BACKGROUND PAPER FOR THE PODIATRIC MEDICAL BOARD

Joint Oversight Hearing, March 24, 2025

Assembly Committee on Business and Professions and Senate Committee on Business, Professions and Economic Development

BACKGROUND, IDENTIFIED ISSUES, AND RECOMMENDATIONS

BRIEF OVERVIEW OF THE BOARD

The Podiatric Medical Board of California (PMBC) is a licensing entity within the Department of Consumer Affairs (DCA). The PMBC is responsible for administering and enforcing the parts of the Medical Practice Act that apply specifically to doctors of podiatric medicine (DPMs).

Podiatry is a branch of medicine that focuses on the foot and ankle. In general, DPMs are licensed to diagnose and treat conditions affecting the foot and ankle to the same extent as a physician, including surgery, although DPMs may only perform ankle surgery in specified locations such as licensed general acute care hospitals. DPMs may also conduct partial foot amputations, treat ulcers above the ankle but below the knee, and perform additional services under the direct supervision of a physician and surgeon as an assistant in surgery, regardless of whether the surgery lies within the DPM scope of practice. The PMBC reported a total of 2,378 licensees at the end of Fiscal Year (FY) 2023-24, 131 of whom were enrollees in a postgraduate residency program.

In addition to certifying individual licensees, the PMBC is charged with approving podiatric medical schools and postgraduate residency programs to ensure that their graduates possess the competency to practice in California. Currently, there are nine board-approved podiatric medical schools in the United States, two of which are located in California.

The PMBC's mission statement, as stated in its *2023-2027 Strategic Plan*, is: "To protect and educate consumers of California through licensing, enforcement, and regulation of Doctors of Podiatric Medicine."

Legislative History

The specific regulation of doctors of podiatric medicine (DPMs) began in 1921 with the creation of a medical certificate for the practice of "chiropody."[1] Licensing authority over this new medical practice was given to the Board of Medical Examiners (now the Medical Board of California), under which it remained for nearly a century in one form or another.[2] The practice of chiropody was originally fairly limited, as the statute prohibited DPMs from treating fractures or conducting amputations, and licensees could only perform surgeries to treat "minor foot ailments" such as bunions, abnormal nails, and corns.[3] By 1941, however, the limitations on surgeries below the ankle had been lifted, as had the prohibition on treating fractures.[4]

In 1957, the legislature created within the Board of Medical Examiners the Chiropody Examining Committee, charged with recommending to its parent board whether to certify applicant DPMs.[5] Upon its creation, the committee was originally composed of five professional licensees, to be appointed by the governor.[6] Four years later, in 1961, the legislature added one governor-appointed public member to the committee and renamed it the Podiatry Examining Committee.[7] Then, in 1976, the board's composition was changed to four licensed professionals and two public members, with the governor remaining in charge of all appointments.[8]

In 1983, due to advancements in podiatric education, the legislature expanded the scope of podiatric practice to include treatment of and surgery on the ankle, provided such surgery occurred within specified healthcare facilities and the podiatrist obtained an extra certification.[9] Three years later, the committee was renamed the California Board of Podiatric Medicine, although it retained its subsidiary status under the Medical Board.[10] In 1998, one more public member was added to the board, resulting in the current composition of four professional members and three public.[11] All four professional members and one public member remain governor appointees, but the legislature now has appointment authority over two of the public members.[12] Additionally, in this same 1998 sunset review process, the legislature voted to remove the additional certification requirement for ankle surgery, concluding that any DPM certified after 1984 was adequately trained for such procedures.[13]

