PEER MISSISSIPPI

Joint Legislative Committee on Performance Evaluation and Expenditure Review

A Review of the Mississippi State Board of Medical Licensure

A Report to the Mississippi Legislature
Report #706
November 6, 2024

PEER Committee

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The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker of the House and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms, with one Senator and one Representative appointed from each of the U.S. Congressional Districts and three at-large members appointed from each house. Committee officers are elected by the membership, with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, the agency examined, and the general public.

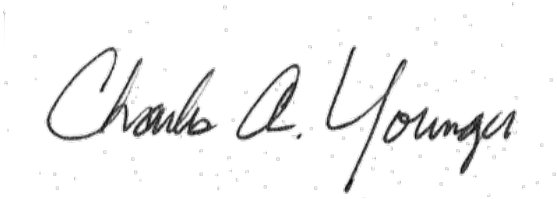
The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

Joint Legislative Committee on Performance Evaluation and Expenditure Review
PEER Committee
P.O. Box 1204 | Jackson, Mississippi 39215-1204

November 6, 2024

Honorable Tate Reeves, Governor
Honorable Delbert Hosemann, Lieutenant Governor
Honorable Jason White, Speaker of the House
Members of the Mississippi State Legislature

On November 6, 2024, the PEER Committee authorized release of the report titled ***A Review of the Mississippi State Board of Medical Licensure.***



Senator Charles Younger, Chair

This report does not recommend increased funding or additional staff.

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Joint Legislative Committee on Performance Evaluation and Expenditure Review

A Review of the Mississippi State Board of Medical Licensure

Report Highlights

November 6, 2024

CONCLUSION: Regulation of the medical profession is necessary to reduce risks to the public. PEER determined several areas in which the Mississippi State Board of Medical Licensure's (MSBML's) regulation of its licensees could be improved (e.g., through amendments in state laws and changes to MSBML's enforcement process). Further, there are policy options for the Legislature to consider—whether an alternative regulatory structure could benefit the state and ways in which the state could better address scope of practice issues within the healthcare profession.

BACKGROUND

The Medical Practice Act (MISS. CODE ANN. Section 74-43-1 et seq. [1972]) defines the practice of medicine and the authority of MSBML. Serious health and safety risks associated with the practice of medicine create a need for state government to protect the public from unprofessional, improper, and incompetent actions.

MSBML regulates physicians, podiatrists, physician assistants, acupuncturists, radiologist assistants, and limited x-ray operators by issuing licenses and establishing and enforcing its rules and regulations.

MSBML is composed of nine physician members that serve six-year terms. As of July 2024, MSBML employed 28 employees.

MSBML is a special fund agency supported by funds collected primarily from licensing and renewal fees. Its revenues and expenditures for FY 2024 were approximately $5.7 million and $3.9 million respectively.

Risk factors associated with the practice of medicine create a need for state government to protect the public from unprofessional, improper, and incompetent actions.

As of July 2024, MSBML regulated 15,950 licensees, the majority of which are medical doctors (MDs).

KEY FINDINGS

- **The Medical Practice Act is no longer aligned with current best practices for regulating physicians and other licensees overseen by MSBML.**
  The statutes regulating physicians have not been updated in many years, and as a result do not reflect current best practices for regulating physicians. Examples include: a lack of full membership for consumer board members, limits on who may nominate a candidate to serve on the Board, outdated examination requirements, and a lack of Board authority to issue fines as disciplinary actions.
- **MSBML's enforcement process fosters an environment in which potential for bias could occur or be perceived.**
  In particular, the Executive Director's discretionary authority in the investigation of complaints and MSBML's failure to utilize a penalty matrix in disciplinary proceedings can increase the risk of potential appearance of bias and unfair treatment.
- **The Board does not adequately oversee the Mississippi Physician Health Program (MPHP) to ensure that MPHP is achieving its mission to help struggling physicians achieve recovery from addictive disorders while also protecting the public.**
  MSBML does not conduct regular performance audits to ensure that physicians in the program are being treated fairly and that MPHP is achieving its goals, nor does it utilize performance metrics to evaluate the MPHP program's compliance and effectiveness.
- **MSBML has improved the Board's internal controls and compliance with state laws since the State Auditor's 2017 compliance review.**
  MSBML addressed compliance and internal control issues related to submission of the *Public Depositors Annual Report*, proper recording of meeting minutes, the timely deposit of cash receipts, procurement card purchases, approval of travel expenses, and recording of employee leave.
- **As of June 30, 2024, MSBML had an estimated ending cash balance of $10.8 million.**
  Maintaining a large cash balance while continuing to collect fees and fines could undermine licensees' and the public's trust in MSBML.

Possible Alternatives to Current Regulatory Structure for Healthcare Professionals

While some states, including Mississippi, regulate healthcare professionals through independent boards, other states utilize an umbrella agency that oversees licensing or licensing boards of multiple professions, including healthcare professionals. The degree of regulatory authority granted to an umbrella agency varies by state, ranging from administrative shared services duties to comprehensive regulatory authority.

Policymakers should consider whether establishing some form of an umbrella agency in Mississippi could benefit the state by increasing efficiency of resources and improving consistency in regulation across healthcare professions.

Options for Addressing Scope of Practice Questions

In Mississippi and nationwide, the expansion of scopes of practice for non-physician healthcare is an emergent issue that must be addressed by state legislatures. Mississippi lacks an objective body responsible for providing recommendations to the Legislature to address such critical scope of practice issues (e.g., overlapping boundaries of practice) within the various healthcare professions. Without such a body, the Legislature may not have the information it needs to make informed scope of practice policy decisions.

Issues with the MSBML's Current Office Location

MSBML leases its approximately 11,000 square foot office space from a private owner for approximately $148,000 per year. Not being located in state-owned office space could be an inefficient use of public funds. Further, the office is larger than recommended by DFA policy for an agency the size of MSBML. However, until more state office space and shared service spaces are made available for smaller special fund agencies, MSBML's options for relocating to maximize efficiency are limited.

Spotlight on Connecticut's Process for Addressing Scope of Practice Issues

A person or entity may request a scope of practice change by submitting a written request to the Connecticut State Department of Public Health (CTDPH) no later than August 15. If the request meets requirements, the CTDPH Commissioner shall establish and appoint at least four members to a scope of practice review committee, and the CTDPH Commissioner serves as an ex-officio member. The committee considers the request, including its potential impact on the health and safety of members of the public, and provides its written findings to the Joint Public Health Committee of the General Assembly, which is responsible for matters relating to public health.

SUMMARY OF RECOMMENDATIONS

The Legislature should consider:

- amending state law to update the Medical Practice Act to bring it in line with modern best practices for regulating physicians and other professionals regulated by MSBML and implement a repealer to encourage periodic review;
- amending MISS. CODE ANN. § 73-25-27 (1972) to require that MSBML implement a penalty matrix to guide the Board's decisions regarding appropriate penalties for violations;
- creating a shared services relationship between the boards regulating healthcare professions (e.g., MSBML, Board of Nursing, Board of Pharmacy), and also consider whether to place boards regulating healthcare professions under an umbrella agency with some level of regulatory authority; and,
- adopting a formal system to review and provide legislators with recommendations for how to resolve scope of practice questions as they arise, such as through the creation of a new committee representing all healthcare professions that would have the authority to develop findings and recommendations related to the modifications of scopes of practice for the Legislature to consider implementing through legislation.

MSBML should:

1. implement further checks and balances into the complaint investigation process in the event that there is disagreement between the Executive Director, Chief of Staff, and Board Attorney regarding the proper course of action;
2. implement practices that ensure that labels within its enforcement database are relevant to the investigation being conducted;
3. implement formal, written policies and procedures defining instances of potential bias for MSBML members and staff, and the appropriate steps for a Board member or staff member to recuse themselves from an investigation or hearing;
4. establish performance metrics that MSBML can use to effectively evaluate MPHP, and mandate regular performance audits of the program to ensure its effectiveness and compliance with its grant authorization;
5. develop plans to expend the licensees' funds held in reserve in an efficient and effective manner for the accomplishment of the agency's goals and objectives and for the benefit of its licensees; and,
6. work with DFA, when space is made available, to move MSBML into state-owned office space that is both more affordable and more efficient in its use of space.

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Senator Charles Younger, Chair | James F. (Ted) Booth, Executive Director

A Review of the Mississippi State Board of Medical Licensure

Introduction

Authority

The PEER Committee conducted this review of the operations of the Mississippi State Board of Medical Licensure (MSBML) pursuant to the authority granted by MISS. CODE ANN. § 5-3-51 (1972) et seq.

Scope and Purpose

PEER sought to:

- describe MSBML and its composition, staffing, and responsibilities;
- determine if the Board complies with relevant statutes for licensing and regulating physicians and related professions;
- determine if the Board is effective and transparent in its regulation of its licensees;
- determine if the Board has effective internal controls in place to protect the interests of the public and make efficient use of its resources; and,
- determine possible alternatives to the current regulatory structure for healthcare professions and determine alternatives for how to address scope of practice questions.

Method

To conduct this analysis, PEER reviewed:

- state agency appropriation bills from FY 2019 to present;
- applicable state and federal laws and regulations; and,
- relevant data and documents provided by MSBML, including licensing and enforcement data, financial records, and contracts.

PEER also interviewed:

- MSBML Board members and MSBML staff;
- personnel from the Federation of State Medical Boards (FSMB);
- personnel from the Mississippi State Medical Association (MSMA); and,
- personnel from various state agencies including the Department of Finance and Administration and the State Personnel Board.

PEER also attended two Board meetings, one of which included disciplinary hearings.

Background

The Legislature established MSBML in 1980[1] to regulate allopathic (MD) and osteopathic (DO) physicians, as well as podiatrists (DPM). The Board's purview has since expanded to regulate other professions, including acupuncturists, physician assistants (PA), radiologist assistants, and limited x-ray operators. State law authorizes MSBML to regulate these professions by making rules and regulations; issuing licenses; and enforcing laws, rules, and regulations.

As of July 22, 2024, MSBML oversaw 15,950 licensees.

Composition and Duties of the Board

As constituted under MISS. CODE ANN. § 73-43-3 (1972), MSBML is composed of nine members that serve six-year terms. In addition, the Board appoints three consumer representatives to serve as non-voting members of the Board. MSBML regulates its licensees by issuing licenses and establishing and enforcing its *Rules and Regulations*.

Members

As presently constituted under MISS. CODE ANN. § 73-43-3 (1972), MSBML is composed of nine members appointed by the Governor with the advice and consent of the Senate. The members serve six-year terms that begin on their date of appointment. No more than four Board members may be from the same State Supreme Court District, and no more than two members shall be faculty for the University of Mississippi School of Medicine. To be eligible for appointment as an MSBML Board member, the individual must:

- have graduated from an accredited medical school;
- have six years of experience practicing medicine; and,
- be nominated by the Mississippi Medical Association (MSMA) for the position. MSMA must nominate three physicians for each vacant position on the Board, making sure to "give due regard to geographic distribution, race, and sex." The Governor must then select a physician to appoint from the list of provided nominees.

In addition to the nine members appointed to the Board by statute, three consumer representatives are appointed by the Board who serve at its will and pleasure to provide insight and assistance in Board discussions. However, because these members are not recognized by statute, they are not voting members of the Board, and cannot serve in elected Board positions or receive Board member benefits, including per diem, for their work.

Advisory committees for acupuncturists, physician assistants, and podiatrists provide recommendations to MSBML related to the regulation of the advisory committee's relevant profession, including potential changes to rules and regulations.

Exhibit 1 on page 3 lists MSBML Board members as of October 2024.

[1] Chapter 458, *General Laws of 1980*.

Exhibit 1: List of MSBML Board Members

Name	City	Initial Appointment Year	Term Ending Date
Voting Members			
Michelle Y. Owens, MD (President)	Jackson	2016	2026
Ken Lippincott, MD (Vice President)	Tupelo	2014	2026
Thomas E. Joiner, MD (Secretary)	Jackson	2019	2030
Randy C. Roth, MD*	Pascagoula	2024	2028
Allen Gersh, MD	Hattiesburg	2018	2030
Kirk L. Kinard, DO	Oxford	2018	2030
Roderick Givens, MD	Natchez	2021	2026
Renia R. Dotson, MD	Greenville	2022	2028
William E. Loper, III, MD	Ridgeland	2022	2028
Non-voting Consumer Members**			
Koomarie "Shoba" Gaymes	Ridgeland	2024	2030
Vacant***	-	-	-
Vacant	-	-	-

* Dr. Roth was appointed by the Governor to complete the remainder of the term of a member who has resigned from the Board but will not be confirmed by the Senate until the 2025 Legislative Session.

** Consumer members have served in an ad hoc committee capacity since 2004, and only began to be referred to as consumer members in 2021. Prior to 2021, they were referred to as Consumer Health Ad Hoc Committee members or Consumer Health Committee members.

*** All three consumer members' terms ended on June 30, 2024, and as of September 6, 2024, two consumer member positions have not been filled.

SOURCE: Mississippi State Board of Medical Licensure.

