an applicant can take the board's jurisprudence exam.

This recommendation would remove the statutory limitation on the number of times a physician licensure applicant can take the Medical Board's jurisprudence exam, allowing applicants the ability to take the jurisprudence exam until passing, regardless of the number of attempts. The recommendation would also direct the board to repeal rules limiting the number of times other board licensees may take their jurisprudence exams.

2.7 Clarify statute to authorize the board to conduct fingerprint-based criminal background checks of all applicants.

This recommendation would clearly authorize the current practice of requiring all applicants to undergo fingerprint-based background checks. This practice ensures the board can effectively monitor all licensees for criminal conduct and take disciplinary action to protect the public when warranted.

2.8 Clarify statute and provide direction for the Medical Board to monitor physician and physician assistant prescribing of controlled substances.

This recommendation would clarify the Medical Board's authority to proactively monitor the Prescription Monitoring Program for improper prescribing of controlled substances by physicians or physician assistants, and pursue necessary enforcement action. The board would conduct any necessary investigations based on a search of the database, and take any appropriate action. This action could include notifying the practitioner about the potentially dangerous prescribing pattern, when doing so would not compromise an investigation, or pursuing necessary enforcement action.

The Medical Board, in its monitoring efforts, should consider the overall volume or combinations of the four classes of drugs the Legislature recognizes as those most likely to be abused — opioids, benzodiazepines, barbiturates, and carisoprodol — as well as additional controlled substances and dangerous combinations of drugs identified by the board as commonly prescribed by practitioners.¹¹

2.9 Authorize the board to establish a risk-based approach to its office-based anesthesia inspection, focusing on the length of time since equipment and procedures were last inspected.

This recommendation would authorize the board to establish a risk-based approach to the office-based anesthesia inspection process. The board should focus its efforts on the inspection of equipment and office procedures instead of the registered physician to ensure that inspectors do not waste time re-inspecting approved equipment and procedures. The board should consider the length of time since the equipment and facility were last inspected as well as the length of time since the physician submitted to an inspection. This recommendation would require the board to better track the office location of physicians who offer office-based anesthesia and to require physicians to inform the board of any other physicians who might share anesthesia equipment.

2.10 Remove the requirement that the Medical Board’s formal complaints filed with the State Office of Administrative Hearings be sworn to.

This recommendation would remove the statutory requirement that board staff attest to all formal complaints. Existing provisions of law that make falsifying a government record a crime would still apply to filed complaints.¹²

Management Action

2.11 Direct the board to make consumer information available to the public on its website.

This recommendation would ensure that practice information about the various professions under the Medical Board’s jurisdiction is more readily available to help the public make more informed decisions when obtaining services and seeking relief in the event of a complaint.

Fiscal Implication

While several of these recommendations would reduce administrative burdens on Medical Board staff, overall the recommendations would not have a significant fiscal impact to the state.

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¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.texas.gov/>. Chapter 53 and Section 202.253, Texas Occupations Code; 22 T.A.C. Section 371.31.

² Section 603.252(a), Texas Occupations Code.

³ Section 37.10, Texas Penal Code.

⁴ Section 2 (Special Provisions Relating to All Regulatory Agencies), page VIII-67, Article VIII (H.B. 1), Acts of the 84th Legislature, Regular Session, 2015 (the General Appropriations Act).

⁵ Section 153.051(d), Texas Occupations Code.

⁶ While statute caps this fee at \$700 dollars, Section 156.005, Occupations Code, requires the board to set the fee the same as a new license fee, which creates a conflict.

⁷ Section 155.056(a), Texas Occupations Code.

⁸ R. Simeone and L. Holland, “An evaluation of prescription drug monitoring programs,” Simeone Associates, Inc., 2006, Carnevale Associates, 2007.

⁹ Section 164.005(a), Texas Occupations Code.

¹⁰ See *Letter Ruling noting concerns about statutory affidavit requirements, Ruben Aleman, MD vs. Texas Medical Board*, Cause No. D-1-GN-14-003480 (53rd Judicial District Court of Travis County, Texas), on appeal to Court of Appeals for the 3rd Judicial District of Texas.

¹¹ Section 168.001(1), Texas Occupations Code.

¹² Section 37.10, Texas Penal Code.

ISSUE 3

Streamlining the Medical Radiologic Technology Program Would Increase Fairness to Licensees and Administrative Efficiency.

Background

In 2015, the Legislature transferred the regulation of medical radiologic technology — the administration of x-rays and related diagnostic procedures — from the Department of State Health Services (DSHS) to the Texas Medical Board, establishing the Texas Board of Medical Radiologic Technology (MRT board) to serve in an advisory capacity to the Medical Board. The MRT board has the authority to make decisions on licensing and enforcement matters and can make proposals for rule changes, subject to Medical Board approval. The MRT board is made up of nine members appointed by the governor for six-year terms and met for the first time in September 2016.

State law establishes three different types of certification for medical radiologic technology professionals: general medical radiologic technologist (MRT), limited medical radiologic technologist (LMRT), and noncertified technician (NCT).¹ Temporary certificates are also available for MRTs and LMRTs for up to one year. The chart, *Medical Radiologic Technology Practitioners in Texas*, lists the total number of certificate holders at the beginning of fiscal year 2015. The education requirements for an MRT in Texas typically are completed as part of a two-year program at a community college, while LMRT education can typically be completed within a year. More information about education, national certification, and qualifying exam requirements for the three different types of medical radiologic technology certificates are presented in Appendix D.

***Medical Radiologic Technology Practitioners in Texas
FY 2015***

Certificate Type	Number Registered
General Medical Radiologic Technologist	24,347
Temporary Medical Radiologic Technologist	682
Limited Medical Radiologic Technologist	625
Temporary Limited Medical Radiologic Technologist	320
Noncertified Technician	4,035
Total	30,009

Rules allow MRTs to perform all radiologic procedures, including those designated by rule as dangerous or hazardous, explained in the textbox, *Examples of Dangerous and Hazardous Procedures Rules*. LMRTs are restricted to practicing on specific parts of the human body and may only perform some of the dangerous and hazardous procedures if they obtain specific training and certification.

Examples of Dangerous and Hazardous Procedures Rules

Dangerous procedures include nuclear medicine studies and the administration of radiopharmaceuticals.

Hazardous procedures include conventional tomography, operating portable x-ray equipment, pelvic girdle radiographs, and sternum radiographs.

Statute permits a noncertified technician to perform an even more limited set of tasks and prohibits an NCT from performing any procedures defined by rule as dangerous or hazardous.² All NCTs are required to be listed on a registry maintained by the MRT board and administered by Medical Board

staff.³ Because physicians, chiropractors, and podiatrists can all delegate to and supervise NCTs, statute requires NCTs under the supervision of these practitioners to register with their respective regulatory boards — in addition to the main registry now under the authority of the MRT board.

Findings

LMRT certification is unduly complicated and creates administrative inefficiencies.

- **Numerous specialty certifications complicate the distinction between LMRTs and MRTs and make enforcement more difficult.** LMRTs are legally permitted to perform many of the dangerous and hazardous procedures MRTs may perform if they obtain the appropriate training and

LMRT Specialty Counts – FY 2015

Specialty Type	Number of LMRTs certified
Extremities	571
Skull	433
Spine	529
Chest	529
Chiropractic	21
Podiatric	100
Cardiovascular	86
Total	2,269

certificates that correspond to either the procedures or particular areas of the body. An LMRT can obtain up to seven specialty certifications, which is why Texas is home to far more specialty certifications than LMRTs. As shown in the chart *LMRT Specialty Counts*, in fiscal year 2015, the state's 625 LMRTs had 2,269 specialties, an average of more than three specialties per LMRT. This disjointed, piecemeal arrangement where the types of procedures a certificate holder can legally perform vary by individual complicates regulators' ability to detect and take enforcement action on violations.