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[1] Senate Bill (SB) 412 (Crowley), Chapter 587, Statutes of 1921.
[2] *Id.*; *See also* SB 798 (Hill), Chapter 775, Statutes of 2017 (removing PMBC from MBC jurisdiction).
[3] *See* SB 412 (Crowley), Chapter 587, Statutes of 1921.
[4] Assembly Bill (AB) 2606 (Andreas), Chapter 1116, Statutes of 1941.
[5] SB 1561 (Gibson et al.), Chapter 1057, Statutes of 1957.
[6] *Id.*
[7] SB 481 (Gibson), Chapter 215, Statutes of 1961; SB 115 (Gibson & McCarthy), Chapter 1821, Statutes of 1961.
[8] SB 2116 (Gregorio), Chapter 1188, Statutes of 1976.
[9] AB 563 (Moorhead), Chapter 305, Statutes of 1983.
[10] SB 1879 (Montoya), Chapter 655, Statutes of 1986.
[11] SB 1981 (Greene), Chapter 736, Statutes of 1998; Business & Professions Code (BPC) § 2462.
[12] SB 1981 (Greene), Chapter 736, Statutes of 1998; BPC § 2462.
[13] SB 1981 (Greene), Chapter 736, Statutes of 1998.

In 2017, the Board of Podiatric Medicine was removed from its subsidiary status under the Medical Board of California and created as a standalone entity within the Department of Consumer Affairs.[14] Despite this separation, however, the Board of Podiatric Medicine developed agreements with the Medical Board for several shared administrative services, a practice which continues today.[15]

Finally, in 2019, the board's name was changed to the Podiatric Medical Board of California (PMBC), conforming to the naming convention of the other California medical boards, the Osteopathic Medical Board of California and the Medical Board of California.[16]

Board Membership

Since 1998, the Business and Professions Code (BPC) has specified that the PMBC is composed of seven members, where four are licensed professionals and three are public members.[17] The governor appoints all four professional members and one public member, while the Senate Rules Committee and the Speaker of the Assembly each appoint one public member.[18] Each professional member must have been a citizen of California and have practiced podiatric medicine in the state for five years to qualify for appointment.[19] The public members also must have been a citizen of the state for at least five years prior to appointment and must not be a licensed professional or affiliated with a podiatric medical institution.[20]

The board currently has one vacancy. The seat to be occupied by a governor-appointed member was vacated in 2023 with the expiry of the member's term, and it has yet to be filled.

Board members are appointed for four-year terms, and members may not serve more than two consecutive terms.[21] Under state law governing all boards within the Department of Consumer Affairs, PMBC is required to convene at least two meetings per calendar year, with one meeting held in northern California and one in southern California.[22] In addition to the biannual minimum, the board may convene at any other time it deems necessary.[23] All board meetings are subject to the Bagley-Keene Open Meeting Act.[24] Members are not paid, but they receive a per diem of $100 for each day spent in the discharge of official duties and are reimbursed for travel and other expenses necessarily incurred in the performance of official duties.[25]

[14] SB 798 (Hill), Chapter 775, Statutes of 2017.
[15] Podiatric Medical Board of California (PMBC), *Sunset Review Report 2025*, at 2, 43.
[16] AB 2457 (Irwin), Chapter 102, Statutes of 2018.
[17] SB 1981 (Greene), Chapter 736, Statutes of 1998; BPC § 2462.
[18] BPC § 2462.
[19] BPC § 2463.
[20] BPC § 2464.
[21] BPC § 2466.
[22] BPC § 101.7.
[23] BPC § 2467.
[24] BPC § 2468.
[25] BPC §§ 103, 2016, 2469.

The current PMBC members and their backgrounds are listed in the table below.