Purview

MSBML has the legal authority to regulate physicians, podiatrists, physician assistants, acupuncturists, radiologist assistants, and limited x-ray operators. Exhibit 2 on page 4 lists the number of licensees, by profession, as of July 22, 2024.

Exhibit 2: MSBML-licensed Practitioners by Profession (as of July 22, 2024)

License Type		# of Licenses
MD		
	MD – Administrative	53
	MD – Limited Institutional	11
	MD – Permanent	12,046
	MD – Restricted Temporary	709
	MD – Temporary Out-of-State	0
	MD – Volunteer	15
DO		
	DO – Administrative	2
	DO – Permanent	1,411
	DO – Restricted Temporary	233
DPM		84
Physician Assistant		
	Physician Assistant	2
	Physician Assistant – Certified	524
Radiologist Assistant		8
Limited X-Ray Operator		822
Acupuncturist		19
Youth Camp License		11
Total Practitioners		**15,950**

NOTE: See Appendix A on page 38 for a list of license classification definitions.

SOURCE: PEER analysis of data provided by the Mississippi State Board of Medical Licensure.

Duties

State law authorizes MSBML to regulate the practice of medicine by making rules and regulations; issuing licenses; and enforcing laws, rules, and regulations. MSBML carries out its enforcement responsibilities by investigating potential violations and administering disciplinary actions, which can include formally reprimanding licensees and suspending licenses.

Organization and Staffing

The Board's FY 2025 appropriation authorizes the Board to employ 30 staff members to assist with Board activities. As of July 22, 2024, the Board employs 28 full-time staff members.

According to the Board's appropriation bill for FY 2025, the Board is authorized to hire up to 30 permanent employees, but as of July 22, 2024, employs only 28 permanent employees.

An attorney from the Mississippi Office of the Attorney General provides the Board with assistance in Board meetings and serves as the hearing officer when a hearing is conducted.

The Board also utilizes contract workers to handle some Board functions. The Board works with two part-time contractors, one who is responsible for human resource functions, and another who is responsible for finance and accounting functions.

Revenues and Expenditures

MSBML is a special fund agency supported by funds collected primarily from licensing fees as set forth in MISS. CODE ANN. § 73-25-14 (1972).

MSBML is a special fund agency that supports its operations by collecting fees from individuals that it regulates. Exhibit 3 on page 5 shows the Board's revenues, expenditures, and end-of-year cash balances from FYs 2019 through 2024.

Exhibit 3: MSBML Revenues, Expenditures, and End-of-year Cash Balances for FYs 2019 through 2024

($)		FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Annual Appropriation		2,987,323	3,405,584	3,554,554	3,604,261	3,604,261	4,047,338
Revenues		**3,916,357**	**4,322,730**	**4,572,242**	**4,631,391**	**5,096,911**	**5,653,440**
Expenditures		**3,197,120**	**3,383,701**	**3,596,762**	**3,307,576**	**3,543,066**	**3,878,570**
	Salaries, Wages, and Fringe Benefits	1,701,052	1,667,510	1,663,083	1,718,489	1,926,005	2,203,131
	Travel	54,369	26,738	22,833	45,289	51,931	50,848
	Contractual Services	996,531	1,017,110	1,108,355	848,449	801,200	877,095
	Commodities	78,917	76,234	73,728	47,427	90,623	53,412
	Capital Outlay/ Equipment	16,251	66,109	98,763	17,922	43,307	64,084
	Subsidies, Loans, and Grants	350,000	530,000	630,000	630,000	630,000	630,000
Net Revenue*		719,237	939,029	975,480	1,323,815	1,553,845	1,774,870
Beginning Cash Balance		2,771,059	4,112,996	5,030,908	6,046,283	7,386,357	9,012,611
Ending Cash Balance[1]		3,490,296	5,052,025	6,006,388	7,370,098	8,940,202	10,787,481

[1] Fiscal year beginning cash balances may differ from previous fiscal year ending balances due to the timing of expenditures in relation to budgetary deadlines (i.e., lapse payments).

SOURCE: PEER analysis of budget requests and appropriation bills for the Mississippi State Board of Medical Licensure.

In FY 2024, the Board collected approximately $5,653,000 in revenues and incurred approximately $3,879,000 in expenditures. For a list of fees collected by MSBML, see Appendix B on page 39.

Need to Regulate Physicians and Related Occupations

Risk factors associated with the practice of medicine create a need for state government to protect the public from unprofessional, improper, and incompetent actions. MSBML, if it fulfills its regulatory functions properly, should diminish the profession's risk to the public.

According to the Federation of State Medical Boards (FSMB), there are 70 medical boards authorized to regulate medicine across the country; there is at least one medical board in each state.

All states regulate the practice of medicine.

The nature of the practice of medicine presents a risk to the public if practitioners are not properly educated, trained, and regulated. There are many risks associated with the medical profession, including:

- improper diagnosis and treatment of illnesses and ailments;
- transmission of communicable diseases and infection in clinical or hospital settings; and,
- physical harm resulting from improper practice or improper use of equipment.

Because of the gravity of these health and safety risks, all states regulate the practice of medicine, and the general purpose and mission of every state medical board is centered around public protection.

Further, due to the risks inherent in the duties of all occupations regulated by the Board, all licensees must be properly educated and trained before being licensed to work in the state. Applicants must complete an application verifying their education and qualifications. All MSBML license applicants except limited X-ray operators must provide the following as a part of the application:

- a copy of a notarized birth certificate or passport;
- a driver's license;
- a passport-quality physical and digital photograph; and,
- a signed affidavit attesting the accuracy of the application.

Applicants must also pass a background check.

In addition to these application requirements, MD, DO, DPM, and PA applicants must provide:

- a record of fingerprints;
- an account for all activities and training since graduation from their post-graduate school; and,
- verification of hospital or staffing privileges currently held or previously held in the past five years.

Exhibit 4 on page 7 shows all other education and training requirements for applicants for licensure of each profession.

Exhibit 4: Requirements for Licensure of MSBML-Regulated Professions

Education Requirements	Experience Requirements	Exam Requirements	Additional Requirements
MD			
- Bachelor's degree - Postgraduate medical degree from an accredited allopathic medical school	- Postgraduate internship - Residency	- Pass the U.S. Medical Licensing Examinations (USMLE)	
DO			
- Bachelor's degree - Postgraduate medical degree from an accredited osteopathic medical school	- Postgraduate internship - Residency	- Pass the Comprehensive Osteopathic Medical Licensing Examination (COMLEX)	
DPM			
- Bachelor's degree - Postgraduate podiatric degree from an accredited podiatry school	- Residency	- Pass the American Podiatric Medical Licensing Examination (APMLE)	- 21 years of age - Of good moral character
PA			
- Bachelor's degree - Postgraduate degree from an accredited physician assistant school		- Pass the Physician Assistant National Certifying Examination (PANCE)	
Radiologist Assistant			
- Graduate of radiologist assistant education program accredited by American Registry of Radiologic Technologists (ARRT) *or* - Graduate of a Radiology Physician Assistant school holding a radiologist assistant certification from ARRT			- 21 years of age - Of good moral character - Current and unencumbered registration with Department of Health - Current certification in advanced cardiac life support
Limited X-ray Operator			
- 12 hours of education in radiologic technology, six of those hours specifically in radiation protection - Education must take place no less than 12 months after date of employment			
Acupuncturist			
- Graduate of accredited acupuncture program that is at least three years in duration	- Supervised clinical internship	- Pass exams administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) - Complete clean needle technique course - Complete CPR course - Pass a state jurisprudence exam - Appear for an interview with MSBML	- 21 years of age - Of good moral character - Must provide favorable references from two acupuncturists licensed in the U.S. with whom the applicant has worked or trained - Must be able to provide proof that the applicant is able to communicate in English

SOURCE: Mississippi State Board of Medical Licensure.

Issues with MSBML Laws and Rules

This chapter discusses issues regarding:

- the Medical Practice Act;
- the Board's enforcement process; and,
- the lack of effective, transparent oversight of MPHP.

Issues Regarding the Medical Practice Act

The statutes governing MSBML and its licensees, referred to as the Medical Practice Act, are no longer aligned with current best practices for regulating physicians and other licensees overseen by the Board.

Statutes regulating physicians were first passed in Mississippi in 1892, but the Medical Practice Act, which officially created MSBML and updated the laws regulating physicians and other licensees, was passed as Senate Bill 2781 in the 1980 Regular Session of the Mississippi Legislature. The Medical Practice Act specifically encompasses MISS. CODE ANN. § 73-25-1 (1972) et seq., which regulates physicians, MISS. CODE ANN. § 73-27-1 (1972) et seq., which regulates podiatrists, and MISS. CODE ANN. § 73-43-1 (1972) et seq., which creates MSBML and provides its authority.

The Medical Practice Act has not been updated because in the past, efforts to update it have not been successful. Further, unlike statutes of many other regulatory bodies in the state, the Medical Practice Act does not include a repealer that requires the Legislature to periodically review the law and reauthorize it. Repealer deadlines encourage discussion regarding updates to legislation and enable the Legislature to make changes that reflect the current state of the profession. Because there is no repealer for the Medical Practice Act, it is possible that there is less urgency to pass changes in the legislation.

Based on analysis of several resources, including past MSBML legislative proposals and a 2023 performance review of MSBML conducted by the Federation of State Medical Boards (FSMB), PEER found that there are several areas in which the Medical Practice Act no longer aligns with current best practices for regulating MSBML's licensees.

Consumer Board Members

Consumer Board member positions are not established or empowered by state law and are instead appointed by the Board itself, serving at the Board's will and pleasure. Therefore, Consumer Board members do not have any statutory authority and do not provide equal representation for the interest of members of the public. Specifically, consumer members have no authority to vote, cannot receive per diem and other benefits of Board membership, and cannot hold an elected position on the Board. This is different than the board structure utilized throughout most of the country, particularly in Mississippi's contiguous states. Alabama, Arkansas, Florida,

Georgia, Louisiana, and Tennessee all have Board members who are not healthcare professionals that have full membership on the board.

Governor Appointees

MSBML Board members are appointed by the governor using a list of nominees provided by MSMA. MSMA is the only organization that can refer nominees for appointment to MSBML, and the governor must choose from those nominees. As a result, all members of the Board are also members of MSMA. This structure places extensive power in the hands of a private professional association of which not all physicians are members. This could create an appearance of deferential treatment toward MSMA and its members and could result in non-MSMA physicians' interests being less represented by the Board. Mississippi is one of only five states that require the governor to select only candidates who are put forward by a state medical association or medical school.

> Per state law, the Mississippi State Medical Association (MSMA) is the only organization that can refer individuals for appointment to the Board.

Medical Licensure Examinations

MISS. CODE ANN. § 73-25-7 (1972) states that MSBML "shall meet at the capitol at least once each year for the purpose of examining applicants for license to practice medicine or osteopathic medicine and shall continue in session until all applicants are examined." However, exams have not been administered by the Board since the adoption of national exams (e.g., USMLE, COMLEX) in the 1990s, which are administered to applicants at testing centers. The Board also no longer collects exam fees, which MISS. CODE ANN. § 73-25-9 (1972) states are set by MSBML and shall be collected prior to an applicant's examination.

These changes in the Board's examination practices, while necessary, are technically in violation of state law.

Discipline and Fines

The Board does not have the authority to issue fines as discipline for most violations, making it difficult to issue "mirror discipline"[2] when other states issue fines as punishment for physicians, and leaving the Board with limited options for adjudicating violations.

In some instances, the Board may consider disciplining licensees for violations in other states where they are also licensed. The lack of discipline options comparable to other states in the Interstate Medical Licensure Compact[3], particularly the lack of authority to issue fines, makes it difficult to mirror actions by other state medical boards that utilize them. This requires MSBML to decide whether to heighten the level of discipline (e.g., issuing a formal reprimand that will be placed on the licensee's permanent record) or lower the level of discipline (e.g., dismiss the offense) for the offending licensee compared to the originating state. This damages the image of

[2] "Mirror discipline" describes instances where MSBML issues a disciplinary action against a licensee for a violation that is committed in another state's jurisdiction, proportional to the discipline issued by the state of jurisdiction.

[3] According to its website, the Interstate Medical Licensure Compact is an agreement among participating U.S. states and territories to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify.

uniformity that is expected of a participating member-state of the Interstate Medical Licensure Compact.

Mississippi Physician Health Program

The Disabled Physicians Act (MISS. CODE ANN. § 73-25-51 [1972] through MISS. CODE ANN. § 73-25-67 [1972]), which creates the process in which a physician suffering from potentially impairing conditions such as a substance abuse disorder may enter the Mississippi Physician Health Program (MPHP) and continue to practice, currently only refers to physicians, when in fact all MSBML licensees are eligible to participate in MPHP programs.

Issues Regarding the Board's Enforcement Process

The Board's approach to disciplining its licensees fosters an environment in which potential for bias or prejudgment could occur or be perceived. In particular, the Executive Director's discretionary authority and the Board's failure to utilize uniform guidelines (e.g., a penalty matrix) in establishing penalties for noncompliant licensees can result in inequitable treatment and unfair penalties. The Board's lack of a recusal rule set out in its public policies and procedures further increases the risk of the potential appearance of bias and unfair treatment.

