MEDICAL BOARD OF CALIFORNIA
INITIAL STATEMENT OF REASONS

Hearing Date: May 8, 2015

Subject Matter of Proposed Regulations:

To amend regulations for continuing medical education (CME) requirements.

Section(s) Affected:

California Code Regulation (CCR) Title 16, Division 13, Chapter 1, Sections 1337 and 1338.

Problems Being Addressed:

On July 24, 2014, at the Medical Board of California (Board), Licensing Committee Meeting, Carol Clothier, Vice President, American Board of Medical Specialties (ABMS), State Health and Public Affairs, made a presentation regarding “Maintenance of Certification (MOC)” requirements. Currently, physicians and surgeons who pass a certifying or recertifying examination by an approved specialty board shall be granted 100 hours of CME credit. However, most approved specialty boards are requiring physicians to participate in a required MOC process to maintain specialty board certification and some of the required CME in the MOC process may not meet the current definition of the Board’s approved CME.

The MOC requirements include CME and additional rigorous requirements to maintain ABMS affiliate board or other Board-approved specialty board certification. Under current regulations, licensed physicians who are participating in MOC to maintain specialty board certification could be required to complete an estimated 12.5 additional hours of CME per year than other physicians not participating in MOC to renew their license. Moreover, the extra CME is an additional expense for physicians and takes time away from their practices and being able to treat patients. Accordingly, under current regulations, physicians engaging in MOC CME have to take more CME, and suffer a greater financial and time burden, than physicians who are not pursuing or maintaining board certification. This is not consistent with the Board’s consumer protection goals.

Additionally, CCR section 1338 currently does not authorize the Board to accept proof of CME attendance directly from specialty boards approved by the Board. If the MOC CME is ultimately approved as meeting the Board’s CME requirements for license renewal, authorizing the Board to accept proof of CME attendance directly from the specialty boards will make responding to audit inquiries from the Board more efficient for physicians.
**Anticipated Benefits from this Regulatory Action:**

These proposed amendments will authorize the Board to accept MOC CME as meeting the Board’s CME requirements for renewal of physician licenses. Moreover, the proposed amendments will allow the Board to accept MOC CME proof directly from approved specialty boards, thereby streamlining the process for physicians complying with an audit inquiry.

The benefits anticipated by the proposed amendments include nonmonetary benefits, such as the protection of the public, since the proposed amendments will allow the Board to accept MOC CME for physicians who are engaging in the rigorous MOC process.

In addition, licensed physicians participating in MOC CME will not be required to complete approximately 12.5 more hours of CME than other physicians who are not participating in MOC. This will result in less cost to physicians, without a decrease in public safety, and will increase the available amount of time physicians may attend to their practices and see patients.

**Specific Purpose of Each Amendment:**

Amend CCR section 1337 (Approved Continuing Education Program Requirements). This section specifies the specific criteria for approved programs and the requirements for CME. Adoption would add subsection (g) to accept continuing education that is required for MOC by ABMS affiliate boards or other specialty boards approved by the Board.

Amend CCR section 1338 (Audit and Sanctions for Noncompliance). This section specifies the audits and sanctions for noncompliance of CME. The proposed amendment would add the new proposed Subsection (g) to CCR section 1338 to allow the Board to accept certifying documents for CME compliance from ABMS affiliate boards or other specialty boards approved by the Board.

**Factual Basis/Rationale:**

On July 24, 2014, at the Board’s Licensing Committee meeting: Carol Clothier, Vice President, ABMS, made a presentation to the Licensing Committee Members regarding ABMS MOC requirements. Ms. Clothier’s presentation described the rigorous MOC requirements to the Licensing Committee Members and why the MOC CME requirements should satisfy the Board’s CME requirements for licensed physicians.

Ms. Clothier explained that MOC is based on the six ABMS/Accreditation Council for Graduate Medical Education (ACGME) competencies, which are: 1) professionalism; 2) patient care and procedural skills; 3) medical knowledge; 4) practice-based learning and improvement; 5) interpersonal and communication skills; and 6) systems-based practice. Physicians participating in MOC are expected to engage in continuous learning and assessment of their medical and surgical knowledge and judgment, their skills, and their professionalism.
The amendment to CCR section 1337 is necessary to recognize MOC CME as meeting the Board’s CME requirements for license renewal. This change is also necessary to rectify the undesirable consequences of the current regulations, because under current law, physicians engaging in MOC CME have to take more CME, and suffer a greater financial and time burden, than physicians who are not pursuing or maintaining board certification.

The amendment to CCR section 1338 is necessary to recognize ABMS and other Board-approved specialty boards as accepted sources for providing a physician’s proof of compliance with CME requirements to the Board.