Board Members	First Appointment	Term Expiration	Appointing Authority
Carolyn McAloon, President, DPM Member, a graduate of UC Berkeley, Dr. McAloon earned a DPM degree from the California College of Podiatric Medicine in San Francisco. She completed both her primary podiatric medicine and surgical residencies as the Veterans Affairs Palo Alto Healthcare Systems in Palo Alto, CA. This is Dr. McAloon's second term as PMBC President. She is a former president of the California Podiatric Medical Association and a member of the American Podiatric Medical Association. Dr. McAloon is the co-owner of a private practice, Bay Area Foot Care.	12/07/18	6/1/24	Governor
Daniel Lee, PhD, Vice-President, DPM Member, a recipient of a PhD in biomedical sciences from Chulalongkorn University and a DPM degree from the California College of Podiatric Medicine, Dr. Lee completed his postgraduate residency at the Los Angeles County/USC Medical Center. He has been a foot and ankle surgeon with Kaiser Permanente since 2011 and a clinical professor at California Northstate University, College of Medicine since 2013.	7/25/20	6/1/24	Governor
Devon Glazer, DPM Member, a recipient of a DPM degree from New York College of Podiatric Medicine, Dr. Glazer completed his residency in the Cornell/Columbia New York Methodist program. He is scientific chair of the Western Foot and Ankle Conference and is involved in surgeon and fellowship training in reconstructive foot and ankle surgery.	7/24/23	6/1/25	Governor
Sumer Patel, DPM Member, after receiving his DPM degree from the California College of Podiatric Medicine, Dr. Patel completed his residency training at Kaiser Permanente in Santa Clara. Throughout his tenure with Kaiser, Dr. Patel has occupied numerous leadership roles, including appointment as the Physician Operating Room Director and the Assistant Physician in Chief of the Kaiser Santa Clara Medical Center.	7/5/23	6/1/26	Governor
Samantha Yu Chang, Public Member, as founder and CEO of Hoya Insurance Agency, Ms. Chang has grown her company into a leading commercial insurance brokerage in the San Gabriel Valley. She is also a member of the Asian Pacific Islander American Public Affairs Association and the Global Federation of Chinese Businesswomen.	11/15/22	6/1/26	Assembly

Board Members	First Appointment	Term Expiration	Appointing Authority
Darlene Trujillo Elliot, Public Member, a Riverside native, Trujillo Elliot is a dedicated public servant, currently serving as the Riverside Public Utilities Administrative Analyst. In this position, she is responsible for the Electric Energy Division's contracts and agreements. She is also the current President of the Riverside Latino Network and an avid community volunteer, promoting cultural and historical learning opportunities in the Riverside community.	1/27/16	6/1/27	Senate
Vacancy, Public Member			Governor

Committees

Because members of licensing boards often have professional responsibilities outside of their board responsibilities, they are usually only able to meet a few times each year. As a result, boards typically use smaller committees that can meet more frequently, explore issues in-depth, and then make recommendations to the full board at public board meetings.

The PMBC currently has five standing committees, each composed of two board members. Typically, a committee is chaired by a more senior member who can share their knowledge and expertise in the committee's subject matter with the more junior committee member. This helps plan for board-member turnover and succession of committee chairs by transmitting institutional knowledge to newer board members. The five standing committees are as follows:

- *Executive Management Committee*: the board's president and vice-president sit on this committee, which provides guidance to administrative staff who carry out budgeting and organizational operations. The committee is also responsible for directing the fulfillment of recommendations made by the board's other committees.

- *Enforcement Committee*: develops and reviews board-adopted policies and disciplinary guidelines. Although it does not review individual enforcement cases, this committee is responsible for developing and recommending enforcement policies to the board.

- *Licensing Committee*: evaluates existing and proposed regulations on educational and professional requirements by considering developments in technology, podiatric medicine, and standard practices in the healthcare industry.

- *Legislative Committee*: monitors and makes recommendations on legislation that may impact the board's statutory mandate. The committee may also recommend pursuit of specific legislation or amendments to advance the board's mandate of protecting the public.

- *Public Education & Outreach Committee*: develops consumer outreach projects, including the board's newsletter, website, public presentations, and other informational publications.

Committee members may only present the agreed-upon positions of the board and may not opine on matters independently.

Staff

In FY 2023-24, the PMBC had 5.2 authorized staff positions. Board staff size has remained at five employees since at least the 2011 sunset review period, and the board reports no current vacancies or staff turnover during the current sunset review period.

Staff includes an executive officer, appointed by the board, who serves as the executive, administrative, and operational officer, as well as its official custodian of records. By regulation, the executive officer is responsible for carrying out the board's policies by delegating to the civil service staff.[26] The current executive officer is Brian Naslund, who has held the position since October of 2016. The other staff members are an administration analyst, an enforcement coordinator, a licensing coordinator, and an office technician.

Fiscal

The PMBC is a special fund agency and receives no support from the General Fund.[27] The PMBC's fund, the Podiatric Medical Board Fund, is primarily funded through license fee revenues. The largest and most consistent source of revenue is the renewal fee for permanent (non-resident) DPM licenses. Revenue from fines, enforcement cost recovery, application fees, and other sources are relatively insignificant (typically under 10% total).