- **LMRT certification adds a needless administrative burden to an already busy agency.** In addition to complicating enforcement efforts, administering the LMRT certification demands much attention from Medical Board licensing staff. The board gained responsibility for more than 43,000 new licensees in 2015 — three professions in addition to medical radiologic technology — so staff must seek efficiencies in their licensing processes. Although the Medical Board does not administer the LMRT licensing exam or specialty certification exams, requests to take the exams must be routed through the board. Staff must analyze each applicant's eligibility to take specialty exams, send notification letters of exam denial or approval, download exam scores from the exam administrator's website weekly, and notify applicants of passage or failure. Staff processed 436 exam requests and 241 exam score sheets in fiscal year 2015. All this effort by board staff is unnecessary given that physicians, chiropractors, and podiatrists can choose to hire an MRT to perform a full range of radiological services or an NCT if their practice requires more limited services.

The disjointed, piecemeal LMRT regulation complicates the board's ability to detect and take enforcement action on violations.

Dual registration of NCTs is redundant, costly to licensees, and does not increase public safety.

The Sunset Act tasks staff with considering the extent to which an agency's programs overlap or duplicate those of other agencies.⁴ Because practitioners

under various boards can supervise NCTs and these boards each have authority to charge fees for the same function, NCT registration presents such overlap and duplication.⁵ Allowing consumers and employers to verify that a technician is in compliance with the law and has successfully completed training is the purpose of the main NCT registry for which the MRT board is now responsible. The registries maintained by the medical, chiropractic, and podiatry boards, on the other hand, simply identify the licensee who will supervise the NCT. These agencies require applicants to submit much of the same documentation, remain in compliance with the requirements of the main registry, and pay a fee, reflected in the chart, *NCT Fees Paid to Supervising Boards*. These fees are in addition to \$60 an applicant to the NCT registry must pay and \$56 a registrant must pay to renew biennially.

NCT Fees Paid to Supervising Boards – FY 2015

	Medical	Chiropractic	Podiatry
Initial Registration	\$130.50	\$35	\$35
Renewal	\$130.50	\$36	\$35
Number of Active NCTs	1,373	128	4

In addition to the unfairness of charging NCTs two separate fees to perform the same job, requiring registration as a means of connecting supervising practitioners to personnel under their order and supervision offers no additional protection to the public. As such, the ability of the other regulatory agencies to ensure public safety will not be undermined by eliminating their individual registries. These agencies can simply refer any NCT that commits a violation to the MRT board for disciplinary action.

Recommendations

Change in Statute

3.1 Abolish the limited medical radiologic technologist certification.

This recommendation would remove both the limited medical radiologic technologist certificate and the temporary LMRT certificate from statute, simplifying and strengthening regulation of medical radiologic technology in Texas. This recommendation would phase in elimination of the LMRT certificate to allow LMRTs time to qualify for MRT licensure or move to NCT status. Under these guidelines, the Medical Board would determine a date to cease issuing new LMRT licenses and would maintain licensure for existing LMRTs until September 1, 2021.

3.2 Eliminate duplication by removing dual-registry requirements for noncertified technicians.

This recommendation would eliminate the requirement that medical, chiropractic, and podiatry boards register noncertified technicians working under the supervision of their respective licensees. The main NCT registry would continue under authority of the MRT board to ensure these registrants meet requirements to practice.

Fiscal Implication

Eliminating the requirement that the medical, chiropractic, and podiatry boards also register noncertified technicians would result in an annual loss to general revenue of \$183,280 as the Texas Medical Board received \$179,177 in revenue from NCT permit fees in fiscal year 2015, the Board of Chiropractic

Examiners received \$3,963, and the Board of Podiatric Medical Examiners received just \$140. Because LMRTs would be likely to move towards MRT or NCT status, elimination of the LMRT license should not have a fiscal impact.

Texas Medical Board

Fiscal Year	Loss to the General Revenue Fund
2018	\$183,280
2019	\$183,280
2020	\$183,280
2021	\$183,280
2022	\$183,280

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¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.texas.gov/>. Section 601.102(b) and Section 601.152, Texas Occupations Code.

² Section 601.056(a), Texas Occupations Code.

³ Section 601.202, Texas Occupations Code.

⁴ Section 325.011, Texas Government Code.

⁵ Section 601.252(c)(2), Texas Occupations Code.

ISSUE 4

The Current Process for Authorizing Qualified Physicians to Practice in Texas Does Not Maximize Mobility Within the Profession.

Background

Licensure compacts are formal agreements among states with similar standards for a profession to recognize each other's licensees without requiring an application for a separate license in each state. Compacts typically begin as efforts of national organizations preparing the statutory framework that state legislatures may adopt. When a minimum number of states join the compact to make it viable, a compact commission composed of representatives of participating states is formed to adopt and implement rules for administering the compact. The Texas Legislature adopted compacts for nurses in 1999, advanced practice registered nurses in 2006, and emergency medical services personnel in 2015.

The Interstate Medical Licensure Compact became active in May 2015 after meeting the required membership of at least seven states. As of October 2016, 17 states have joined the compact, and two others are actively considering legislation to do so.¹ Like compacts adopted before it, the Interstate Medical Licensure Compact helps expedite and simplify licensing for physicians seeking to practice medicine in multiple states. The compact would also facilitate the exchange of information, including investigative and disciplinary information, among member states. The medical licensure compact's interstate commission will provide oversight and administration of the compact, including creating and enforcing administrative rules and promoting interstate cooperation. Each state participating in the compact will have two representatives to the interstate commission.

Findings

The process for authorizing qualified physicians from other states to practice in Texas is not streamlined.

To satisfy state law, the Texas Medical Board currently places multiple requirements on physicians from other states applying for a Texas medical license. In addition to the items listed in the textbox, *Requirements to Obtain a Medical License in Texas*, applicants must have any state in which they have ever been licensed, regardless of the current status of the license, submit directly to the Medical Board a letter verifying the status of the license and a description of any sanctions or pending disciplinary matters. Medical Board staff verify this information and ensure these practitioners do not have a disciplinary action or criminal history that would disqualify them from practicing in

Requirements to Obtain a Medical License in Texas

- Sworn affidavit verifying no record of disciplinary proceedings exists
- Copy of applicant's fingerprints
- List of all post-graduate training since graduation from medical school
- List of all professional affiliations for the past five years, including training programs; this requires applicants to send the medical board's evaluation form to each facility in which they have practiced
- Board specialty and current position
- List of all periods of unemployment or employment outside the field of medicine

Answering yes to certain questions about professional, criminal, or educational history requires applicants to complete and submit additional forms.

Texas. National education standards and nationally recognized examinations help this process work more smoothly, and almost 14,000 of the roughly 73,000 physicians with a Texas medical license as of fiscal year 2015 had acquired that license through reciprocity. However, the Medical Board's current reciprocity process can take more than a month and is cumbersome, requiring applicants and Medical Board staff to make considerable efforts to satisfy licensure requirements, and this process can delay the ability of physicians to fill immediate health care needs in Texas.

Increasing the ease with which physicians can practice in Texas could improve access to health care.