To evaluate MSMBL's enforcement standards regarding complaints and violations, PEER obtained read-only access to complaint and investigative case details located in the MSBML Enforcement Database, which currently stores entries from 2020 to present.

Issues with Near-unilateral Power of the Executive Director

Until this year, the complaint management process had been in place since at least 2011. In this process, the Executive Director decided which complaints warranted an investigation and which should be dismissed. This created the potential for the Executive Director's personal bias to affect decisions made regarding complaints. MSBML has since implemented an alternative system for complaint management.

> The Board's Executive Director still ultimately determines whether complaints against licensees should be dismissed or whether an investigation is warranted.

The newly implemented system includes the MSBML Board Attorney and the MSBML Chief of Staff in the decision regarding whether a given complaint warrants an investigation. The Board Attorney, the Chief of Staff, and the Executive Director consider and vote individually on how to address received complaints. If the vote is not unanimous, the Executive Director, the Board Attorney, and the Chief of Staff meet to discuss any disagreements prior to reaching a final decision on the matter.

According to the Executive Director, since implementing this new system, unanimous decisions have been rare, occurring only approximately 25% of the time, which has resulted in several discussions about complaints and a general slowdown of the process. However, after the group meets to discuss a disagreement, the Executive Director still ultimately makes the final determination on whether to proceed with an investigation. Because the Board Attorney and the Chief of Staff report directly to the Executive Director, they could be less willing to challenge the Executive Director's judgement when they disagree. As a result of the Executive Director maintaining unilateral final authority and the imbalanced power dynamic, the new complaint

process may still raise the same concerns of the potential influence of personal bias as the original one.

Additionally, while this new system has been implemented, the Board has not yet developed a written policy describing the new system, which could lead to further concerns about a lack of consistency and transparency in how decisions are made.

Potential Alternative Complaint Management Processes

In an interview with FSMB personnel, an FSMB consultant stated that it would be logical to engage some form of review team or committee for the complaint process instead of continuing to use the current system in which the MSBML Executive Director serves as the "arbiter of complaints," exerting final judgement over all complaints received.

Some state medical boards have established more objective review protocols. For example, the FSMB consultant stated that members of the Oregon Medical Board (OMB) must review every case submitted, which alleviates the potential bias created by choosing which cases to evaluate. However, this approach requires the per diem payment of Board members for time spent reviewing cases on top of compensation for expected attendance. It may also increase the time required of Board members, which may not be feasible for some members.

The FSMB Director of State Legislation and Policy cited another existing system in which two members of a state's medical board participate in a review panel alongside staff for complaints. Although the system addresses the potential for bias, it may restrict some Board members from participating in hearing proceedings.

Vermont involves Board members in the reception and management of complaints against Board of Medical Practice (VBMP) licensees. The 17 part-time VBMP Board members are divided into three regional investigative committees that meet monthly to review cases and assigned complaints. Both public and professional Board members comprise each investigative committee. Complaints are assigned based on the region of the licensee identified in order to nullify potential bias or other conflicts. Supervised by the VBMP Executive Director, VBMP investigative staff coordinate with the assigned investigative committee on case proceedings. The assigned investigative committee will determine whether a violation has been committed following general investigations, possibly consulting with subject-matter experts. If no violation has occurred, the investigative committee will recommend that the case be dismissed by the Board. If the assigned investigative committee determines that a violation has occurred and that action may be warranted, then VBMP will involve an assistant attorney general on behalf of the assigned investigative committee to take subsequent steps to either settle the case per VBMP Board rules or pursue further disciplinary action in front of the Board. The Board and the VBMP Executive Director reserve the authority to internally generate and pursue complaints for more pressing, founded matters. Board members of the assigned investigative committee for a given case abstain from participating in hearing panels, which require a minimum of three Board members.

Issues with the Uniform Disciplinary Actions

MSBML does not presently utilize a penalty matrix to determine disciplinary measures. Instead, MSBML considers violations on a case-by-case basis, using the various violations and corrective action options listed in the Medical Practice Act, along with other relevant sections to inform disciplinary decisions. However, there is no language linking violations and corresponding disciplinary actions.

> In the absence of a penalty matrix, the consistency of disciplinary outcomes, across cases with comparable violations and circumstances, cannot be ensured.

Use of a Penalty Matrix in Virginia

Some medical licensure boards in other states have established guidelines for the determination of disciplinary action for a given violation. After a ten-year study of disciplinary outcomes of Virginia Board of Medicine (VBM) cases, the Virginia Board of Health Professionals (VBHP) recommended the *Virginia Sanction Reference Points Instruction Manual* (Manual) for integration into VBM's disciplinary decision-making procedures.

The Manual contains various sets of worksheets, broken down by case types, which assist with scoring, offer recommended sanctions, and provide room for judgmental deviation. Worksheet sets cover "Impairment," "Patient Care," and "Fraud/Unlicensed Activity" case types. Worksheets in the Manual address the circumstances of the respondent, namely their history, and more immediate case circumstances individually, accounted for in separate columns of scoring fields in each case type worksheet. Of the fields included, scoring for priority level, degree of patient injury (if applicable), and relevant respondent history contribute the most weight toward the "Total Offense Score" and the "Total Respondent Score." These totals correspond with the axes of the Manual's penalty matrix, a grid housing split cells of recommended sanctions wherein each cell describes high- and low-intensity disciplinary options.

Worksheet sets are complete with coversheets that identify case and respondent details, the case type of the selected worksheet set, the penalty matrix-recommended sanction result, the actual imposed action, the explanation for any deviation from the recommended action (if applicable), the date of completion, and the identity of the worksheet preparer (Board member).

Incorporating the Manual introduced an additional layer of documentation that only served to aid uniformity of disciplinary actions. VBHP cited the following advantages of utilizing the Manual:

- making sanctioning decisions more predictable;
- providing an education tool for new Board members;
- adding an empirical element to a process/system that is inherently subjective;
- providing a resource for VBM and those involved in proceedings;
- "neutralizing" sanctioning inconsistencies;
- validating Board member or staff recall of past cases;

- reducing the influence of potential personal bias (e.g., identity of the Board member, overall Board makeup, race, or ethnic origin); and,
- helping predict future caseloads and need for probation services and terms.

There are currently no legal requirements concerning the use of penalty matrices for MSBML disciplinary action determination.

Delivering judgment without the direction of formal disciplinary guidelines, accompanied by a penalty matrix, introduces the potential for an appearance of bias that could lead to arbitrary and capricious[4] enforcement decisions.

Issues with the Enforcement Database Labels

MSBML's Enforcement Database is divided into complaints, investigative cases, and compliance cases. Most complaints are submitted electronically by a complainant. As a result, some complaint files may not be fully accurate, complete, or relevant. In many cases, the violation type field, in which a complainant is required to select from preset checkbox options the type of violation being reported, is marked incorrectly, and may not match the actual violation committed. Violation types listed are broadly defined (e.g., "Unprofessional Conduct – Substandard Care") and some violations may reasonably be categorized under more than one violation type.

Although investigative staff manually create new investigative case entries, several fields are auto populated from the complaint file. Investigative cases are automatically labeled with the violation type(s) selected by the complainant. While investigators are able to manually change the violation type, the Investigations Supervisor stated that this rarely occurs.

Inexact violation labels result in poor case record organization. Investigative staff may experience difficulty when attempting to find and reference past cases involving similar violations. Though the Database includes search features with filters, a search may not produce all relevant results or may produce results that are irrelevant.

Additionally, the inconsistency of correct labeling of violations keeps the Board from being able to easily track and report the number of violations by violation type. This information would provide Board members, investigative staff, and third-party evaluators the ability to analyze trends in complaint information that could identify potential issues and inconsistencies in enforcement decisions and provide rationale for potential changes to statutes, policies, or procedures.

Issues with the Board's Lack of a Publicly Available Recusal Rule

MISS. CODE ANN. § 73-43-11 (1972) empowers MSBML with the authority to investigate alleged violations of the Medical Practice Act, conduct hearings on disciplinary matters, and promulgate reasonable rules and regulations necessary to discharge its functions and enforce provisions of the law regulating the practice of medicine. The process for how a complaint is investigated and how a violation is adjudicated is detailed in the Rules of Procedure within the Board's rules and regulations. The Rules of Procedure specify how a complaint is determined to justify further investigation, how investigators may collect evidence, and how hearings are conducted. However, the proper procedure for recusal from an investigation or hearing is not defined in statute or the Board's rules, either for Board members or for MSBML staff.

[4] Arbitrary and capricious judgments are defined as willful and unreasonable action without consideration or regard for the facts and circumstances.

Board members and staff stated to PEER that Board members do receive training and written guidance when first joining the Board about the appropriate time to recuse themselves from disciplinary hearings, but there is no written resource or policy available for the public to view. Board members noted that in the past, recusals have occurred when a member knows the person who is the subject of the hearing or otherwise has knowledge or involvement in the case before the Board. When a Board member wishes to recuse, they must only notify the Board in the hearing to do so. While it is good practice to train Board members to recuse themselves to avoid potential bias, having a written policy that defines potential instances in which this might occur would provide the public with transparent guidelines that could help avoid any potential appearance of bias in hearings.

Similarly, there is no defined policy for what defines instances of potential bias for Board staff, particularly those involved in investigations, or how those conflicts should be addressed. As discussed in the issues with the Board's enforcement process, this is particularly important for the Executive Director, who has broad power to determine whether it is appropriate to investigate a complaint or move forward with prosecuting a violation. The Executive Director stated that in the past he has recused himself from an investigation review due to the potential for bias and referred his responsibilities to the Board Deputy Director and the Board Attorney. While the decision to recuse is appropriate, creating a formal, written policy for how a staff member should be recused and who assumes that person's responsibilities would provide the public with transparent guidelines that could help avoid any potential appearance of bias in complaint investigations.

Issues Regarding Mississippi Physician Health Program Oversight

The goal of the Mississippi Physician Health Program (MPHP) is to help struggling physicians achieve long-term recovery from addictive disorders and other illnesses and maintain their licenses. The Board does not adequately oversee the program to ensure that the treatment of Board-referred individuals is fair and that MPHP is achieving its mission while also protecting the public.

Purpose and Structure of MPHP

MISS. CODE ANN. § 73-25-55 (1972) states that if MSBML has "reasonable cause to believe that a physician licensed to practice medicine in this state is unable to practice medicine with reasonable skill and safety to patients because of a condition" such as mental illness, physical illness (e.g., loss of motor skills, mental deterioration as a result of age), or substance abuse, the Board shall require the physician to submit to an examination by an examining committee created by "MSMA or its constituent bodies." MPHP was created to serve as the constituent body that evaluates and monitors disabled physicians.

According to the Federation of State Physician Health Programs, PHPs operate in 47 states. Their primary duties are to coordinate the effective detection, evaluation, treatment, and monitoring of physicians with addictive disorders and other illnesses. MPHP indicates that its primary focus is on intervention and recovery with long-term, intensive monitoring. The utilization of PHP services is sometimes a preferred alternative to disciplinary action, which could include physicians' loss of licensure.

While MPHP is technically a subsidiary of MSMA, it operates independently and contracts with MSBML to perform its function. MSMA maintains a standing committee, the Mississippi Physician

Health Committee (MPHC), that provides clinical oversight of MPHP and its monitoring of its participants, but otherwise does not have regular involvement in the day-to-day operations of the program, which are conducted by MPHP's medical director and staff. When a licensee is to be evaluated for participation in the program, an examining committee is created by the medical director to perform the evaluation. The examining committee is composed of MSMA members unless the licensee being evaluated is not a member, in which case the medical director will form the committee of physicians who are also not members of MSMA.

Relationship between MSBML and MPHP

The relationship between MSBML and MPHP is formalized through a grant agreement, signed annually, that defines the expectations for MPHP, and its use of the grant funding that is included in MSBML's line-item appropriation each year. Specifically, the grant agreement describes the following:

- required organizational structure of MPHP, including keeping a full-time medical director on staff;
- process for establishing examining committees to evaluate potentially impaired licensees;
- reporting requirements (including in the event of a participant relapse); and,
- requiring MSMA auditors to conduct an annual financial audit of MPHP's expenses and internal financial controls.

The agreement also states that all monitoring agreements require participants to notify MSBML if they seek licensure or practice in another state, and that the participant must notify the respective regulatory agency and state physician health program of their participation in MPHP. Finally, the term of the agreement is set as one year, with the agreement automatically renewing for successive one-year periods unless either party gives written notice of termination no less than 90 days prior to the end of the current term.

MPHP Funding and Program Participation

The Legislature annually appropriates funds to the Board for MPHP.

As shown in Exhibit 5 on page 15, appropriated funding for the program increased from $350,000 in FY 2019 to $600,000 in FY 2025, a 71% increase. While MPHP receives funding from other sources (e.g., fees paid by participants), the majority is from legislative appropriations of MSBML special funds.