Averaged across the past four fiscal years, the PMBC's most significant revenue sources were:

- Renewal fees—84.8%
- Enforcement cost recovery—6.0%
- Initial license fees—5.5%
- Investment income—0.91%
- Application fees—0.69%

The PMBC and other licensing boards also try to maintain a healthy fund reserve, a fund balance that can cover economic uncertainties, potential litigation, salary or price increases, and other unexpected expenditures. However, the PMBC's fund reserve balance has declined over the past several fiscal years according to DCA budget reports, which project insolvency in the near future.

At the close of FY 2023-24, the PMBC had 2.8 months in reserve funds and is projected to finish FY 2024-25 with only 0.7 months in reserve. If this structural imbalance continues, DCA projections indicate a negative fund balance by the end of the following FY, FY 2025-26.

[26] *See* 16 CCR § 1399.655.

[27] For more information related to state funds, *see Glossary of Budget Terms*, CAL. DEPT. OF FINANCE, https://dof.ca.gov/wp-content/uploads/sites/352/budget/publications/2008-09/governors-budget-summary/SGBT.pdf.

Fund Condition (Dollars in Thousands)						
	FY 20-21	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25***	**FY 25-26***
Beginning Balance**	$572	$481	$516	$381	$416	$114
Revenues/Transfers	$1,292	$1,424	$1,455	$1,491	$1,463	$1,463
Total Resources	$1,864	$1,905	$1,971	$1,872	$1,879	$1,573
Authorized Budget	$1,510	$1,579	$1,613	$1,617	$1,661	$1,712
Expenditures***	$1,383	$1,388	$1,587	$1,456	$1,769	$1,806
Fund Balance	$481	$517	$384	$416	$110	-$223
Months in Reserve	4.2	3.9	3.2	2.8	0.7	-1.5

* Projections—may not reflect actual values at end of FY.
**May not match prior fund balance due to prior year adjustments.
***Includes reimbursements, e.g. cost recovery for disciplinary actions.

Expenditures by Program Component

PMBC expenditures can be broken down by administrative, licensing and education, and enforcement costs. All licensing boards also pay a pro-rata contribution to cover various administrative services provided by the DCA, which include training and planning, legal affairs, legislative affairs, information technology, communications, public affairs, and investigative services, among other services.

Additionally, PMBC contracts with the Medical Board of California (MBC) for some shared administrative services, including processing fictitious name permits, intake and initial review of complaints, and various tasks related to the finalization of disciplinary actions. The board estimates that expenditures for these tasks would be "four or five times" higher without the shared services agreement, as completing these tasks independently would require hiring additional staff.

Averaged over the past four fiscal years, the top PMBC expenditure categories were as follows:

- Enforcement—45.0%
- Administration—33.5%
- DCA pro rata—12.1%
- Licensing—7.8%
- Examinations—1.6%

The board's expenditure data indicate a general trend of increased costs across all program components. In each component, personnel services appear to be the leading cause of increased costs, likely due to mandated compensation increases for civil service staff.

Fees

The PMBC's fees are established under the Medical Practice Act.[28] The biennial renewal fee for permanent DPM licensees comprised over 90% of the board's fee-based revenue in the past four years and roughly 84% of its total revenue from all sources during the same period. This fee has

[28] BPC §§ 2443, 2499.5.

been increased several times since the late-2010s to ameliorate continual budget shortfalls.[29] Because structural deficits persist, the board is seeking another increase of the biennial renewal fee during this sunset review cycle.

The tables below display all current fee amounts (left) and the recent history of biennial license renewal fees for permanent DPMs (right). All fees are currently set at their statutory maxima.