On October 24, 2014, after consideration and discussion, the Board authorized staff to proceed with the regulatory process to amend CCR, Title 16, Division 13, sections 1337 and 1338 to add CME that is required for MOC to be approved as meeting the Board’s CME requirements for licensed physicians and surgeons, and to streamline physicians’ ability to comply with an audit inquiry by allowing the Board to accept MOC CME proof directly from approved specialty boards.

**Underlying Data:**

**Technical, Theoretical, and/or Empirical Studies, Reports, or Documents Relied Upon**

1) At the July 24, 2014, Medical Board of California, Licensing Committee meeting, Carol Clothier, Vice President, ABMS made a presentation to the Licensing Committee Members on MOC, and why the Board should accept MOC CME as meeting the Board’s CME requirements for licensing renewal. A copy of Ms. Clothier’s PowerPoint presentation is included in this rulemaking file.

2) At the July 25, 2014 meeting, the Board adopted a motion to approve staff to begin the regulatory process to allow ABMS MOC to meet CME requirements. This motion is in the Board’s July 2014 meeting minutes, under Agenda Item 15.

3) At the October 24, 2014 meeting, the Board adopted a motion to approve the language for the proposed regulatory change. This motion is in the Board’s October 2014 meeting minutes, under Agenda Item 19.

4) Medical Board of California’s 2013-2014 Annual Report.

5) Printout of Accreditation Counsel for Continuing Medical Education (ACCME) website page identifying approved California-based CME providers.

**Business Impact**

According to the Board’s 2013-2014 Annual Report, about 50,000 in-state licensees are renewed annually. This number leaves out retired and disabled licensees, who do not have to comply with any CME requirements for license renewal.
It is estimated that half, or 25,000, are board certified by an ABMS affiliated board, or other specialty board approved by the Board. Of those, it is estimated 25%, or 6,250 participate in MOC.

Some of the MOC participants will have all of their CME coursework qualify for license renewal in California; others will not. Thus, with this new regulation, it is estimated each of the 6,250 licensees will not have to complete an additional 12.5 hours of CME each year to renew their license in California.

Some CME is free. However, on the high end, there are some courses that cost up to $1,500 an hour. It is estimated the average cost is $200/hour.

Thus, the following conclusion is reached: 6,250 licensees times 12.5 hours of CME times $200 an hour equals a savings to those licensees impacted by this regulation of approximately $15.625 million annually (or, a savings of $2,500 for each impacted physician).

Conversely, there is an impact on California businesses that are CME providers. It is estimated that half of the mandatory CME hours annually are completed in California; the other half in other states. As a result, there may be economic impact of $7.8125 million in lost potential revenue to California businesses. Of the approximate 300 California-based CME providers, it appears that none are small businesses. The loss of potential revenue to California-based CME providers would average $26,000 per business.

In summary, it is estimated this regulation may save impacted physicians $15.625 million annually, while CME providers collectively may not receive $7.8125 million in potential income.

**Economic Impact Assessment:**

- The proposed amendments are unlikely to create or eliminate jobs within the State of California. The CME providers do not appear to be small businesses. Most are universities and professional associations that are involved in a number of different activities. Additionally, these CME providers may be able to adapt to qualify for providing different aspects of MOC CME.

- The proposed amendments are unlikely to create new business or eliminate existing businesses within the State of California. The CME providers do not appear to be small businesses. Most are universities and professional associations that are involved in a number of different activities.

- The proposed amendments are unlikely to affect the expansion of businesses currently doing business within the State of California. The CME providers do not appear to be small businesses. Most are universities and professional associations that are involved in a number of different activities.
This regulatory proposal is likely to benefit the health and welfare of California residents because the proposed amendments will allow the Board to accept MOC CME as an additional pathway for physicians to meet the Board’s CME requirements, and will allow the Board to accept proof of CME compliance directly from specialty boards approved by the Board. This will reduce the burden on participating physicians so they may spend more time attending to their practices and caring for patients.

This regulatory proposal does not affect worker safety because the proposed amendments represent the addition of MOC CME to meet the Board’s established CME requirements.

This regulatory proposal does not affect the state’s environment because the proposed amendments represent the addition of MOC CME to meet the Board’s established CME requirements.

Specific Technologies or Equipment:

This regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No reasonable alternative to the regulatory proposal would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific.

Set forth below are the alternatives which were considered and the reasons each alternative was rejected or accepted:

1. Do not seek a regulatory change. This alternative was rejected, because the Board wants to rectify the undesirable consequences of the current regulations. Under current law, physicians engaging in MOC CME have to take more CME, and suffer a greater financial and time burden, than physicians who are not pursuing or maintaining board certification. This is not consistent with the Board’s goal of consumer protection.

2. Adopt the proposed regulatory amendments. This alternative was determined to be the most appropriate so that the Board may recognize MOC CME as meeting the Board’s CME requirements for license renewal, and may streamline physicians’ ability to comply with an audit inquiry by allowing the Board to accept MOC CME proof directly from approved specialty boards.