Exhibit 5: MSBML Line-Item Appropriated Funding for MPHP Grant

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Annual MPHP Appropriation	$350,000	$400,000	$500,000	$500,000	$500,000	$600,000	$600,000

SOURCE: PEER analysis of appropriation bills for the Mississippi State Board of Medical Licensure.

MSBML stated that as of July 19, 2024, there were approximately 138 participants in MPHP, including participants now located out-of-state. This number represents less than 1% of the Board's total licensees.

MPHP Program Requirements

Physicians and other medical professionals can enter MPHP programs in two ways. He or she may enter the program confidentially if he or she is referred by oneself, family, friends, or coworkers. When a person is in the program under this status, personal information is anonymized, allowing MPHP to provide updates on those voluntary participants to MSBML without disclosing their identities. If a licensee is referred to MPHP's examining committee and admitted into the program as a result of disciplinary action by the Board, their information is available to the Board without being anonymized.

According to the Board's Attorney and its Compliance Officer, as well as an anonymized sample quarterly report provided by MSBML, program participants are placed "under contract" with MPHP through a signed agreement that lays out the terms of participation in the program. Contracts may be for a set period of time, typically five years, but can also be lifetime commitments. While a participant is under contract, MPHP advocates on the participant's behalf for their continued compliance with the program and their ability to continue working as a licensed medical professional. The program's monitoring can be intensive; participants are required to submit to regular drug screenings, attend support group meetings multiple times a week (e.g., Alcoholics Anonymous), provide MPHP with monthly calendars, and report hours worked per week. As required by the grant agreement, if a participant moves out of state, MPHP and MSBML must be notified, and the participant must register with the physician's health program in the new state of residence. The new state's physician's health program keeps MPHP informed of the participant's compliance with the program.

If a participant fails to comply with the contract in any way (e.g., failed drug tests, continuous absences from support group meetings), MPHP can inform MSBML that they have withdrawn their advocacy of the participant, which then allows the Board to take immediate disciplinary action against the licensee. MPHP must also report any use of unapproved substances by a program participant to the MSBML Executive Director within 24 hours of the occurrence, regardless of the program's continued advocacy of the participant. The MSBML Executive Director has the authority to determine if the relapse needs to be brought to the Board's attention. If it is brought to the Board's attention, MSBML has the authority to allow MPHP to continue to manage the problem or determine if disciplinary action is ultimately necessary.

To satisfy the reporting requirements laid out in MPHP's grant agreement with MSBML, MPHP provides quarterly reports to MSBML regarding the status of participants in the program, with self-referred licensees anonymized in updates. The Board is updated on every participant at least once per year. Updates are focused on participants' compliance with monitoring agreements, any significant violations, and changes to participants' status in the program (e.g., participant has completed term of contract). MSBML leadership also meets with MPHP leadership monthly to discuss any updates of note and emergent issues with participants. Further, MSBML receives a copy of an annual financial audit of MPHP conducted by auditors from MSMA.

MPHP Oversight Issues

Given the relatively low number of participants, MSBML is making a significant investment of its special funds into the program. Therefore, MSMBL should provide its licensees and the Legislature

with the information needed to be assured that funds are being spent as intended and that the program is effective in achieving its goals, which include helping physicians achieve long-term recovery and maintain their licenses, while also protecting the public.

Additionally, questions regarding oversight have been raised regarding PHPs. They have a great deal of authority and physicians sometimes object to the recommendations or decisions they make. Although there is a process to appeal these decisions, it can be difficult and costly.

Based on the documentation provided, MSBML does not conduct the following activities, which would demonstrate adequate oversight of the program:

- Periodic announced and unannounced audits of participant information to ensure compliance with the grant agreement and with best practices; and,
- Tracking and reporting of performance measures to demonstrate program effectiveness.

Both regular performance audits and performance metrics are key tools for ensuring program compliance and effectiveness. The lack of public accountability for the program makes it difficult to ensure both MPHP's benefits to public safety and fair treatment of licensees within the program.

Lack of Periodic Audits

A proactive approach, including announced and unannounced audits of participant information, to ensure compliance could be beneficial. Due to the concerns noted above, MSBML should ensure that physicians are being treated fairly and ethically as a part of these audits.

There has been scrutiny of PHPs in other states. For example, in 2014, the North Carolina State Auditor (NCOSA) found deficiencies in the oversight of North Carolina's Physician Health Program (NCPHP), stating that the North Carolina Medical Board received periodic reports from the program, but did not conduct periodic evaluations of its activities. NCOSA conducted a follow up review in February 2019 and noted that NCPHP and the North Carolina Medical Board implemented several policies and procedures to improve oversight over NCPHP and its operations as a result of its 2014 report.

NCPHP now conducts tri-annual performance audits, the first conducted in 2017, with hired independent consultants, whose reports are provided to and discussed with the NCPHP Board of Directors, North Carolina Medical Board, and the North Carolina Medical Society. NCPHP also provides a Financial, Performance, and Quality Assurance report to the North Carolina Medical Board semiannually. Finally, NCPHP directives and physician evaluations are reviewed by the NCPHP's Compliance Committee that is composed of members from the NCPHP Board of Directors and the North Carolina Medical Board. NCOSA noted that the changes improved the North Carolina Medical Board's "ability to identify and correct any potential abuse of authority, lack of due process, or other significant noncompliance with [NCPHP] requirements."

Similarly, if MSBML, MSMA, or a third-party monitor was actively overseeing MPHP via regular audits, they could potentially identify any noncompliance issues or other concerns.

Lack of Performance Measures

There is no requirement in statute or in the grant agreement between the Board and MPHP to provide general performance metrics on the MPHP's program. As such, there

are no established performance metrics (e.g., referral statistics, evaluation outcomes, participant success rates) regularly reported to MSBML.

While information on the MPHP program and its participants can be sensitive and rightfully need to be protected, it is still possible to create meaningful performance metrics to effectively evaluate the program. Information provided for these metrics would not require disclosure of confidential or protected information, and could instead provide general statistics, such as referral statistics, evaluation outcomes, number of participants, activities facilitated or sponsored by MPHP, contracts completed, advocacies withdrawn, and success rates over time.

Issues with Financial Management and Internal Controls

This chapter discusses:

- a follow-up of issues found in the Office of the State Auditor's report;
- issues with the Board's large cash balance; and,
- issues with the Board's current office location.

Audit Report Follow-Up

In FY 2017, the Mississippi Office of the State Auditor conducted a compliance review of MSBML and found several deficiencies. The Board has since implemented changes that have improved the Board's internal controls and its compliance with state laws.

In FY 2017, the Mississippi Office of the State Auditor (OSA) conducted a compliance review of MSBML and found several deficiencies in the Board's internal controls and operations. In particular, OSA found issues in the following areas:

- compliance with state laws for the timely submission of MSBML's *Public Depositors Annual Report*;
- compliance with state laws for the proper recording of minutes for Board meetings;
- compliance with state law for the timely deposit of cash receipts;
- internal controls related to procurement card purchases, namely record of supervisor approval;
- internal controls related to review and approval of travel expenses; and,
- internal controls related to recording of employee leave.

MSBML has taken steps to address the issues raised in OSA's report and has improved the Board's operations and internal controls. Specifically, the Board has taken the following steps:

- The FY 2023 Public Depositors Annual Report was submitted on July 21, 2023, within the 30-day window required by state law. However, the FY 2024 Public Depositors Annual Report was submitted on August 5, 2024, five days outside the window required by law.
- Drafts of Board minutes for Board meetings are available within 30 days of the meeting, are approved by the Board at the next regularly scheduled Board meeting, and are signed by the Board president when approved, in accordance with state law.
- MSBML no longer keeps petty cash in the office and does not accept cash for payment of any fees. Almost all payments are now made through an online portal on the Board's website.

- Procurement card purchases are now approved by the deputy director, who signs all receipts of purchases made on the procurement cards.
- All travel reimbursement forms are now approved by a supervisor, with the supervisor signing the form to signify approval before a reimbursement is paid. For Board members, all forms must be submitted to and approved by either the executive director or the deputy director.
- Employees must submit a form requesting leave or compensatory time that must be approved and signed by a supervisor. If the executive director must take leave, a form is still submitted and is signed and approved by the deputy director.

At the time of the OSA compliance review, the Board was experiencing a change in leadership that could have exacerbated some of the issues with internal controls found in the review. In response to the review, the executive director laid out plans to address each of the findings and implement OSA's recommendations, including hiring a deputy director who would be charged with improving internal control and compliance with state law in financial matters of the Board.

Issues with the Board's Large Cash Balance

As of June 30, 2024, the Board had an estimated ending cash balance of approximately $10.8 million, or approximately 267% of the Board's most recent appropriated spending authority. The key factors contributing to this balance includes the Board collecting more funds from fees than necessary to cover the Board's cost of operations. Maintaining a large cash balance while continuing to collect fees and fines could undermine licensees' and the public's trust in the Board.

As described previously, MSBML is a special fund agency that is supported through funds collected from its licensees. Unlike agencies that receive support from the state's general fund, any funds collected by the agency but not expended in the operation of the agency generally remain within the agency's accounts at the end of the fiscal year. As of June 30, 2024, MSBML had an ending cash balance in its accounts of $10,787,481.

The balance remaining at the end of FY 2024 is not the result of a difference in only FY 2024's operations but a summation of all the differences between MSBML's collections and expenditures over time. For example, over the last five fiscal years (FY 2020 through FY 2024) MSBML's annual revenue collections have averaged approximately $4,855,000 while its appropriated spending authority (the amount of funds MSBML is legally allowed to spend during a fiscal year as directed by the legislature) has averaged only approximately $3,651,000.

The difference between the funds collected and the Board's actual cost of operations is one factor that has contributed to the large cash balance currently maintained by MSBML.

MSBML has also not fully utilized the appropriation approved by the Legislature, as MSBML's expenditures averaged approximately $3,542,000 for the period reviewed (FY 2019 through FY 2024). One possible explanation for the shortfall in spending is vacancies in employee PINs. As a part of the appropriations process, state agencies must budget projected expenditures for personnel salaries and benefits. Budget guidelines require the submitted budgets to account for full funding of these categories for all authorized agency PINs. Subsequent appropriations by the Legislature are also based on these full funding figures. Any time an agency has a vacancy in one

or more PINs during a fiscal year, the funds allocated for that position, unless repurposed for other expenditures, may remain unspent, creating a residual fund balance.

While MSBML should strive to efficiently expend revenues entrusted to it, licensees should have an expectation that any fees and fines collected by the MSBML will be expended for the efficient and effective accomplishment of the agency's mandate and to fund its operations. Maintenance of a large cash balance could serve to undermine the licensees' trust in the agency.

Issues with the Board's Current Office Location

MSBML leases its approximately 11,000 square foot office space from a private owner for approximately $148,000 per year. Not being located in state-owned office space could be an inefficient use of public funds. Further, the office is larger than recommended by DFA policy for an agency the size of MSBML. However, until more state office space and shared service spaces are made available for smaller special fund agencies, the Board's options for relocating to maximize efficiency are limited.

MSBML has been located in its current office space since November 2007, and has since renewed the lease three times, with the current lease extending through January 31, 2026. The office is located in Jackson, but is not located downtown in the Capitol district, but rather is located off of Lakeland Drive near Flowood.

MSBML's office space is not located in a state-owned building, with a current lease agreement that sets the cost of the lease at $738,250.20 for the five-year term, paid in monthly flat rate payments of $12,304.17. This will account for 3.3% of the Board's authorized spending for FY 2025.

Further, DFA policy recommends that agencies utilize the space leased efficiently, with a standard of 225 square feet per employee or less recommended, and for agencies not to exceed 250 square feet without prior approval. If all 30 employee PINs and two contractors are conservatively all considered full-time occupants, MSBML's space utilization efficiency is 341.78 square feet per employee, far exceeding DFA's recommendation.

In PEER Report #609, *Potential Cost Savings from Increasing the Utilization of State Property and Shared Support Services* (June 2017), MSBML is named as a potential candidate for cost savings by moving to a state-owned office space that would be capable of providing shared services to health-related regulatory boards, which would not only save money on office space expenses, but also on office equipment rentals and financial and accounting services.

Many state-owned office spaces are currently undergoing renovations, and there is a waitlist of two to three years to relocate into a state office building. DFA is also prioritizing general fund agencies over special fund agencies for placement in state office space, as their funding structure allows for their use of the space to be offset by their contribution to the state's general fund.

A key reason for the Board exceeding the square footage efficiency standards in its office is the large hearing room where Board meetings take place. DFA staff noted that rooms like this are often the reason that Board offices exceed recommended space requirements, and could be resolved by utilizing shared services space, like the newly renovated hearing room found in the Robert E. Lee building in the Capitol Complex. However, until more office space and shared

service spaces are created, there are few alternatives to having in-office meeting space for smaller agencies like MSBML.

While MSBML is a special fund agency that receives its funding from licensing fees of the professionals it regulates, and has no effect on the state's general fund, the licensees should have an expectation that funds they provide to the Board are being used in an efficient and effective manner. By not being located in a state-owned building, the Board is required to expend funds that could be used to benefit licensees or to otherwise improve the Board's operations. Further, by leasing an office space that is larger than recommended for the agency's size, it could be spending more money than is considered an efficient use of public funds.