Many parts of Texas experience physician shortages. The U.S. Census Bureau of Primary Health Care has reported that Texas has one of the highest numbers of physician shortage areas in the country.² The addition of millions of new patients to the healthcare system that resulted from passage of the Affordable Care Act is likely to continue to compound the need for increased access to health care.³ In fact, projected growth and aging of the U.S. and Texas population suggest the demand for physician services will grow substantially faster than supply.⁴ Given the critical shortage of healthcare practitioners, particularly in rural and underserved areas, the state has a strong incentive to encourage additional physicians to practice in Texas. Increasing the administrative ease with which a physician can be authorized to practice in Texas could improve access to care in the state's critically underserved areas while also relieving the Medical Board's increasing administrative workload.

An interstate licensure compact would streamline the licensure of physicians wishing to practice in multiple states.

Even for already licensed physicians, applying for a license in an additional state is complicated, time consuming, and costly. The complexity of the process often warrants physicians hiring third party companies to assist in completing medical licensure applications. Adopting the Interstate Medical Licensure Compact would allow physicians licensed in a member state to acquire a license from other member states more quickly and simply than having to obtain multiple licenses through the standard process. The compact does not affect the scope of practice of participating states. Physicians practicing through compact licenses would be governed by the laws and regulations of the state in which they are practicing and subject to that state's disciplinary processes. In addition, the compact enhances the ability of states to share investigative and disciplinary information, strengthening public protection.

The compact does not affect the scope of practice of participating states.

To participate in the compact, a physician would designate a member state as the "state of principal license" and select the other member states in which the physician wishes to obtain an expedited medical license to practice. Facilitated by the interstate commission, the physician would apply for an expedited license through the medical board of the physician's state of principal license, which would charge the physician a fee to verify eligibility to the interstate commission. The interstate commission then transmits the physician's information and fees to the additional states. Once the additional states receive this information and the applicant's licensure fees, the physician would be granted a license

in these states. The average number of days for the Texas Medical Board to issue a medical license to an out-of-state applicant in fiscal year 2016 was 42 days, but participation in the compact would allow the board to issue licenses to such applicants within a few days upon receipt of their eligibility and fees from the interstate commission.

While physicians continue to pay licensure and renewal fees to the medical board of their state of principal license, all other renewal fees go to the medical board of the other state or states in which the physician has a license. The Texas Medical Board, like all state medical boards participating in the compact, would retain all fees it currently collects and would have the authority to charge and collect fees for any activity associated with implementing the compact. The interstate commission would have authority to charge fees to physicians participating in the compact, but the interstate commission has used federal grant money to design and establish the compact and does not anticipate charging fees.

As shown in the textbox, *Eligibility Requirements for the Interstate Medical Licensure Compact*, any physician that wants a license through the compact would have to meet eligibility requirements, such as having a full and unrestricted medical license, a record free of any disciplinary action, and passage of nationally accepted exams. While one of the prerequisites for participation in the compact is also possession of a board specialty certification, the compact does not prescribe how a physician must acquire or keep a board specialty certification current, which means time unlimited specialty certifications, maintenance of certification, and any of the other less expensive methods for maintaining specialty certification would be acceptable. The Texas Medical Board estimates that roughly 70 percent of physicians licensed in Texas would qualify to participate in the compact.

Eligibility Requirements for the Interstate Medical Licensure Compact

- Possess a full and unrestricted license to practice medicine in a member state
- Possess board specialty certification
- Have no disciplinary action on any state medical license
- Not be under investigation by any licensing or law enforcement agency
- Have passed the nationally accepted exams (or an equivalent) for allopathic or osteopathic medicine within three attempts
- Have successfully completed an accredited graduate medical education program or an equivalent

Like any other state, for Texas to participate in the medical licensure compact, the Legislature will need to pass legislation that adopts the compact into state law. The medical licensure compact would not supersede the Texas Medical Practice Act or any other state law, nor would the interstate commission's authority supersede that of the Texas Legislature or any other state legislature. Rather, the role of the interstate commission is to determine and maintain the compact's administrative processes, rules, and information technology.

Recommendation

Change in Statute

4.1 Adopt the Interstate Medical Licensure Compact.

This recommendation would add the Interstate Medical Licensure Compact language to Texas statute. As a tool to simplify the administrative processes related to out-of-state licenses, the compact would not affect the scope of practice for Texas physicians. The Legislature would retain full authority over the Medical Board and the practice of medicine in the state through the Texas Medical Practice Act and other applicable state laws.

Adopting the compact would allow qualified physicians from other member states to obtain a Texas license without having to go through the Medical Board's standard administrative licensing process. Physicians licensed in Texas who establish Texas as their state of principal license may apply for a license elsewhere through the compact. The following compact provisions would be added to statute:

- Require all physicians practicing in Texas to comply with the Texas Medical Practice Act and Texas Medical Board rules.
- Authorize the Medical Board to take disciplinary actions against an out-of-state physician, including revoking the physician's Texas license, for violating Texas statutes or Medical Board rules. Suspensions or revocations of the license issued by the physician's state of principal license would be the responsibility of that state.
- Require the Medical Board to participate in a coordinated database and reporting system that includes licensure, adverse actions, and investigative information on each licensee in compact states. As a condition of joining the compact, every state must require its licensees to undergo fingerprint or other biometric background checks, which is already required in Texas.
- Provide for either two members of the Medical Board or one board member and the board's executive director to serve as voting representatives to the interstate commission.
- Authorize the Medical Board to develop rules as necessary to implement the compact.

Fiscal Implication

Adopting the Interstate Medical Licensure Compact would have a positive fiscal impact. The Medical Board would be able to charge fees to cover all costs of processing Texas physicians' applications for other state medical licenses through the compact, as well as all costs of issuing Texas medical licenses to out-of-state applicants applying through the compact. In addition, the Federation of State Medical Boards estimates that 80 percent of physicians across the country would be eligible to participate in the compact, which means that many of the nearly 4,000 out-of-state applicants for Texas medical licensure that the Medical Board receives annually would be able to apply for a Texas license through the compact. As such, the Medical Board's workload with respect to out-of-state applications is likely to decrease by reducing much of the staff's processing and vetting activity. The exact amount of savings cannot be quantified until more is known about the number of states joining the compact.

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¹ As of October 2016, Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, West Virginia, Wisconsin, and Wyoming have enacted the Interstate Medical Licensure Compact. Michigan and Pennsylvania both are considering legislation to enact the compact.

² Statewide Health Coordinating Council, *Texas State Health Plan, 2011–2016: A Roadmap to a Healthy Texas* (Austin: Statewide Health Coordinating Council, 2010), 116.

³ Ibid.

⁴ Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections Through 2025* (Washington, D.C.: Association of American Medical Colleges, 2008), 6.

ISSUE 5

An Undefined Structure and Few Funding Sources Limit the Texas Physician Health Program's Success.

Background

Established in 2009, the Texas Physician Health Program (program) is administratively attached to the Texas Medical Board and serves physicians and other board licensees that have physical or mental health conditions, including substance use disorder, through a monitored recovery program. The president of the Medical Board appoints the 11-member governing board that oversees a staff of 8.5 employees, including a medical director and part-time general counsel. The program had 381 participants at the end of September 2016, about 75 percent of whom were physicians. See the table, *Texas Physician Health Program Participants*, for more detail. In fiscal year 2015, the program received 313 referrals. About 30 percent of participants referred themselves to the program, and the Medical Board referred the rest. Most Medical Board referrals are confidential and do not involve violations of laws or rules, but in fiscal year 2015, the board made eight public referrals as part of disciplinary action against the licensee. The board also made another 10 private disciplinary referrals for violations that did not involve standard of care or doctor-patient boundaries, or a felony.