PMBC Fee Category	Fee Amount	Avg. Yearly Revenue*	% of Fee Revenue*
Delinquency Renewal Pod. Corp.	$150	$1,750	0.12%
Penalty Fee	Variable	$4,750	0.34%
Resident/Limited License	$100	$4,750	0.34%
Duplicate Certificate	$100	$1,750	0.12%
Letter of Good Standing	$100	$4,750	0.34%
Citation Fines	Variable	$2,250	0.16%
Application Fee	$100	$10,500	0.75%
Fictitious Name Permit	$70	$1,750	0.12%
Fictitious Name Permit Renewal	$50	$5,500	0.39%
National Board Certification	$100	$9,750	0.69%
Initial License Fee	$800	$77,500	5.52%
Permanent DPM License Renewal	$1,318	$1,279,000	91.10%
*Averaged across the past four fiscal years			

Date Range	Permanent DPM License Renewal Fee
2002–2019	$900
2019–2021	$1,100
2021–Present	$1,318
2025 Proposals	$1,850–$1,950

Cost Recovery

The Medical Practice Act allows the board to recover certain costs from a licensee who has been subject to an adverse judgment for unprofessional conduct. Under this authority, the board may request that the presiding administrative law judge order payment of reasonable costs incurred during the investigation and prosecution of a case.[30] If a licensee fails to pay the ordered sum of cost recovery, the board may seek to enforce the order in a court of law and is prohibited from reinstating or renewing a license until the balance has been paid.[31]

The PMBC indicates that it exercises its cost recovery authority in most cases where a licensee has violated the Medical Practice Act, including those resolved through stipulated settlement agreements. However, the board typically refrains from pursuing recovery in cases where a license has been suspended or revoked and the licensee does not intend to petition for reinstatement.

Cost recovery is a fairly minor source of revenue, averaging roughly 6% of total revenue during this sunset review cycle. The PMBC reports the following cost recovery data since FY 2020-21:

Cost Recovery	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Total Enforcement Expenditures	$634,000	$532,000	$681,000	$559,000
Cases Eligible for Recovery*	9	7	7	5

[29] *See* SB 1549 (Figueroa), Chapter 691, Statutes of 2004 (making temporary $900 fee permanent); SB 1480 (Hill), Chapter 571, Statutes of 2018 (temporary increase to $1,100 until 2021); AB 3330 (Calderon), Chapter 359, Statutes of 2020 (permanent increase to $1,318).
[30] BPC § 2497.5(a).
[31] BPC § 2497.5(d)–(e).

Cost Recovery	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Cases Recovery Ordered	5	6	2	4
Amount of Cost Recovery Ordered	$59,000	$96,000	$73,000	$193,000
Amount Collected**	$67,000	$85,000	$85,000	$125,000
*Any case of disciplinary resulting from a violation of the Practice Act **BPC § 2497.5(f) allows the Board to deposit cost recoveries as a reimbursement in the previous fiscal year's balance (e.g., a cost recovered in FY 2021-22 may be counted under FY 2020-21).				

Licensing

In general, licensing programs serve to protect consumers of professional services and the public from undue risk of harm. The programs require anyone who wishes to practice a licensed profession to demonstrate a minimum level of competency through education, examinations, and experience. The requirements for podiatric licensure and the scope of podiatric medical practice are detailed in Article 22 of the Medical Practice Act.[32] The act makes it a misdemeanor for an unlicensed person to practice podiatric medicine or to use any title reserved for podiatrists.[33]

The board issues two types of license: doctor of podiatric medicine (DPM) and podiatric resident. Both categories are certified to practice podiatric medicine, but residents may only practice within the confines of their enrollment in a supervised, board-approved postgraduate training program.[34]

The board also issues fictitious name permits, which allow individuals, partnerships, and professional corporations to practice podiatric medicine under an assumed name.[35]

All three board-issued certifications, the DPM license, resident license, and fictitious name permit, expire after two years and must be renewed to avoid delinquency.[36]

The board reports the following license data since FY 2020-21:

		FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Doctor of Podiatric Medicine (DPM)	Active	2198	2210	2241	2247
	Out of State	237	243	252	242
	Out of Country	3	3	2	2
	Delinquent/Expired	340	329	271	257
	Retired	84	59	63	72
	Inactive	15	13	15	15
Resident	Active	130	128	130	131
	Out of State	0	0	0	0
	Out of Country	0	0	0	0
	Delinquent/Expired	0	0	0	0
	Inactive	0	0	0	0
Fictitious Name	Active	302	284	256	258

[32] *See generally* BPC §§ 2460–2499.8.
[33] BPC §§ 2314(a), 2472, 2474.
[34] BPC § 2475.
[35] BPC § 2415.
[36] BPC §§ 2423, 2499.7(a).