Other Regulatory Considerations

This chapter discusses:

- possible alternatives to current regulatory structure for healthcare professionals; and,
- alternatives for addressing scope of practice questions.

Possible Alternatives to Current Regulatory Structure for Healthcare Professionals

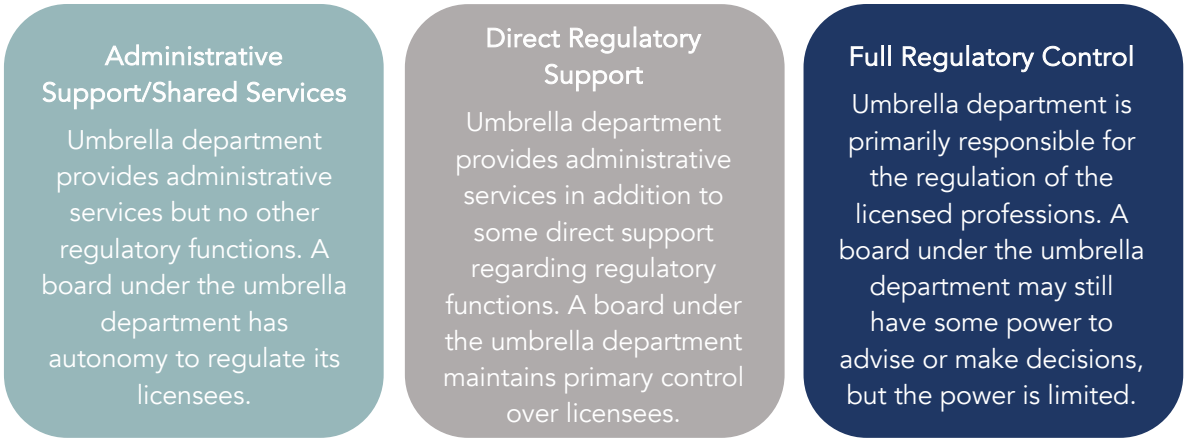
While some states, including Mississippi, regulate healthcare professionals through independent boards, other states utilize an umbrella agency that oversees licensing or licensing boards of multiple professions, including healthcare professionals. The degree of regulatory authority granted to an umbrella agency varies by state, ranging from administrative shared services duties to comprehensive regulatory authority. Policymakers should consider whether establishing some form of an umbrella agency in Mississippi could benefit the state by increasing efficiency of resources and improving consistency in regulation across healthcare professions.

While medical boards function autonomously in some states, including Mississippi, other states place their medical boards within umbrella departments[5] that oversee the regulation of multiple professions. In some states, the medical board is housed within a Department of Health or Department of Health and Human Services that administers several healthcare professions. In other states, the medical board is housed within a department dedicated to licensing and regulating various healthcare professions and other licensed occupations like real estate, accountancy, and engineering.

The level of authority granted to the umbrella departments varies from state to state, with the department's duties ranging from solely administrative tasks to comprehensive regulatory functions. The following section describes three structures that differ based on the degree of regulatory authority the umbrella department exercises over the medical profession and other occupations under its purview. These structures include:

- administrative support/shared services;
- direct regulatory support; and,
- full regulatory control.

[5] An umbrella department is a department that coordinates activities and resources of other organizations, which are usually related or have a similar purpose.



Administrative Support/Shared Services Umbrella Department

In the administrative support/shared services structure, the umbrella department and the regulatory boards under it have a strictly shared-services relationship (i.e., the department provides administrative services but no other regulatory functions). The boards maintain regulatory autonomy and authority over their licensees, with the ability to license, investigate complaints, and take disciplinary action. The following are examples of states that have implemented an administrative support/shared services umbrella structure.

Colorado

Overview of the Umbrella Department

Colorado's professional licensing and regulation is housed in the Division of Professions and Occupations (CODPO) of the Colorado Department of Regulatory Agencies. CODPO oversees 46 licensing boards and programs that are responsible for over 50 licensed professions. Its primary function is to provide the boards and commissions it oversees with management support including:

- budgeting support;
- office space allocation; and,
- final approval of rules passed by boards and commissions to ensure that they are fair and impartial.

CODPO also provides a centralized licensing portal for all professional licensing boards that licensees use to apply for and renew licenses, but CODPO is not responsible for the license processing for professions with specific boards. It also does not have any involvement in the investigation of complaints made to the regulatory boards. These duties are the responsibility of each licensing board.

Overview of the Medical Board

The Colorado Medical Board (COMB) is composed of seventeen members appointed by the Governor. COMB operates under the umbrella of CODPO, but still maintains the regulatory authority for the professions the board oversees, namely MDs, DOs, PAs, and anesthesiologist assistants. The specific duties of COMB include:

- promulgating rules to regulate professions under its purview that are fair, impartial, and nondiscriminatory;

- conducting investigations, holding hearings, and taking evidence in all matters relating to complaints and potential violations of laws and rules governing the conduct of licensees;
- facilitating the licensure of qualified applicants; and,
- facilitating the licensure of physicians under the Interstate Medical Licensure Compact Act.

Colorado	Colorado Division of Professions and Occupations	Colorado Medical Board
Administrative Duties	✓	
Adopts/Changes Rules and Regulations		✓
Approves/Processes Licenses		✓
Conducts Investigations		✓
Holds Hearings and Rules on Violations		✓

Missouri

Overview of the Umbrella Department

The Division of Professional Registration (MODPR), located within the Department of Commerce and Insurance, oversees a total of 41 professional licensing boards and commissions across several fields, including, but not limited to, healthcare, accountancy, architecture, and engineering.

MODPR provides administrative support, clerical services, financial management, accounting, and budgeting to all the regulatory boards and commissions assigned to MODPR. Apart from these shared services, the boards maintain independent authority over the licensing, investigation, and disciplining of their respective professions.

Overview of the Medical Board

The Missouri Board of Registration for the Healing Arts (MOBRHA) is composed of nine members appointed by the Governor. The powers and duties of MOBRHA include, but are not limited to, the following:

- issuing licenses;
- promulgating rules and regulations;
- processing and investigating complaints; and,
- taking disciplinary action.

Missouri	Missouri Division of Professional Registration	Missouri Board of Registration for the Healing Arts
Administrative Duties	✓	
Adopts/Changes Rules and Regulations		✓
Approves/Processes Licenses		✓
Conducts Investigations		✓
Holds Hearings and Rules on Violations		✓

Direct Regulatory Support Umbrella Department

In the direct regulatory support structure, the umbrella department, in addition to providing administrative shared services, has at least some direct involvement in the regulation of the professions through licensing and investigatory authority. However, the boards still maintain primary control over adopting and modifying rules and regulations that govern the professions the board oversees, setting license qualifications, and acting as the primary regulatory body in disciplinary decisions. The following are examples of states that have implemented a direct regulatory support umbrella structure.

Florida

Overview of the Umbrella Department

The Medical Quality Assurance Division (MQA) of the Florida Department of Public Health (FLDPH) manages or supports 26 regulatory boards and councils responsible for the regulation of 58 professions, including the Florida Board of Medicine (FLBM). FLDPH is primarily responsible for duties including, but not limited to, the following:

- providing administrative shared services to the boards it oversees;
- creating and submitting budgets for all boards under the department's purview;
- appointing executive directors for each board;
- license processing, including the hosting of an online licensing portal; and,
- legal and investigative services, including the receiving and processing complaints against licensees.

Overview of the Medical Board

FLBM is responsible for the regulation of MDs, PAs, anesthesiologist assistants, and medical assistants. FLBM is composed of 15 members who are appointed by the Governor.

While the FLDPH is involved in the disciplinary process, FLBM maintains the authority to adjudicate complaints and hold hearings to decide on potential disciplinary actions. Additionally, FLBM is responsible for adopting rules and regulations and enforcing them through the disciplinary process for all licensees overseen by the board.

Florida	Medical Quality Assurance Division	Florida Board of Medicine
Administrative Duties	✓	
Adopts/Changes Rules and Regulations		✓
Approves/Processes Licenses	✓	
Conducts Investigations	✓	
Holds Hearings and Rules on Violations		✓

South Carolina

Overview of the Umbrella Department

The Department of Labor, Licensing, and Regulation (SCDLLR) oversees 43 boards that regulate professions and occupations across several industries, including healthcare, accountancy, architecture, and real estate, among others.

SCDLLR is responsible for all administrative, fiscal, investigative, inspectional, clerical, secretarial, and license renewal operations and activities of the boards and commissions under its purview. Some of these duties include, but are not limited to, keeping record of board proceedings, maintaining rosters of licensees, determining the boards' financial position, and evaluating professional qualifications and licensing standards.

To assist with its investigative responsibilities, SCDLLR has established an Office of Investigations and Enforcement that is tasked with investigating complaints involving possible violations of a professional or occupational practice act and performing routine inspections.

While the professional boards receive an array of direct support from SCDLLR, the boards maintain ultimate regulation-setting, licensing, and disciplinary authority over their licensees.

Overview of the Medical Board

The South Carolina Board of Medical Examiners (SCBME) is composed of 13 members.

The statutory powers and duties of SCBME and the other boards under SCDLLR include, but are not limited to, the following:

- determining the eligibility of applicants for examination and licensure;
- examining applicants for licensure;
- establishing criteria for issuing, renewing, and reactivating licenses;
- adopting a code of professional ethics;
- evaluating and approving continuing education course hours and programs;
- conducting hearings on alleged violations;
- resolving consumer complaints;
- disciplining licensees; and,
- promulgating regulations.

South Carolina	South Carolina Department of Labor, Licensing, and Regulation	South Carolina Board of Medical Examiners
Administrative Duties	✓	
Adopts/Changes Rules and Regulations		✓
Approves/Processes Licenses		✓
Conducts Investigations	✓	
Holds Hearings and Rules on Violations		✓

Full Regulatory Control Umbrella Department

In the full regulatory control structure, the umbrella department is primarily responsible for the regulation of the licensed professions, with primary control over the adoption of rules and

regulations, and, in many instances, the processing of license applications, investigation of complaints, and adjudication of complaints. The department may still form regulatory boards for some of the professions under its purview, but the board's power is limited to advising the department on potential regulatory changes, acting as expert arbiters in disciplinary proceedings, or serving as ad hoc committee members to research and address regulatory questions such as modifications to professional scopes of practice. The following are examples of states that have implemented a full regulatory control umbrella structure.

Connecticut

Overview of the Umbrella Department

The Connecticut State Department of Public Health (CTDPH) is responsible for regulation and oversight of 82 healthcare practitioner license types, including physicians, as well as licensing for drinking water certification, emergency medical services, environmental health practitioners, environmental laboratory certifications, health care facilities, and restaurants and food establishments.

CTDPH has full regulatory authority for all the professions it oversees, and, as a result, is responsible for the promulgation of rules and regulations, processing of licenses, and investigation of complaints and potential violations against licensees. Final authority in regulatory matters lies with the Commissioner of Public Health (CTDPH Commissioner), who is assisted by advisory boards and commissions in the creation of rules and regulations and adjudication of disciplinary proceedings.

Overview of the Medical Board

The Connecticut Medical Examining Board (CTMEB) is composed of 21 members appointed by the Governor.

The Board is responsible for the following duties:

- hearing and deciding matters concerning suspension or revocation of licensure;
- adjudicating complaints against practitioners;
- imposing sanctions against practitioners where appropriate; and,
- advising the CTDPH Commissioner on the promulgation of rules and regulations.

Connecticut	Connecticut State Department of Public Health	Connecticut Medical Examining Board
Administrative Duties	✓	
Adopts/Changes Rules and Regulations	✓	
Approves/Processes Licenses	✓	
Conducts Investigations	✓	
Holds Hearings and Rules on Violations		✓

**** NOTE:*** *The Connecticut Medical Examining Board advises on promulgation of rules and regulations.*

Utah

Overview of the Umbrella Department

The Division of Professional Licensing (UTDPL) within the Department of Commerce is legislatively charged with administering and enforcing laws related to the licensing and

regulation of approximately 60 categories of licensure, including but not limited to physicians and surgeons, other healthcare professions, accountancy, and architecture. To fulfill its licensing responsibilities, UTDPL has established seven bureaus focused on the regulation of similar groups of occupations and professions.

Each bureau is headed by a bureau manager who is assisted by a board secretary, two or more licensing specialists, and in some cases, several auditors or other licensing or compliance specialists. The staff of each bureau is responsible for processing license applications, answering questions, and responding to other inquiries for each profession within its respective bureau.

To fulfill its investigative responsibilities, UTDPL has established a Bureau of Investigations composed of approximately 30 investigators who are trained and experienced to receive, process, analyze, and investigate complaints. If an investigation reveals that a professional has violated the terms of his or her license, UTDPL is statutorily authorized to take disciplinary action against the licensee.