***Texas Physician Health Program
Participants – September 2016***

Physician	285
Physician-in-Training (Resident)	48
Physician Assistant	30
Medical Radiologic Technologist	9
Medical Student	3
Respiratory Care Practitioner	3
Acupuncturist	1
Surgical Assistant	1
Noncertified Radiologic Technician	1
<i>Total</i>	<i>381</i>

Participants sign an agreement that establishes a plan for treatment that may consist of clinical care, drug testing, participation in self-help groups like Alcoholics Anonymous, worksite monitors, and worksite restrictions. If program staff and the governing board find that participants are in substantial noncompliance with their agreements, they are referred to the Medical Board for possible enforcement action. Examples of substantial noncompliance include relapse documented by positive drug screens and repeated failure to submit required reports from treating providers. The Medical Board also receives notice of every positive drug screen and consults with the program on the participant's situation, though the board does not have access to the participants' names.

The program's funding is a line item in the Medical Board's budget, and the program was appropriated \$561,420 in fiscal year 2015. Statute directs the program to cover its costs through participant fees to the extent reasonably possible.¹ The program charges participants \$1,200 — the maximum allowed by statute — and received \$422,600 in participant fees in fiscal year 2015. Since the Medical Board brings in far more fee revenue than required for operations, the board made up the program's shortfall.

The program does not have performance measures set by the Legislative Budget Board but does track the length of time to process referrals, participant statistics, and participant outcomes. While the program has been included in the Medical Board's internal audit risk assessment, it has not been the subject of an audit.

Findings

The unclear relationship between the Texas Physician Health Program and the Texas Medical Board contributes to organizational instability.

While statute specifies that the program is administratively attached to the board, details of that relationship are not established in statute or rules.² A 2010 memorandum of understanding between the program and the Medical Board addresses only the confidentiality of board records the program receives. While the program's policies and procedures manual states that the Medical Board is responsible for providing human resources, accounting, purchasing, timekeeping, records management, and information technology services, the manual was not jointly written by the board and program, and the extent to which the board is actually providing those services is unclear. The program particularly struggles with human resources and has had three medical directors in just seven years, numerous employee grievances, and a complaint filed against it with the U.S. Department of Labor. For a recent employee grievance, the program's governing board had to rely on counsel from the Office of the Attorney General because the Medical Board would not provide assistance, and the program's general counsel had already advised the medical director and therefore could not also advise the governing board without a conflict of interest.

The program struggles with human resources and has had three medical directors in seven years.

The Texas Physician Health Program's insufficient funding limits the program's reach.

The program has failed to generate sufficient revenue to cover its costs by more than \$100,000 for each of the last three fiscal years, almost half of its existence. While the Medical Board has easily made up the program's shortfall with its excess revenue, the Medical Board has kept one staff position at the program frozen, limiting the number of participants that the program can serve. While estimates of how many physicians have potentially impairing conditions range from 12 to 15 percent, the program is currently serving just 0.4 percent of Texas physicians.³ Clearly not all physicians who may need program services will seek them, and some physicians receive monitoring services from county medical societies, but the program's reach is still quite limited. Given the current physician shortage in Texas, helping physicians return safely to practice is of great importance to the state.

The program has failed to generate sufficient revenue to cover its costs for each of the last three fiscal years.

Many other states' physician health programs have contractual relationships with state medical boards and more funding options than the Texas Physician Health Program.

Texas is one of 47 states with a physician health program. Many of these programs are nonprofit organizations that have contractual relationships with their states' medical boards, and the contracts include requirements to meet certain performance measures and to conduct regular compliance audits. These contracts, performance measures, and audit requirements help ensure programs

meet their obligations to assist participants with their recovery while at the same time ensuring public protection by taking swift action if participants relapse and cannot practice safely. In addition, many state physician health programs receive a portion of license renewal fees in addition to donations from malpractice insurance companies, hospitals, healthcare systems, and medical societies to augment their funding. While statute authorizes the Texas Medical Board to accept gifts, grants, and donations, the program does not have that authority in its statute.⁴

Recommendations

Change in Statute

5.1 Require the Texas Medical Board and Texas Physician Health Program to develop a memorandum of understanding covering services and operations, including performance measures and auditing requirements.

This recommendation would require the Medical Board and the program to establish a memorandum of understanding (MOU) in rules to include performance measures, such as the number of participants that successfully complete the program and the number that relapse, and a clear list of services the board will provide for the program. The MOU should also provide for an internal audit at least once every three years to ensure the program is properly documenting and referring all noncompliance to the board. The board and the program should adopt the MOU in rules by January 1, 2018. Because the program is already administratively attached to the Medical Board, an MOU works better to formalize the arrangement than would a contract. Clearly establishing the relationship between the program and board would help ensure consistency even as staff at each entity change over time. While the program's affiliation with the Medical Board may always dissuade some licensees from seeking services, clarifying the relationship in an MOU in rules would provide additional transparency.

5.2 Authorize the Texas Physician Health Program to accept gifts, grants, and donations.

By authorizing the program to accept gifts, grants, and donations, this recommendation would increase the likelihood that malpractice insurance companies, hospitals, and other entities may donate to the program. Further, the program could seek grants from sources such as the federal government and private foundations. In addition, Recommendation 2.4 in this report, which eliminates fee caps, would allow the program to potentially charge participants more than the current \$1,200 fee to generate additional revenue if necessary for operations. While charging licensees such as noncertified radiologic technicians such a large fee may not be feasible, physicians may more easily absorb higher fees.

Fiscal Implication

Clearly authorizing the program to accept gifts, grants, and donations should encourage more financial contributions to the program, but the amounts could not be estimated.

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¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.texas.gov/>. Section 167.011(b), Texas Occupations Code.

² Section 167.005(c), Texas Occupations Code.

³ Robert DuPont, A. Thomas McLellan, Gary Carr et al., "How are addicted physicians treated? A national survey of Physician Health Programs," *Journal of Substance Abuse Treatment* 37 (2009): 1.

⁴ Section 162.162, Texas Occupations Code.

ISSUE 6

The State Has a Continuing Need to Regulate the Practice of Medicine and the Other Allied Health Professions at the Texas Medical Board.

Background

Texas began regulating the practice of medicine — the profession of preventing, diagnosing, and treating disease — in 1837 when the Lone Star State was a republic. After several iterations of a regulatory structure throughout the 19th and 20th centuries, the Legislature renamed this body the Texas Medical Board in 2005. Today, the Medical Board's mission is to protect and enhance the public's health, safety, and welfare by ensuring quality health care for the citizens of Texas through licensure, enforcement, and education.

The Texas Medical Board is comprised of 19 governor-appointed members: twelve physician members — nine of whom are doctors of medicine and three of whom are doctors of osteopathic medicine — and seven members who represent the public. In addition to licensing and regulating physicians, the Legislature, since the 1990s, has added seven other health professions to the Medical Board's oversight and administration. Housed under the Texas Medical Board are four other boards and three advisory committees, with the Medical Board exercising policymaking for the agency and oversight over the rulemaking of the associated advisory boards and committees. The advisory boards assist Medical Board staff by reviewing license applications and taking enforcement actions against their licensees, but the advisory committees do not have oversight of license applications or enforcement actions for their licensees. As of fiscal year 2016, the Medical Board is home to roughly 132,000 licenses, of which about 78,600 are physicians. The textbox, *Texas Medical Board Professions*, lists the total number of licensees for each of the eight programs under the board's jurisdiction.