Permit	Out of State	0	0	0	0
	Out of Country	0	0	0	0
	Delinquent/Expired	147	173	196	198

DPM Licensing Requirements. Each applicant for a permanent (non-resident) DPM license must complete the following requirements: four academic years of podiatric medical education in a board-approved college or school, amounting to a minimum of 4000 hours of total instruction;[37] at least two years of postgraduate podiatric medical and surgical training in a general acute care hospital approved by the Council on Podiatric Medical Education (CPME);[38] passage of Parts I–III of the American Podiatric Medical Licensing Examination (APMLE) within the 10 years preceding the application;[39] and passage of a background check verifying that the applicant has committed no acts, crimes, or negligent medical practices constituting grounds for denial.[40]

DPMs licensed in another state may obtain certification in California under roughly the same education, residency, and background check requirements. However, such out-of-state applicants only need to show completion of Part III of the APMLE within the preceding 10 years, not the entire exam.[41]

DPM Scope of Practice. DPMs are licensed to practice podiatric medicine, defined as "the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot."[42] However, while DPMs may perform foot and ankle surgeries, there are some limitations on these practices. First, DPMs are not authorized to administer non-local anesthesia; if a procedure requires general anesthesia, it must be administered by another medical professional for whom it is included in their scope of practice.[43] Second, ankle surgery is only permitted within certain specified healthcare facilities licensed under the Health and Safety Code.[44]

In addition to these medical and surgical treatments of the foot and ankle, DPMs are authorized to conduct partial amputations of the foot no further proximal than the Chopart's joint.[45] DPMs may also treat ulcers on the leg below the tibial tubercle.[46] And finally, DPMs may act as an assistant to a surgeon in procedures that would ordinarily fall outside a DPM's scope of practice.[47]

[37] BPC § 2483(a).
[38] BPC § 2484.
[39] BPC § 2486(b).
[40] BPC § 2486(e)–(f).
[41] BPC § 2488.
[42] BPC § 2472(b).
[43] BPC § 2472(c).
[44] BPC § 2472(e).
[45] BPC § 2472(d)(1)(C).
[46] BPC § 2472(f).
[47] BPC § 2472(d)(1)(B).

Podiatric Resident Licensing Requirements. In California, resident trainees in postgraduate podiatric medical and surgical programs must be licensed by the Board, as they are considered practitioners of "podiatric medicine," as defined.[48] The educational qualifications for receiving a podiatric resident license are the same as for a permanent DPM license: graduation from an approved four-year podiatric medical school.[49] However, because Part III of the APMLE is often completed during one's residency, statute only requires completion of Parts I and II within the past 10 years to receive a resident license.[50]

In addition to licensure of in-state podiatric residents, the act provides a pathway for out-of-state residents and instructors to participate in interstate exchange programs. Under this scheme, California hospitals that function as part of the teaching program for approved podiatric medical schools may exchange residents and instructors with other board-approved schools from outside the state.[51]

Podiatric Resident Scope of Practice. The podiatric resident license allows enrollees in postgraduate training programs to practice podiatric medicine within the same scope as a permanent DPM licensee.[52] However, as supervised trainees, resident licensees may only practice podiatric medicine at times and places prescribed by the board-approved postgraduate program in which they are enrolled.[53] Like full DPM licensees, residents are permitted to practice outside the scope of podiatric medicine under supervision: A resident may participate in training rotations outside the scope of podiatric medicine, provided they are supervised by a physician with a medical doctor or doctor of osteopathy degree.[54]

Education

Under the Medical Practice Act, the board is charged with approving schools of podiatric medicine, approving postgraduate residency programs, and promulgating any regulations necessary to set educational requirements.[55] The purpose of PMBC approval is to ensure that school curricula meet the minimum requirements for licensure, and that residency programs adequately prepare graduates for unsupervised practice. As such, applicants for resident and permanent licenses must have attended both a board-approved school and a board-approved residency program.[56] In practice, the board defers to a national accreditation agency, the Council on Podiatric Medical Education (CPME), for accreditations and audits of podiatric medical schools and approvals of