Overview of the Medical Board

Although UTDPL possesses ultimate regulatory authority, it does maintain discipline-specific boards that provide advisory support for the regulation of their professions. Previously, UTDPL maintained a Physicians Licensing Board with eleven members, which consisted of only physicians, surgeons, and public members. However, effective October 1, 2024, UTDPL replaced the Physicians Licensing Board with the Medical Licensing Board with 15 members, which expanded professional representation to include:

- physicians;
- surgeons;
- osteopathic physicians;
- osteopathic surgeons;
- a physician who is a board-certified psychiatrist;
- physician assistants; and,
- public members.

Boards within UTDPL have the following responsibilities:

- making regulatory and statutory recommendations to UTDPL;
- recommending policy and budgetary matters;
- approving and establishing a passing score for applicant examinations;
- screening applicants and recommending them for licensure;
- assisting with establishing standards of training supervision;
- conducting complaint hearings and acting as presiding officer in complaint hearings; and,
- issuing adjudicative recommendations which UTDPL may accept, modify, or reject.

The boards also collaborate with UTDPL to do the following:

- approve educational programs;
- prescribe license qualifications;
- set rules for licensure;
- define unprofessional conduct;
- establish advisory peer committees to the board and prescribe their scope of authority; and,
- establish conditions for reinstatement and renewal of licenses.

Utah	Utah Division of Professional Licensing	Utah Physicians Licensing Board
Administrative Duties	✓	
Adopts/Changes Rules and Regulations	✓	
Approves/Processes Licenses	✓	
Conducts Investigations	✓	
Holds Hearings, and Rules on Violations	✓	✓

**** NOTE:*** *The Physicians Licensing Board advises on promulgation of rules and regulations.*

Alternatives for Addressing Scope of Practice Questions

In Mississippi and nationwide, the expansion of scopes of practice for non-physician healthcare is an emergent issue that must be addressed by state legislatures. Mississippi lacks an objective body responsible for providing recommendations to the Legislature to address such critical scope of practice issues (e.g., overlapping boundaries of practice) within the various healthcare professions. Without such a body, the Legislature may not have the information it needs to make informed scope of practice policy decisions.

The American Medical Association (AMA) defines "scope of practice" as:

> *activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity.*

State laws and regulations outline the legal scopes of practice for healthcare providers, specifying the types of health services they are authorized to offer and the conditions under which these services may be delivered. This regulatory framework is managed by various state agencies and regulatory boards that vary in authority, autonomy, and control.

Physicians were the first healthcare providers to secure licensure. In almost every state, physicians were granted exclusive authority to practice medicine, which includes almost any activity directed at health or sickness. MISS. CODE ANN. Section 73-25-33 (1) (1972) defines the practice of medicine as:

> *The practice of medicine shall mean to suggest, recommend, prescribe, or direct for the use of any person, any drug, medicine, appliance, or other agency,*

whether material or not material, for the cure, relief, or palliation of any ailment or disease of the mind or body, or for the cure or relief of any wound or fracture or other bodily injury or deformity, or the practice of obstetrics or midwifery, after having received, or with the intent of receiving therefor, either directly or indirectly, any bonus, gift, profit or compensation; provided, that nothing in this section shall apply to females engaged solely in the practice of midwifery.

PEER asked the Board how it addresses scope of practice issues, and the Board provided the following statement:

"The authority of the Board is defined by statute and is limited to specific types of healthcare professions. Other professions are governed by other boards and their enabling statutes. Defining the scope of practice for healthcare professionals not assigned to the regulatory authority of the Board is not within its purview."

Over time, other health care providers (i.e., nurses, nurse practitioners, pharmacists, optometrists, midwives, podiatrists, physical therapists, and clinical psychologists) sought licensure and authority to practice. The scope of practice of non-physicians was carved out from medicine's universal domain by focusing on a single part of the body (e.g., podiatrists and dentists) or a subset of functions pertaining to a body part (e.g., optometrists). Professionals treating the whole person, such as nurses, utilized alternative language to avoid conflicting with the defined scope of practicing medicine. For example, the nursing scope of practice includes the ability to conduct "assessments" instead of "diagnoses" of patients' ailments.

In Mississippi and nationwide, the expansion of scopes of practice for non-physician healthcare professionals is a fraught and emergent issue that must be addressed by state legislatures that are not necessarily equipped with the subject matter expertise to effectively weigh the risks and benefits of proposed expansions.

In the 2024 Regular Session, there were 17 bills seeking to expand the scopes of practice for non-physicians in Mississippi. None of the bills passed.

Some prominent examples of how healthcare professions and legislatures nationwide have attempted to expand scopes of practice include the following examples:

- Pharmacists have sought the authority to modify prescriptions either independently or with a collaborating physician. This scope of practice expansion seeks to increase access to medical care and improve health outcomes for patients by allowing a pharmacist to change to a patient's medication regiment based on their professional judgment and patient health updates to seek the best health outcome without needing a follow up appointment with the prescribing physician. Some physicians argue that allowing pharmacists to independently modify prescriptions may compromise patient safety, as pharmacists typically lack the full clinical training of physicians, and they may not have the comprehensive patient history that physicians possess;
- Nurse practitioners have sought the authority to practice without oversight from a collaborating physician. This expansion of scope of practice could improve access to healthcare in rural areas and could also reduce costs of operation for nurse practitioners.

Some physicians argue that nurse practitioners operating without a collaborating physician could compromise patient safety, because nurse practitioners lack the full clinical training of physicians. Further, some physicians argue that the impact on healthcare access would be negligible because nurse practitioners are no more likely to move to rural areas that need increased access to healthcare as physicians; and,

- Podiatrists have sought allowance to diagnose and treat, including with surgery, ailments of the ankle and lower leg. Because many of the muscles and ligaments extend beyond the foot into the ankle and lower leg, determining when a podiatrist may treat a foot injury that involves such a muscle or ligament can be difficult. As a result, podiatrists are taught in podiatry school and residency training how to treat ailments of these ligaments that extend to the ankle and lower leg and are allowed to treat such ailments in some states. Expanding podiatrists' scope of practice to include treatment of the ankle and lower leg could improve healthcare access and reduce potential confusion for the public, without necessarily sacrificing healthcare quality. However, some physicians contend the podiatrists lack the comprehensive clinical training to properly treat ailments of the ankle and leg and could therefore compromise patient safety.

One argument used in favor of these expansions of scopes of practice is that they will expand access to healthcare for the public, particularly in rural areas located farther from a hospital or other reliable healthcare options. However, AMA, MSMA, and other physician professional associations dispute the effectiveness of these efforts, and as a result have strongly opposed legislation nationwide to expand scopes of practice for non-physicians. In the 2023 Legislative Session alone, there were 11 bills seeking to expand the scopes of practice for non-physician healthcare professionals, all of which were opposed by MSMA, and none of which ultimately passed. In the 2024 Legislative Session, there were 17 bills to expand the scope of practice for non-physicians, none of which passed. In fact, since 2015, 75 scope of practice bills related to 10 different healthcare professions, including podiatrists, nurse practitioners, and physician assistants, have been introduced in the Mississippi Legislature. Only one bill (H.B. 1302, 2021 Regular Session, which expanded the scope of practice for optometrists) has passed the Legislature and become law.

Policymakers should implement scopes of practice for healthcare providers that are consistent with education, training, and licensing standards for each profession. Clear standards and processes for justifying expanding scope of practice could allow for more objective and informed legislation. Further, increased flexibility in the regulatory process could eliminate the need for frequent statutory amendments. The following discussion lists states that have adopted structural reforms to address these policy goals.

Colorado

The Nurse Physician Advisory Task Force for Colorado Healthcare (NPATCH) is a policy task force housed in CODPO that is responsible for "facilitating communication between practices of nursing and medicine." NPATCH is composed of the following 12 members appointed by the Governor:

- five physicians, one of which is a representative of COMB;
- five nurses, one of which is a representative of the Colorado State Board of Nursing (COSBN); and,
- two consumer representatives.

NPATCH may make recommendations related to scopes of practice of health care professions and other related questions to ensure the quality of healthcare in the state but may only do so when there is a consensus of the members of the task force (i.e., "an agreement, decision, or recommendation that all members of the task force can actively support, and that no member actively opposes"). All recommendations are addressed to the executive director of CODPO.

Connecticut

Any person or entity, acting on behalf of a healthcare profession, may request to establish a new scope of practice or change a profession's scope of practice by submitting a written request to CTDPH no later than August 15 of the year preceding the next regular session of the Connecticut General Assembly. If the request meets all the prerequisite requirements for submission, the CTDPH Commissioner shall establish and appoint members to a scope of practice review committee, which must have the following members:

- two members recommended by the requestor to represent the healthcare profession making the request;
- two members recommended by each person or entity that has submitted a written impact statement on behalf of professions directly impacted by the request; and,
- the CTDPH Commissioner or the commissioner's designee, who shall serve as ex-officio, nonvoting member of the committee and the committee's chairperson.

The CTDPH Commissioner may appoint additional members to the committee that include representatives from professions with a proximate relationship to the request if it is deemed that such an appointment would be beneficial to a resolution. The committee will then consider the request, including its potential impact on the health and safety of members of the public, and provide its written findings to the joint standing committee of the General Assembly for matters relating to public health no later than the February 1 following the date of the committee's establishment. The General Assembly may then proceed as it wishes related to the findings of the committee.

Nebraska

The Division of Public Health (NEDPH) within the Department of Health and Human Services oversees the regulation and licensure of 41 health-related professions and occupations, as well as the regulation and licensure of healthcare facilities and services. NEDPH is vested with full regulatory authority over the health professions, including the power to issue licenses, investigate complaints, and discipline licensees. The Nebraska State Board of Health (NESBH), which is housed in NEDPH and is composed of the following Governor-appointed members:

- 13 members from 11 healthcare professions, including MDs, DOs, nurses, and pharmacists;
- one professional engineer;
- one hospital administrator; and,
- two members of the public.

NESBH has the authority to advise NEDPH on matters related to communication and cooperation among the professional boards and to help mediate issues related to the regulation of healthcare professions, including issues of scopes of practice.

An applicant group composed of any health professional group or organization, any individual, or any other interested party, may propose that a health professional group not previously regulated be regulated by the division or that a change be made to the scope of practice of a regulated health profession. To initiate the review process, the applicant group must submit an application and fee to NEDPH. NEDPH, with the advice of NESBH, then appoints a technical committee, with six appointed members and one member from the NESBH who does not have a vested interest in the matter. The committee evaluates the application and compiles a report and recommendations for the NESBH, which then composes its own report for NEDPH. NEDPH then creates a final report and submits it to the Legislature.

In addition to an applicant group, the Director of Public Health and the chairperson of the Health and Human Services Committee or the chairperson in consultation with the members of the Health and Human Services Committee of the Legislature may initiate a directed review to determine the advisability of credentialing a health professional group not previously regulated, of changing the scope of practice of a regulated health profession, or of other issues regarding the regulation of health professions.

Virginia

One of the boards within Virginia's Department of Health Professionals is the Board of Health Professions (VABHP), which consists of one member from each of the state's 13 health regulatory boards and five at-large members appointed by the Governor.

As outlined in its statutory powers and duties, the VABHP has the authority to serve as a forum for resolving conflicts among the health regulatory boards and to examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts.

Recommendations

1. The Legislature should consider amending state law to update the Medical Practice Act to bring it in line with modern best practices for regulating physicians and other professionals regulated by MSBML and implement a repealer to encourage periodic review of the legislation. In particular, the Legislature should consider amendments to:

    - MISS. CODE ANN. § 73-43-3 (1972) to allow for the appointment of consumer members to the Board, and to allow other individuals and entities besides MSMA to nominate candidates for appointment to serve on the Board;
    - MISS. CODE ANN. § 73-25-7 (1972) and MISS. CODE ANN. § 73-25-9 (1972) to reflect current testing practices for licensure of physicians;
    - MISS. CODE ANN. § 73-25-30 (1972) to allow for the issuing of fines as a disciplinary measure for violations; and,
    - MISS. CODE ANN. § 73-25-51 (1972) through MISS. CODE ANN. § 73-25-67 (1972) to reflect that all licensees regulated by MSBML are eligible to participate in MPHP.

2. To help prevent inequitable treatment and unfair penalties, the Legislature should amend MISS. CODE ANN. § 73-25-27 (1972) to require that the Board implement a penalty matrix to guide the Board's decisions regarding appropriate penalties for violations.

3. To ensure fair and impartial investigations and hearings, the Board should:

    - implement further checks and balances into the complaint investigation process in the event that there is disagreement between the Executive Director, Chief of Staff, and Board Attorney about the proper course of action. For example, if there is disagreement, rather than the Executive Director having the authority to make the final decision, the disagreement could be taken to a designated Board member or committee to make an ultimate decision on whether or not to investigate the complaint. If the complaint is investigated and results in a hearing, the Board members involved must recuse themselves from the hearing;
    - implement practices that ensure that labels within its enforcement database are relevant to the investigation being conducted, to ensure that they can be used to effectively as a resource to compare similar cases, and for MSBML and third-party evaluators to analyze trends in information that could identify potential issues and inconsistencies in enforcement decisions and provide rationale for potential changes to statutes, policies, or procedures; and,
    - implement formal policies defining instances of potential bias for Board members and staff, and the appropriate steps for a Board member or staff member to recuse themselves from an investigation or hearing.