Texas Medical Board Professions – FY 2016

Profession	Number of Licensees	Structure
Physicians	78,575	Rulemaking Board
Physician Assistants	8,058	Advisory Board
Acupuncturists	1,241	Advisory Board
Surgical Assistants	452	Advisory Committee
Medical Physicists	671	Advisory Committee
Medical Radiologic Technologists	26,868	Advisory Board
Perfusionists	397	Advisory Committee
Respiratory Care Practitioners	15,540	Advisory Board
Total	131,802	

Findings

The state has a continuing need to regulate the practice of medicine and the allied health professions housed at the Medical Board.

A primary role of the state is to protect the public from harm. For certain professions, the state seeks to provide this protection through regulation designed to ensure qualified practice and effective enforcement when practice standards are not met.

No other healthcare practitioner has greater autonomy or authority over patient care than a physician.

- **Potential for harm.** No other healthcare practitioner has greater autonomy or authority over patient care than a physician. Consequently, no other healthcare discipline poses a greater risk to patient and public safety than the practice of medicine. Improper practice of medicine can result in a range of harm to patients, including extreme pain, disfigurement, disability, and even death. In particular, physicians have unparalleled authority to prescribe highly addictive and dangerous drugs, some of which have contributed to an epidemic of addiction and overdose throughout the country. Likewise, as allied health professions that serve under the order and supervision of physicians have developed and grown, the state has seen the need to ensure they practice safely as well.
- **Qualified practice.** State regulation seeks to mitigate risk to the public by ensuring physicians and the allied health practitioners operating under their supervision are qualified to provide care and by taking enforcement action to ensure compliance with requirements for safe practice. Requiring practitioners to meet education, training, and other qualifications and to demonstrate competence by passing examinations are important ways for the state to assure the public that licensed practitioners can safely practice. Regulation also promotes established standards of care and compliance with laws and rules by providing a mechanism to investigate and, as necessary, discipline and even remove from practice licensees who fail to meet them.

An analysis of the Medical Board's comprehensive data suggests the board is successfully fulfilling its mission.

The central role physicians serve in healthcare delivery contributes to a heightened scrutiny by the Legislature as well as by the media, patients' rights advocates, and others of the actions of the Texas Medical Board. Legislative interest in the Medical Board also likely stems from the board's past struggles with major performance deficiencies. Sunset staff found that the Medical Board struggled significantly in absorbing four additional licensing programs that transferred to the agency in 2015 from the Department of State Health Services. However, while the quality of customer service and the length of time for license issuance and renewal suffered considerably in the first several months of the transition, the board still managed to meet its performance target and statutory requirement for the timeliness of physician license issuance by the conclusion of the fiscal year. The board also reports that pre-transition customer service level has largely resumed. Sunset staff also examined the Medical Board's complaint and disciplinary data covering fiscal years 2009 to 2015. Fluctuations appeared to occur among the types violations that received disciplinary actions, but the Medical Board provided a consistent level of enforcement over those years.

The Medical Board provided a consistent level of enforcement over the past seven years.

In addition, after observing multiple disciplinary proceedings and board and committee meetings, and conducting more detailed analysis of various Medical Board datasets, Sunset staff did not detect any obvious indications of bias in favor or against any type of practitioner. In response to media coverage of

physicians retaining their licenses even after committing sexual boundary violations, Sunset staff analyzed each of the files for three fiscal years of cases in which the Medical Board took disciplinary action against a physician for committing a sexual boundary violation. Staff found few cases resulting in physicians losing their licenses. However, Sunset staff also determined that the Medical Board issued disciplinary actions that rarely strayed from the board's penalty guidelines. Because many of the cases involved less egregious offenses, such as inappropriate communication with patients, the violations appeared to warrant punishment but not license revocation. Sunset staff also noted that cases involving more serious allegations, such as sexual assault, often did not result in a criminal conviction, which likely undermined the Medical Board's ability to revoke the physician's license.

No substantial benefits would result from transferring the Medical Board's functions to another agency at this time, as regulatory consolidation has already occurred under the Medical Board.

For well over a century, the state has regulated the practice of medicine through an independent regulatory agency. This structure reflects the common approach for Texas health licensing agencies responsible for overseeing complex medical activities that pose a significant and direct risk to public health and safety, such as the dental, pharmacy, and nursing boards. This independent structure is intended to provide an agency's focused attention on the practice it regulates. Overseen by a board composed of physicians and public members, the Medical Board receives technical expertise from practitioners in developing rules and regulations reflecting the complex needs of medicine and enforcing requirements on those who violate equally complex practice standards.

With the establishment of seven other licensing programs at the Medical Board, including the 2015 transfer of four programs, the board has become an umbrella licensing agency by default. While the Medical Board does not fit the traditional umbrella model because it regulates medical providers under a physician-oriented board instead of a structure that accounts for broader regulatory authority, consolidation of health profession regulation has already occurred under the Medical Board, which uses the same functionally aligned staff approach to administering its eight regulatory programs that is common to more typical umbrella agencies. Given the complex medical activities overseen by the Medical Board and its responsibility for eight programs and nearly 132,000 licensees, no significant benefit would result from transferring the board's functions to another agency.

While unusually large, the appointed Medical Board functions well and makes strategic use of its membership.

With 19 members, the Medical Board is larger than the other health occupational licensing boards. To take advantage of its large size, the Medical Board assigns its members to serve on six standing committees, including the licensure

The Medical Board rarely strayed from its penalty guidelines for cases involving sexual boundary violations.

The Medical Board has become an umbrella licensing agency by default.

The board must approve all rule proposals for each of the eight professions it now regulates.

committee and disciplinary process review committee. The workload for Medical Board members is substantial and increased in late 2015 when the Legislature transferred to the board four new programs with more than 43,000 licensees. In fiscal year 2015, even before the four new programs transferred, the Medical Board issued more than 5,000 new licenses and renewed more than 48,000 licenses. Many of these licensees require extra scrutiny from members of the licensure committee at each of the Medical Board's five annual meetings to ensure they are qualified to practice in Texas. Also in fiscal year 2015, the board took nearly 150 enforcement actions for violations relating to quality of care alone. One board member must sit on each informal settlement conference panel that may result in enforcement action, and the board held 610 of these conferences in fiscal year 2015. Each member of the disciplinary process review committee analyzes from 25 to 45 cases before each of the Medical Board's annual meetings to ensure the case was handled appropriately. In addition to this substantial enforcement activity for physicians, the board must also approve all rule proposals for each of the eight professions it now regulates.

Most states regulate the practice of medicine either through an independent board or through a semi-autonomous board housed within an umbrella agency.

All states license physicians, with 23 states, including Texas, regulating the practice of medicine through an independent agency and 28 states doing so through a board within an umbrella health agency or umbrella regulatory agency. For most of the states where regulation of medicine occurs through a board within an umbrella health or regulatory agency, the boards in these arrangements have authority over licensing and enforcement actions as well as rulemaking. All 23 states with standalone medical boards use the medical board to regulate other allied health professionals, such as physician assistants, as well.

Statutes of the medical, physician assistant, acupuncture, respiratory care, and medical radiologic technology boards do not reflect standard language typically applied across the board during Sunset reviews.

The Sunset Commission has developed a set of standard recommendations that it applies to all state agencies reviewed unless an overwhelming reason exists not to do so. These across-the-board recommendations (ATBs) reflect an effort by the Legislature to place policy directives on agencies to prevent problems from occurring, instead of reacting to problems after the fact. ATBs are statutory administrative policies adopted by the Sunset Commission that contain "good government" standards for state agencies. The ATBs reflect review criteria contained in the Sunset Act designed to ensure open, responsive, and effective government.