4. MSBML should establish performance metrics that can be used to effectively evaluate MPHP, and mandate regular performance audits of the program to ensure its effectiveness and compliance

with its grant authorization. These audits and performance metrics should be defined and mandated in future grant authorization agreements.

5. As a special fund agency, MSBML should develop plans to expend the licensees' funds held in reserve in an efficient and effective manner for the accomplishment of the agency's goals and objectives and for the benefit of its licensees. Part of the Board's plan for its reserves could include utilizing existing funds to financially assist licensees by covering their renewal fees for a period of time.

6. When space is made available, MSBML should work with DFA to move the Board into state-owned office space that is both more affordable and more efficient in its use of space.

7. To address potential structural regulatory inefficiencies, the Legislature should consider, at a minimum, creating a shared services relationship between the boards regulating healthcare professions (e.g., MSBML, Board of Nursing, Board of Pharmacy). Options for a shared services structure could include:

    - requiring all boards regulating healthcare professions to enter into a Memorandum of Understanding to centralize key administrative functions (e.g., finance, IT, reception) to one department that shares services with all boards, to eliminate cost redundancies and improve efficiency; or,
    - creating a shared services relationship between boards regulating healthcare professions and the Mississippi State Department of Health (MSDH), which would allow the boards to maintain full regulatory control while centralizing key administrative functions within MSDH to eliminate cost redundancies and improve efficiency.

    The Legislature should also consider whether to place boards regulating healthcare professions under an umbrella agency with some level of regulatory authority. Options for this model could include:

    - placing boards regulating healthcare professions under the umbrella of MSDH, with the boards maintaining primary regulatory control and MSDH providing administrative shared services and some centralized regulatory support (e.g., a centralized licensing portal, centralized staff for fielding and investigating complaints); or,
    - giving MSDH, or a new board within MSDH comprised of representatives from each healthcare profession, primary regulatory authority for the professions currently regulated by independent boards. In this structure, the boards regulating healthcare professions may still serve in an advisory capacity on regulation changes or serve as jurists in disciplinary proceedings, but final regulatory authority would be held by MSDH or its representative board.

8. To help with issues addressing scope of practice questions, the Legislature should consider adopting a formal system to review and provide legislators with recommendations for how to resolve scope of practice questions as they arise. One example could be the creation of a new committee, comprised of one member from each board regulating healthcare professions, one member of the public appointed by the Governor, and members of professions without board representation (e.g., podiatrists, physician assistants) appointed by the Governor. The committee would have the authority to develop findings and recommendations related to the modifications of scopes of practice. Recommendations could be the result of a consensus of the committee or could be the result of a review conducted for a formal request submitted by members of the public

to expand or modify a profession's scope of practice. Once findings and recommendations are developed, the committee's report would be forwarded to the Legislature so that the recommendations could be addressed in the next legislative session.

Appendix A: Definitions of MSBML License Classifications

License Type	Definition
Administrative	Allows the licensee to engage in professional, managerial, or administrative activities related to the practice of medicine or the delivery of health care services but does not include nor permit the practice of clinical medicine or the right to engage in medical research. The applicant is required to provide a notarized statement which indicates that he or she will not provide medical or clinical services to or for patients while in possession of an administrative medical license.
Limited Institutional	Available only to graduates of foreign medical schools who are employed or are being considered for employment to practice medicine in one or more Mississippi state-supported institutions located in the same county.
Permanent	A permanent license entitles a licensee to practice their profession unrestricted within the state of Mississippi.
Physician Assistant – Certified	Denotes PAs who were board-certified by NCCPA at the time license was issued, which exempts the PA from the requirement to complete 100 hours of continuing medical education (CME) in two years.
Restricted Temporary	Entitles the physician to practice medicine only within the confines of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved postgraduate training program in this state.
Temporary Out-of-State	Allows an out of state post-grad trainee who is in an ACGME or AOA approved training program to rotate into a Mississippi ACGME or AOA-approved training program for up to 4 weeks to learn a specific procedure or technique for their specialty which was not provided in their initial training program.
Volunteer	Available for physicians or physician assistants who are retired from active practice, or who are serving in the military, and wish to donate their expertise for the medical care and treatment of indigent and needy persons or persons in medically underserved areas of the state.
Youth Camp License	Allows nonresident and retired physicians to practice medicine at a youth camp on a temporary basis.

SOURCE: Mississippi State Board of Medical Licensure.

Appendix B: MSBML Fees

License Type		Fee ($)
Initial License		
	Medical/Osteopathic Application	550.00
	Medical/Osteopathic Incomplete Application Fee	50.00
	Restricted Temporary Application	50.00
	Temp Incomplete Application Fee	10.00
	Limited Institutional Application	250.00
	Limited Incomplete Application Fee	10.00
	Out-of-State Resident Training Application	50.00
	Short-term Training Permit Application	25.00
	Podiatry Application	550.00
	Podiatry Incomplete Application Fee	50.00
	Compact Licensure (Fees paid to the Compact)	600.00
	Physician Assistant	550.00
	Physician Assistant Incomplete Application Fee	50.00
	Radiologist Assistant	500.00
	Radiologist Assistant Incomplete Application Fee	50.00
	Acupuncturist	400.00
	Acupuncturist Incomplete Application Fee	50.00
	Limited X-Ray Machine Operators	50.00
	Limited X-Ray Machine Operator Incomplete Application Fee	10.00
	Reinstatement of License Application	250.00
	Youth Camp License Application	25.00
	Volunteer Application	0.00
	Administrative License Application	550.00
	Administrative Incomplete Application Fee	50.00
Renewals (Frequency)		
	Medical/Osteopathic (annual)	300.00
	Podiatry (annual)	200.00
	Physician Assistant (annual)	150.00
	Radiologist Assistant (annual)	150.00
	Acupuncture (annual)	150.00
	Acupuncture Late Renewal Fee	200.00
	Restricted Temporary (annual)	50.00

	Limited Institutional (annual)	100.00
	Limited X-ray Machine Operator (biennial)	50.00
	Out-of-State Training (15 days only)	50.00
	Short-term Training Permit (15 days only)	25.00
	Compact (annual) - (fees paid to the Compact)	0.00
	Volunteer (annual)	0.00
	Administrative License (annual)	300.00
	Late fee for Late Renewal	25.00
	Penalty per month for Late Renewal	5.00
	Medical/Osteopathic (annual)	300.00
	Podiatry (annual)	200.00
License Verification		
	Verification/Certification	25.00
	Physician Profile System (Standard Billing)	500.00
	Physician Profile System (Specialized Billing)	250.00
Miscellaneous Fees		
	Name Change (Wall certificate/Wallet card)	100.00
	Name Change (Wallet Card only)	20.00
	Duplicate Wall Certificate	100.00
	Original Wall Certificate	100.00
	Duplicate Wallet Card	20.00
	Copy Cost (per page)	0.15
	Electronic Copy of Records (CD)	10.00
	Scan Cost (per page)	0.10

SOURCE: Mississippi State Board of Medical Licensure.

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MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

Kenneth Cleveland, M.D. | Executive Director

November 14, 2024

VIA HAND DELIVERY

Mr. James F. (Ted) Booth
Executive Director
PEER Committee
501 North West Street,
Suite 301-A
Jackson, Mississippi 39201

RE: Agency Response to Report Entitled "A Review of the Mississippi State Board of Medical Licensure"

Dear Sir:

Please accept this letter as the official Response of Mississippi State Board of Medical Licensure (MSBML) to the report of the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER) entitled "A Review of the Mississippi State Board of Medical Licensure." The Board appreciates the opportunity to respond to the Report.

The Board believes that much of the report is well-taken and does not require any response. Therefore, in this Response, the Board will focus its attention on those areas where the Board thinks that additional information may be relevant and helpful to consideration of the issues.

RESPONSE TO REPORT NARRATIVE:

Issues Regarding the Medical Practice Act: The Board believes this narrative section of the Report is accurate. The Medical Practice Act should be updated and revised to address the practice of medicine in the twenty-first century. The Board has endeavored to draft and propose legislation to update the law for the last six years, but those efforts have not succeeded. In fairness, the nomination process could be viewed as preferential

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to MSMA. Section 73-43-3 requires the Governor to select from MSMA-proposed candidates. The Governor should be permitted to consider qualified candidates proposed by any legitimate source or organization, including MSMA. The Board has consistently proposed legislation to implement such a change.

Furthermore, Consumer Board Members should be officially recognized and compensated equally on par with Physician Board Members. Additional significant statutory updates the Board supports are contained in 2024 SB2240, which passed the Senate but died in committee in the House.

Issues Regarding the Board's Enforcement Process: The Board disagrees with the statement that "[t]he Board's approach to disciplining its licensees fosters an environment in which potential for bias or prejudgment could occur or be perceived." The nine-person Board reviews, evaluates, and decides each case on its merits. The Board (not the Executive Director) makes findings of fact and conclusions of law as required by statute, assisted procedurally by an Assistant Attorney General who serves as Hearing Officer, and determines the appropriate level of discipline for each case. The Report offered no evidence or examples of bias in the Board's decision-making process. Instead, the Report focuses on the complaint intake and processing procedures.

The Board continues to work on its recent and ongoing changes to the complaint intake and processing portions of the enforcement process. The Board does not agree that the process reflects bias but agrees that the perception of potential bias could be reduced with further changes to the complaint processing system. The Report does not contain any evidence or suggestion of actual inequitable treatment or unfair penalties, merely the potential for a subjective perception that such might hypothetically occur.

Several months ago, a Complaint Committee was established and is working to review and process complaints. This pilot-project is still being tested to evaluate and ensure that both complainants and licensees are given full consideration. Written guidance will be developed regarding this process. As many of the complaints involve complex medical diagnoses, evaluations, and treatments, having a physician on the Committee is critical to the basic understanding of the issues. In many states, the executive director of the licensure board is an attorney, which requires such licensing authorities to employ at least one licensed physician as a medical director in addition to an executive director. In Mississippi, the executive director has traditionally been a licensed physician, which eliminates the need and additional expense of employing a separate medical director. The current Executive Director, Kenneth E. Cleveland, M.D., is a licensed physician, trained as a general surgeon. Therefore, the Executive Director brings specialized medical expertise to the complaint review and decision-making process. The Board believes that combining these roles is both efficient and cost-effective. At the end of the day, one person needs to be in charge and make an informed and educated decision based upon the unique facts and circumstances of each case.

That is the essence of due process and the antithesis of arbitrary and capricious decision making. As this is a new complaint processing procedure, the Board and staff remain committed to fine-tuning the system to ensure that complaint resolution is performed in a fair, equitable, and efficient manner.

One potential refinement would be that if the Committee members cannot reconcile disagreements as to the resolution of a complaint, the default procedure should be requesting that the licensee respond in writing and tasking Investigations to gather additional information.

Issues with the Uniform Disciplinary Actions:

Use of a Penalty Matrix: The appropriate use of a formal written penalty matrix could assist the Board in their decision-making process. President of the Board, Michelle Owens, M.D., has been tasked to prepare a draft matrix for consideration. Review of past Board disciplinary decisions reflects that, in fact, the Board already administers discipline in a fair and uniform manner. However, the use of a penalty matrix, designed to emulate criminal sentencing guidelines, could assist the Board in future decisions as well as reinforce public confidence in Board decisions. Such a matrix would provide a starting point for resolution of infractions of various types and a range of potential levels of discipline based on past Board decisions. The matrix would need to be in the form of guidelines that permit the Board to consider both exacerbating and mitigating factors in determining the appropriate discipline in each case. Imposition of a rigid, inflexible matrix with insufficient allowance for consideration of the unique facts and circumstances of each individual case could easily result in arbitrary and capricious decisions rather than fairness or predictability.

Issues with the Enforcement Database Labels: The Board believes that this is a reporting and data processing issue rather than a substantive issue. Refinement of the labels assigned to incoming complaints could improve efficiency but would not affect the review procedure itself. Beginning in 2020, the Board implemented the use of the Mississippi Enforcement and Licensing System (MELS), a computer system that has replaced hard copy processing of both licensing and investigatory functions. The use of MELS has already substantially increased efficiency and recordkeeping for both of these primary functions. The MELS system was developed and customized for the Board by Thoughtspan Technology, and customized versions of the same basic system are used by the Board of Nursing, and the Board of Pharmacy. On information and belief, the Board of Dental Examiners is implementing a similar system. Every two weeks, meetings are held with the Thoughtspan team, the Board's IT Department, and the Board's Executive Staff to identify and resolve issues or inefficiencies in MELS. Regardless of the labels automatically generated by MELS or subsequently assigned by investigative staff, complaints are processed based on the substance of each complaint, not the label assigned.

Issues with the Board's Lack of a Recusal Rule: When new Board members undergo orientation, they are instructed by the Board Attorney concerning recusal standards and state ethical requirements applicable not only to Board Members but other state officials as well. In practice, Board Members do recuse themselves from certain matters based on personal or professional conflicts of interest. From time-to-time individual Board Members have conferred with the Board Attorney for legal advice concerning the need for potential recusal. Similarly, members of the Staff, including the Executive Director and the Board Attorney, have recused themselves from matters based on actual or potential conflicts. However, formalizing the Board's recusal policy and procedures in a publicly available rule would promote transparency.

Issues Regarding MPHP Oversight: Additional oversight of the Mississippi Physician Health Program (MPHP) is warranted. Efforts to improve and increase oversight have been ongoing since the current Executive Director took the office in 2018. MPHP receives a very substantial grant from the Board to help physicians and other licensees struggling with substance abuse disorders and other illnesses. The primary role of MPHP is threefold: to assist licensees who can be rehabilitated and returned to safe practice to do so, to identify licensees who cannot return to safe practice because of their illnesses, and to provide expert advice to the Board as to each individual licensee who participates in the Program. Further, by law, when the Board has reasonable cause to believe that a physician is unable to practice safely due to mental illness, physical illness, or substance abuse, the Board has a mandatory duty to refer such a physician to an examining committee for evaluation. Through a Memorandum of Understanding and Grant Agreement, MPHP performs the functions of the Examining Committee for the Board, as their special expertise and experience makes MPHP ideal to fulfill this function.

Dr. Scott Hambleton, Chair of the Board of Directors of MPHP, provided the following information as to measures under way to provide increased oversight and transparency concerning MPHP:

Beginning in 2018, MSBML began a process of enhancing the performance and effectiveness of MPHP operations by initiating changes to MSBML Licensure Renewal questions, in response to Federation of State Medical Boards Guidelines, to facilitate licensees' participation in the program.

As of July 19, 2024, MPHP monitored approximately 138 participants. This number represents approximately 1% of the licensed physicians (including podiatrists) in MS. While this number may seem low, it represents a very robust monitoring program, based on a 12% lifetime prevalence of substance use disorders in physicians. Over a 30-year career, this amounts to 0.4% of actively practicing physicians being monitored per year, or 2% of physicians over a 5-year period, which is the usual monitoring contract agreement term. Approximately 25 new physicians begin a monitoring agreement every

year, and 25 physicians complete a 5-year monitoring contract. Over a 5-year period, this represents a total of approximately 240 physicians, representing 1.8% of physicians.

Mississippi typically ranks 50th in terms of physician to population ratio. It is difficult to recruit and retain physicians in our state, so rehabilitation of our physicians is a necessity. MPHP provides an incredibly effective mechanism to safely accomplish this. Studies have demonstrated that physicians practice medicine safely both during monitoring and after successful completion of a monitoring contract, with lower risks of malpractice claims, and significantly enhanced patient safety. (www.FSPHP.org).

Based on physician workforce data from the American Medical Association's (AMA) Economic Impact Study, which is commonly used to assess the economic contributions of physicians nationwide, each physician plays a pivotal role in the broader economy. Here are some key findings relevant to Mississippi (based on typical national models and studies):

- Economic Output: Each physician generates an average of $3.2 million in economic output annually. This output includes revenues from medical services provided by the physician as well as the indirect effects, such as purchases of goods and services, that ripple through the local economy.

- During a 5-year period, based on 240 MPHP physician participants, this amounts to $768 million of economic output that is protected because of MPHP services. If these physicians were not effectively rehabilitated, the negative financial impact on the state would be devastating. Considering the MSBML's annual investment of $600,000 per year for MPHP services, this return on investment is quite remarkable. Also, considering that MPHP services significantly enhance public safety, by assurance of a healthy physician workforce, the value of MPHP to the state is critical.

- Wages and Benefits: The average physician in Mississippi contributes to approximately $1.4 million in wages and benefits paid to workers directly and indirectly supported by their practice.

- State and Local Taxes: Each physician typically contributes over $126,000 in state and local tax revenues, which helps fund essential public services like education, public safety, and infrastructure.

The recommendation for periodic audits of MPHP services is very important. In essence, MPHP provides monitoring and advocacy services for safety-sensitive workers. Appropriately evaluating the effectiveness of these services protects the public. Appropriate evaluation of MPHP services depends on utilization of subject matter experts (SMEs).

The Federation of State Physician Health Programs (FSPHP) has created credentialling services for the treatment providers that physician health programs utilize to evaluate and treat their participants called Evaluation and Treatment Accreditation (FSPHP-ETA™). This accreditation evaluates specific metrics unique to the evaluation and treatment of safety-sensitive workers, including such areas as cohort specific treatment, relapse prevention, fitness for duty, etc. This accreditation process will help to ensure that physician health programs are using the best available resources.

FSPHP has also created a review process to evaluate the performance of individual state physician health programs, called the Performance Enhancement and Effectiveness Review (FSPHP-PEER™). This review process will provide performance metrics for all physician health programs and will be conducted by carefully vetted subject matter experts. The review will evaluate MPHP operations, including governance, internal review, liability and immunity, confidentiality, mandated reporting, informed consent and participation, conflicts of interest, records maintenance, and quality assurance, education and outreach, interjurisdictional monitoring, funding and resource alignment, referral and intake process, monitoring, evaluation and treatment provider selection, elements of monitoring, toxicology testing, professional re-entry, results and relapse data analysis, and others. This review process has been in development for the last several years, with national stakeholder input and oversight and is currently in the Pilot testing phase. MPHP is slated to complete this review in FY25.

MPHP provides a detailed financial report to MSBML on a quarterly basis with financial and income statements, detailing expenses and revenue. Additionally, MPHP provides an annual report detailing activities, and general participant information, including diagnosis, term of monitoring, referral source, compliance, MSBML disciplinary action, licensure status, specialty, and others for each participant.

MPHP undergoes an annual financial audit by Harper, Raines, Knight & Company.

MPHP has recently undergone a significant change in governance, in an effort to improve accountability, streamline operations, and increase transparency by engaging a representative Board with SMEs with expertise in physician impairment, public health, organized medicine, liability, and MSBML regulations. The composition of the new Board of Directors will include one physician representative from each of the Mississippi State Department of Health; the Medical Assurance Company of Mississippi; MSBML; one member of the MSMA Alliance; three physician members of the MSMA Board of Trustees; three physicians who are past participants of the MPHP; and one at-large member. The MPHP is a 501(c)(3) subsidiary of the MSMA, and the MPHP Board of Directors reports to the MSMA Board of Trustees, which governs all MSMA subsidiaries. The MSMA BOT approved the changes to the Board of Directors of MPHP, effective August 2024. This new governance structure will increase the accountability of MPHP staff and operations,

with increased financial transparency. The next scheduled Board meeting is October 24th. One of the first agenda items is to secure funding to conduct a process and procedures audit, at the request of MSBML, to ensure compliance with 501(c)(3) rules and regulations and to inform the decisions of the newly formed Board of Directors.

Issues with the Board's Large Cash Balance: Since the Executive Director took office in 2018, and a Deputy Director with extensive qualifications and experience in accounting and state finance was retained, the Board has developed a substantial cash balance through sound fiscal management. The cash balance has grown from the effects of COVID, the growth of telemedicine, and the expansion of the Interstate Medical Licensure Compact, which have resulted in a large increase in the number of physicians licensed in Mississippi. Prior to COVID, single-state medical licensure was the norm, but post-COVID many physicians hold licenses in numerous states, including Mississippi.

As of June 30, 2024, MSBML had an ending cash balance in its accounts of $10,787,481. Of the ending cash balance, $5.6 million is deferred income that is used for the operations of the agency. MSBML collects licensing fees one time each year. Licensing renewal income ($4.6 million) is collected between May 1 and June 30 for the upcoming fiscal year. The additional growth in collections is a result of approximately 3,000 out-of-state licenses issued to physicians. In this case, the $10,787,481 less the appropriation for FY 2025 of $4,047,338 would leave an ending cash balance of $6,740,143 before deferred income.

Possible Alternatives to Current Regulatory Structure for Healthcare Professionals:

The Report analyzes the approaches that several states have taken to organize healthcare regulation under an umbrella agency or organization with various levels of authority. However, that is a minority position, as most states have not created umbrella entities to oversee healthcare regulation. Use of an umbrella entity would necessarily add a layer to the existing regulatory structure. The Board of Medical Licensure, the Board of Nursing, the Board of Pharmacy, and the Board of Dental Examiners, while not formally linked through an umbrella agency, consult on a frequent basis to promote cooperation, consistency, and high standards, all of which protect public health and safety.

Placing healthcare regulation under an umbrella agency would literally be a step back in time for the State of Mississippi. Prior to 1980-81, all healthcare regulation in the State was under the umbrella of the Mississippi State Department of Health. Apparently recognizing the inefficiencies such a large bureaucracy entailed, the Legislature at that time saw fit to separate the regulation of healthcare professionals into the current constituent Boards. The Report does not discuss the Legislature's decision to decentralize healthcare regulation, nor the potential benefits to such an approach compared with the putative benefits of centralized regulation. Regulation of the various

healthcare professions requires a high level of training, specialization, and expertise. Under the current system, specialists in medical licensure, nursing, and pharmacy are assigned to appropriately regulate and protect the public. Adding an umbrella organization to the current regulatory structure would not reduce the high level of specialization and expertise necessary to protect the public, it would simply add a level of bureaucracy over and above the current structure. The Report also does not take into consideration the expense that such a large regulatory restructuring would entail, potentially offsetting apparent financial gains.

Alternatives for Addressing Scope of Practice Questions:

The authority of the Board is defined by statute and is limited to specific types of healthcare professions. Other professions are governed by other boards and their enabling statutes. Defining the scope of practice for health care professionals not assigned to the regulatory authority of this Board is not within its purview, and this analysis is misplaced when included in a Report about the Board of Medical Licensure.

The specific authority set forth in this Board's enabling statute, Section 73-43-11, reads, in relevant part: "setting policies and professional standards regarding the medical practice of physicians, osteopaths, podiatrists and physician assistants practicing with physician authority," Miss. Code Ann. § 73-43-11(a), and "[t]o promulgate and publish reasonable rules and regulations necessary to enable it to discharge its functions and to enforce the provisions of law regulating the practice of medicine . . . ." Miss. Code Ann. § 73-43-11(g). Physicians have full "scope of practice" subject to the policies, standards, reasonable rules, and regulations promulgated by the Board. The only non-physician licensees subject to scope of practice regulation by the Board are physician assistants, acupuncturists, podiatrists, and radiologist assistants, as the Legislature has assigned such authority over those health professions to the Board. The Board does not oversee or regulate the performance or scope of practice for nurses (licensed practical nurses, registered nurses, nurse practitioners, CRNAs, and other advanced practice nurses), optometrists, chiropractors, dentists, massage therapists, psychologists, pharmacists, or any other type of healthcare worker licensed or certified under state law. Each of those professions is governed by its own regulatory board. The scope of practice for practitioners is determined by the Legislature, set forth in relevant statutes. This Board has clearly defined authority, oversight, and investigative functions that do not include defining the scope of practice for licensees of other regulatory entities.

RESPONSE TO REPORT RECOMMENDATIONS:

Recommendation 1: The Board agrees with Recommendation 1 of the Report suggesting amendments to Section 73-43-3 concerning Board nominations; Sections 73-25-7 and 73-25-9 to reflect current testing practices for licensure of physicians; Section 73-25-30 to allow for the issuing of fines as a disciplinary measure; and Sections 73-25-

51 and 73-25-67 to reflect that all licensees regulated by this Board are eligible to participate in MPHP.

Recommendation 2: The Board agrees in part and disagrees in part with Recommendation 2. Implementation of a penalty matrix could be beneficial, as discussed herein, but statutory implementation is unnecessary. The Board could implement such a matrix through regulation, reviewed and approved by the Occupational Licensure Review Commission.

Recommendation 3: The Board agrees with Recommendation 3 that some refinements to the complaint review and processing procedures could be beneficial. The Board does not agree that the specifics recommended in the Report are warranted.

Recommendation 4: The Board agrees in principle with Recommendation 4. The enhanced oversight procedures already being implemented by and for the Mississippi Physician Health Program, including the use of performance metrics, audits, and financial reporting, should continue.

Recommendation 5: The Board agrees with Recommendation 5 concerning reduction of the cash balance.

Recommendation 6: The Board agrees that its current office space is suboptimal.

Recommendation 7: The Board acknowledges that the Legislature has the prerogative to consider regulatory structural alternatives as stated in Recommendation 7. However, the Report does not contain a full analysis and discussion of potential alternatives or a complete cost/benefit analysis. Healthcare regulation is a highly specialized area and requires substantial expertise. The Report analyzes umbrella regulatory structures used in a minority of states but does not analyze the benefits of decentralized regulation for healthcare professionals, which is the structure chosen by the majority of states. Protection of public health and safety is the guiding principle of medical regulation and should always remain the first and foremost consideration.

Recommendation 8: Recommendation 8 speaks to matters that do not lie within the regulatory authority of the Board. Therefore, the Board does not believe Recommendation 8 is appropriate or properly included in this Report.

Sincerely,

Michelle Y. Owens, M.D., President
Mississippi State Board of Medical Licensure

Kenneth E. Cleveland, M.D., Executive Director
Mississippi State Board of Medical Licensure

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