Statutes for the medical, physician assistant, acupuncture, respiratory care, and medical radiologic technology boards contain standard language requiring board members to receive training and information necessary for them to properly

discharge their duties. However, statute does not require Medical Board staff to create a training manual for all board members or specify that the training must include a discussion of the scope of, and limitations on, the boards' rulemaking authority. In addition, the Medical Board lacks clear authority for the use of alternative procedures for rulemaking for the respiratory care and medical radiologic technology programs. Clarifying this authority would ensure the Medical Board develops and applies a written, comprehensive plan that encourages procedures for negotiated rulemaking for these two licensing programs.

The board's three reporting requirements serve a useful purpose and should be continued.

The Sunset Act establishes a process for the Sunset Commission to consider if reporting requirements of agencies under review need to be continued or abolished. The Sunset Commission has interpreted these provisions to apply to reports that are specific to the agency and not general reporting requirements that extend well beyond the scope of the agency under review. Reporting requirements with deadlines or that have expiration dates are not included, nor are routine notifications or notices, or posting requirements. The Medical Board has three reporting requirements — one is an overview of physician licensing, another covers all investigations pending after one year, and the third contains aggregate data on all complaints received as well as complaint data sorted by type. Appendix E provides more information on these reports, all of which Sunset staff determined still serve a useful purpose to increase the transparency of the board's operations.

Recommendations

Change in Statute

6.1 Continue the Texas Medical Board for 12 years.

This recommendation would continue the Medical Board and its various components until 2029. As part of this recommendation, the Medical Board's three reporting requirements would also continue as they serve a useful purpose to promote transparency into the board's operations.

6.2 Apply the standard Sunset across-the-board recommendations to the medical, physician assistant, acupuncture, respiratory care, and medical radiologic technology boards.

This recommendation would require Medical Board staff to create a training manual for all board members that must include a discussion of the scope of, and limitations on, the boards' rulemaking authority. This recommendation would also expand the Medical Board's statutory requirement to develop a policy to encourage the use of negotiated rulemaking procedures for the adoption of their rules to all licensing programs under the Medical Board's jurisdiction with the authority to propose rules, including those for respiratory care and medical radiologic technology. Just as it does for members of the Medical Board, Medical Board staff would be required to coordinate the implementation of this policy and provide training to advisory board members to implement the procedures for negotiated rulemaking.

Fiscal Implication

Based on fiscal year 2016 appropriations and employee benefits expenditures, continuing the Texas Medical Board would continue to require approximately \$17.4 million in annual costs. These costs are entirely paid for by the licensing fees the agency collects. The state would also continue to receive approximately \$12.5 million collected annually by the Medical Board in excess of the board's costs. The recommendation regarding alternative dispute resolution can be accomplished with existing resources and does not require the hiring of additional staff.

APPENDICES

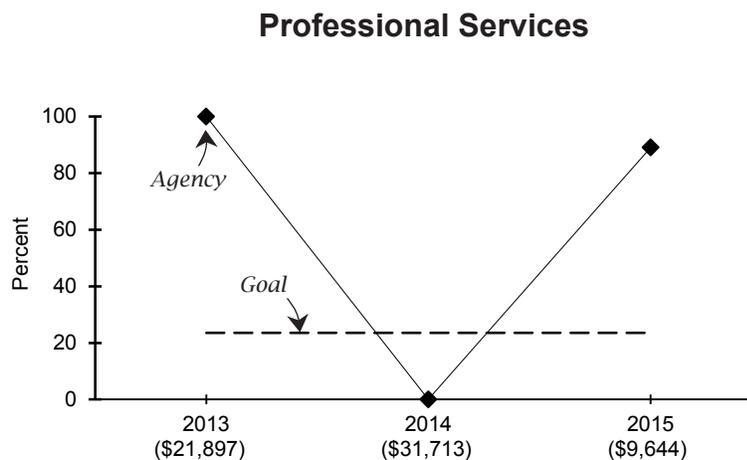
APPENDIX A

Historically Underutilized Businesses Statistics 2013 to 2015

The Legislature has encouraged state agencies to increase their use of historically underutilized businesses (HUBs) to promote full and equal opportunities for all businesses in state procurement. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews.¹

The following material shows trend information for the Texas Medical Board's use of HUBs in purchasing goods and services. The board maintains and reports this information under guidelines in statute.² In the charts, the dashed lines represent the goal for HUB purchasing in each category, as established by the comptroller's office. The diamond lines represent the percentage of board spending with HUBs in each purchasing category from 2013 to 2015. Finally, the number in parentheses under each year shows the total amount the board spent in each purchasing category.

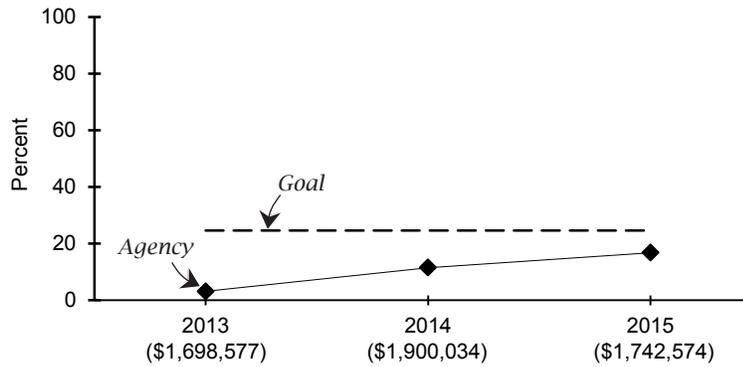
The board met the statewide purchasing goal for professional services in fiscal years 2013 and 2015. However, the board did not meet the goal in fiscal year 2014, as the vendor the board used was not classified as a HUB that year. The board did not meet the statewide purchasing goal for other services for fiscal years 2013, 2014, or 2015. However, the board's purchases for commodities exceeded the statewide purchasing goal for these years. While the board has complied with other HUB-related requirements such as adopting HUB rules, creating HUB subcontracting plans for large contracts, and appointing a HUB coordinator, the board has not developed a mentor-protégé program due to a lack of resources. The board also has not created a HUB forum program, but the board's HUB coordinator does participate in most other state HUB events and forums and reports that participation in these events has resulted in increased purchases from additional HUB-qualified vendors.



The board met the statewide purchasing goal in 2013 and 2015 but did not meet the goal in 2014. The board's expenditures in this category involved a vendor no longer classified as a HUB during fiscal year 2014, which explains the drop in that year.

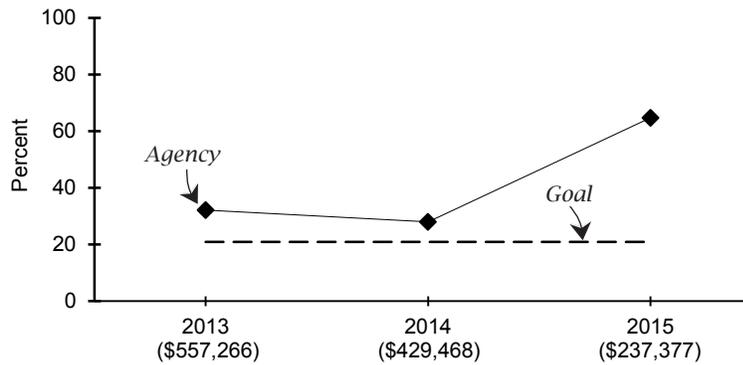
Appendix A

Other Services



The board did not meet the statewide purchasing goal in this category for fiscal years 2013, 2014, or 2015.

Commodities



Purchases in this category exceeded the statewide purchasing goal for 2013, 2014, and 2015.

¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.texas.gov/>. Section 325.011(9)(B), Texas Government Code.

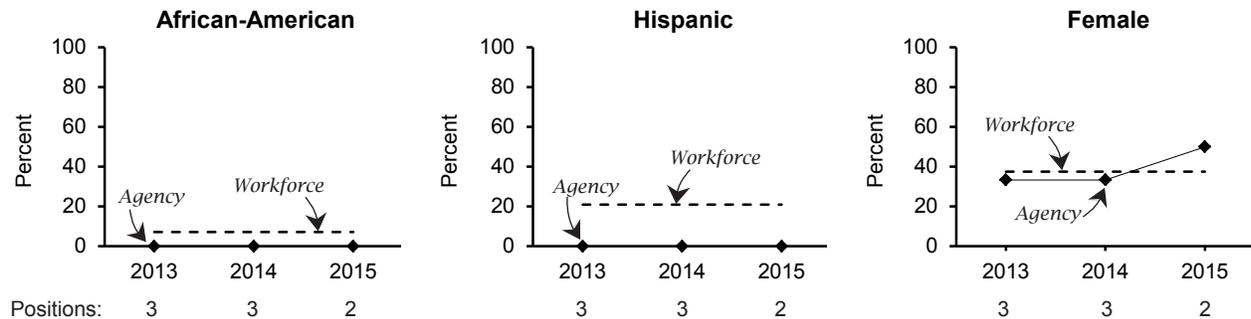
² Chapter 2161, Texas Government Code.

APPENDIX B

Equal Employment Opportunity Statistics 2013 to 2015

In accordance with the requirements of the Sunset Act, the following material shows trend information for the employment of minorities and females in all applicable categories by the Texas Medical Board.¹ The board maintains and reports this information under guidelines established by the Texas Workforce Commission.² In the charts, the dashed lines represent the percentages of the statewide civilian workforce for African-Americans, Hispanics, and females in each job category.³ These percentages provide a yardstick for measuring agencies' performance in employing persons in each of these groups. The diamond lines represent the board's actual employment percentages in each job category from 2013 to 2015. The board failed to meet African-American and Hispanic statewide percentage targets for administration and professional job categories for all three fiscal years but met the female statewide percentage targets for most of these years. The board also met or exceeded civilian workforce percentages for African-Americans in technical, administrative support, and service/maintenance categories during fiscal years 2013 through 2015.

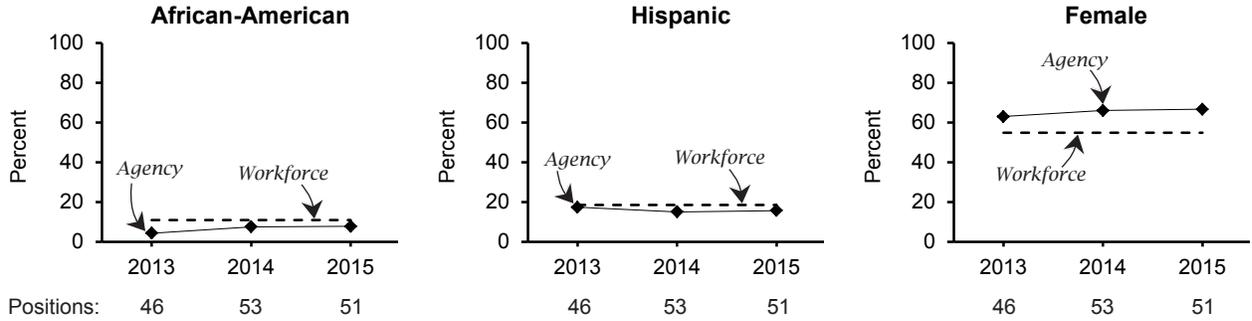
Administration



The board fell below the civilian workforce percentage for African-Americans and Hispanics for all three years. The small number of employees in this category makes it difficult for the board to meet these percentages. The board met the civilian workforce percentage for the females for 2015 after not meeting it for 2013 and 2014.

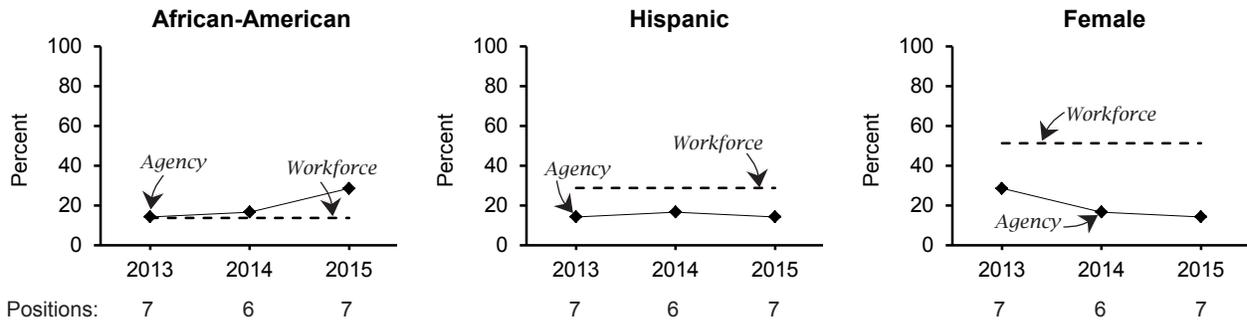
Appendix B

Professional



The board fell slightly below the civilian workforce percentages for African-Americans and Hispanics for each of the three years. The board met the civilian workforce percentage for the female category for all three years.

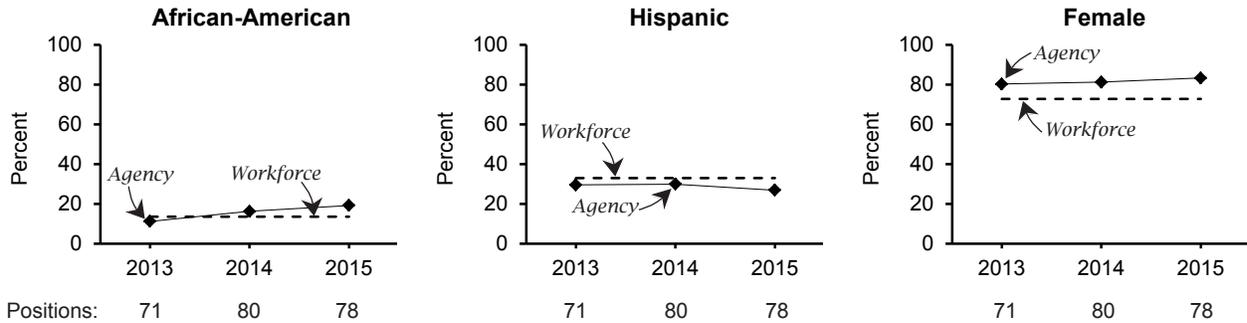
Technical



The board met the civilian workforce percentages for African-Americans in all three years. The board fell below the percentages for Hispanics and females in each of the last three years. Due to the small numbers of employees in this job category, the board has difficulty meeting the statewide percentage.

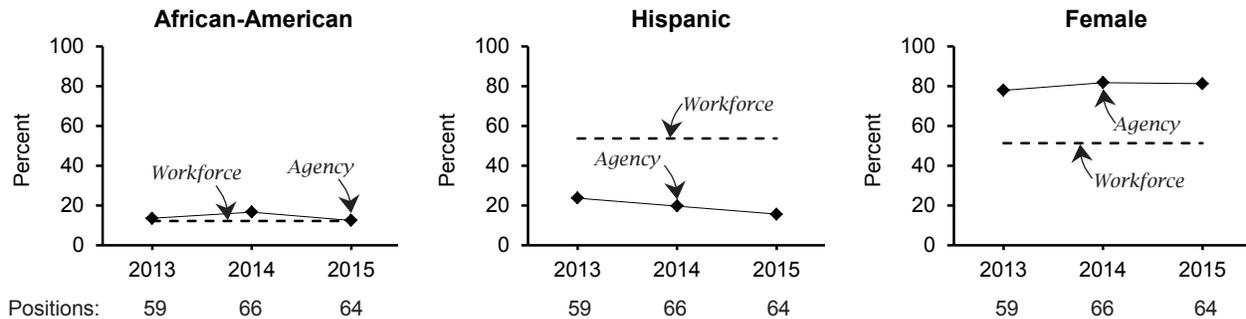
Appendix B

Administrative Support



The board met the civilian workforce percentages for African-Americans in 2014 and 2015, after coming in just below in 2013. For Hispanics, the board was slightly below the percentages in all three years. The board met the civilian workforce percentage for females category for all three years.

Service/Maintenance



The board met the civilian workforce percentages for African-Americans and females for all three years but fell below the percentages for Hispanics in each of the three years.

¹ All citations to Texas statutes are as they appear on <http://www.statutes.legis.texas.gov/>. Section 325.011(9)(A), Texas Government Code.

² Section 21.501, Texas Labor Code.

³ Based on the most recent statewide civilian workforce percentages published by the Texas Workforce Commission.

APPENDIX C

Health Professions Council

In 1993, the 73rd Legislature created the Health Professions Council (HPC) to increase efficiency across member agencies by providing administrative support services. The council consists of representatives from 12 independent licensing boards and the Department of State Health Services Professional Licensing and Certification Unit (PLCU), as reflected in the table, *HPC Member Agencies*.

HPC Member Agencies – FY 2016

Agency	Licenses (at start of FY16)	Funds Transferred to HPC in FY16
Texas Board of Chiropractic Examiners	6,537	\$20,361
State Board of Dental Examiners	31,280	\$257,118
Texas Funeral Service Commission	4,811	\$43,845
Texas Medical Board	85,244*	\$32,378
Texas Board of Nursing	419,685	\$71,651
Texas Board of Occupational Therapy Examiners	13,985	\$33,527
Texas Board of Physical Therapy Examiners	24,412	
Texas Optometry Board	4,409	\$27,715
Texas State Board of Pharmacy	113,806	\$331,400
Texas State Board of Podiatric Medical Examiners	1,162	\$13,401
Texas State Board of Examiners of Psychologists	9,512	\$52,774
Department of State Health Services – PLCU	175,140	\$11,846
State Board of Veterinary Medical Examiners	9,770	\$31,038
Non-Member Agencies Receiving Limited Services		
Texas Board of Professional Geoscientists receives information technology support services		\$13,000
Texas Board of Professional Land Surveying receives database administration and support		\$11,808
Texas State Board of Plumbing Examiners receives database administration and support		\$130,658
Office of Public Insurance Counsel receives information technology support services		\$6,641
Total		\$1,089,161

* As of August 31, 2015

- **Funding and staffing.** The council's funding comes from transferred appropriations from member agencies, with each agency paying for services it receives. Council members elect a chair and vice chair to preside over the council for two-year terms. The council has seven employees to perform its

Appendix C

main functions and occasionally uses staff from member agencies to carry out specific programs. For example, an Optometry Board staff member provides added technology support to the eight smallest member agencies, and a Board of Nursing staff member offers new employee Equal Employment Opportunity (EEO) training to all member agencies.

- **Services.** HPC offers the following services to member agencies:
 - Website, information technology, and document imaging software support
 - Shared regulatory database and database administration
 - Purchasing, payroll, and human resources support
 - Trainings relating to state finance, accounting, auditing, and EEO guidelines
 - Shared toll-free telephone line for consumer complaints

APPENDIX D

Types of Medical Radiologic Technology Certification With Education and Training Requirements

Certificate Type	Education Requirement	Continuing Education	National Certification	Exam Requirement
Medical Radiologic Technologist	Completion of JRCNMT ¹ , JRCERT ² , or ARRT ³ accredited Program	24 hours for each biennial renewal period	Registered by AART or the NMTCB ⁴	Passage of exam administered by AART or NMTCB
Limited Medical Radiologic Technologist	<ul style="list-style-type: none"> • Completion of JRCNMT or JRCERT accredited program; or • Completion of program approved by the Medical Board; or • Current certification as MRT 	12 hours for each biennial renewal period	N/A	Passage of AART exam for limited scope of procedure
Noncertified Technician	Completion of a Medical Board-approved NCT program (120 hours total)	6 hours for each biennial renewal period	N/A	N/A

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¹ JRCNMT is the Joint Review Committee on Educational Programs in Nuclear Medicine Technology.

² JRCERT is the Joint Review Committee on Education in Radiologic Technology.

³ ARRT is the American Registry of Radiologic Technologists.

⁴ NMTCB is the Nuclear Medicine Technology Certification Board.

APPENDIX E

Texas Medical Board Reporting Requirements

Report Title	Legal Authority	Description	Recipient	Sunset Evaluation
1. Biennial Report on Licensure	Section 155.007(h)-(j), Occupations Code	Requires the Medical Board to issue a report on the state of its licensing process. This report must include a projected yearly budget for board staffing and technology improvements that will allow the board to issue licenses within a reasonable number of days.	Governor, Legislative Budget Board, relevant legislative committees (Senate Health and Human Services and House Public Health)	Continue
2. Annual Report on Investigations Over One Year Old	Section 153.056, Occupations Code	Requires the Medical Board to report information regarding any investigations that remain pending after one year, including the reasons the investigations remain pending.	Recipients of the annual financial report	Continue
3. Annual Report on Complaints and Complaint Disposition by Type	Section 154.002(a)(b), Occupations Code	Requires the Medical Board to prepare a statistical report each fiscal year that provides aggregate information about all complaints the board received categorized by type of complaint.	Legislature and the public	Continue

APPENDIX F

Staff Review Activities

During the review of the Texas Medical Board, Sunset staff engaged in the following activities that are standard to all Sunset reviews. Sunset staff worked extensively with board personnel; attended medical board, advisory board, advisory committee, and TXPHP governing board meetings; met with interested legislators and staff from key legislative offices; conducted interviews and solicited written comments from interest groups and the public; reviewed case files, database query results, documents and reports, state statutes, legislative reports, previous legislation, and literature; researched the organization and functions of similar agencies in other states; and performed background and comparative research.

In addition, Sunset staff also performed the following activities unique to this agency:

- Accompanied Medical Board staff on an investigation of a registered pain management clinic
- Accompanied Medical Board staff on inspections of a registered pain management clinic and the facility of office-based anesthesia providers
- Toured an acupuncture school
- Attended more than a dozen Medical Board informal settlement conferences, a cease-and-desist hearing, and a formal hearing at the State Office of Administrative Hearings
- Solicited feedback through an electronic survey of Medical Board licensees and individuals who filed complaints with the board
- Interviewed representatives of consumer and patient advocacy organizations
- Interviewed representatives from the Federation of State Medical Boards, other states' physician health programs, and state organizations representing physicians and other health professionals
- Interviewed staff from the State Office of Administrative Hearings

Sunset Staff Review of the *Texas Medical Board*

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