[48] BPC § 2475.
[49] *Id.*
[50] BPC § 2475.1.
[51] BPC § 2475(b).
[52] *See* BPC § 2475.
[53] *Id.*
[54] BPC § 2475(a).
[55] BPC §§ 2483, 2475.2, 2475.3; 16 CCR §§ 1399.662, 1399.666–67.
[56] BPC §§ 2483–88.

residency programs.[57] Although it is not statutorily bound to do so, the board currently has approved every CPME-accredited school.[58]

Podiatric Medical Schools & Colleges. Since the late-2000s, there have been nine CPME-accredited schools, two of which are located in California.[59] However, in 2022, CPME granted candidacy status to two additional podiatric medical schools, one in Pennsylvania and another in Texas.[60] The Texas school, University of Texas Rio Grande Valley, has since advanced to the pre-accreditation stage as of January 2025.[61] If this school becomes nationally accredited, the board may then issue an approval under California law, provided it meets the curricular requirements in the act.[62]

These curricular requirements do not specifically apply to the approval of podiatric medical schools, but rather to the education an applicant must demonstrate to receive a license.[63] In fact, there are no provisions of the act that directly set out requirements for approval of podiatric medical institutions. However, regulations indicate that the board holds educational institutions to the minimum curriculum required of individual licensees, as any graduate from an institution that fails to meet these standards would be ineligible for licensure in California.[64] So, the curricular requirements for individual licensure effectively create curricular requirements for institutions of podiatric medical education.

The curricular standards mandate that licensees complete, and therefore that schools provide, a minimum of 4,000 course-hours over at least four academic years, which amounts to 32 months of actual instruction.[65] The act also requires curricula to include courses on specific subjects. These requirements include an extensive list of courses on systemic and podiatric medicine as well as education on the responsibilities of healthcare providers, such as medical ethics and the detection of domestic abuse.[66]

Apart from the curriculum requirements placed on individual licensees, the act gives little guidance on the approval of podiatric medical schools and colleges. As such, the board typically defers to CPME determinations of whether an institution has capable administration, sufficient resources, fair admission policies, competent faculty, adequate exam passage rates, and other measures of

[57] *See* BPC § 2475.3; 16 CCR §§ 1399.662, 1399.666–67.
[58] *See* 16 CCR §§ 1399.662, 1399.666–67.
[59] *See* 16 CCR § 1399.662; PMBC, *Sunset Review Report 2025*, at 20; *List of Podiatric Medical Colleges*, COUNCIL ON PODIATRIC MED. ED., https://www.cpme.org/podiatric-medical-colleges/list-of-podiatric-medical-colleges/#CA (last visited Feb. 28, 2025).
[60] *List of Podiatric Medical Colleges*, *supra* note 62.
[61] *Id.*
[62] 16 CCR § 1399.662.
[63] *See* BPC § 2483.
[64] *See* 16 CCR § 1399.662.
[65] BPC § 2483.
[66] *Id.*

educational effectiveness.[67] These parameters are evaluated during both the initial accreditation process and in post-accreditation reviews conducted every eight years, or sooner if the institution has recently failed to meet certain measures.[68] Accredited institutions that fall out of compliance are placed under monitoring or probation, followed by withdrawal of accreditation if compliance issues persist, or restoration of good standing if the issues are remediated.[69]

Postgraduate Residency Programs. In addition to approving podiatric medical schools and colleges, the board is charged with approving postgraduate residency programs.[70] Applicants for permanent licensure must demonstrate completion of a board-approved residency program, and applicants for a resident's license must demonstrate current enrollment in such a program.[71] Unlike approvals of schools, the act does directly create guidelines for board approval of residency programs.[72] The act requires that a residency program be approved by CPME and that, in the judgment of the board, reasonably conforms with the Institutional Requirements developed by the Accreditation Council for Graduate Medical Education.[73] This accreditation guide is incorporated by reference into the board's regulations, which also contain additional requirements for residency programs.[74] The additional regulatory requirements include maintenance of a 75% pass rate for Part III of the APMLE among the program's students, provision of emergency medical training through emergency room rotations, and certain administrative requirements.[75]

Postgraduate residency programs are typically three years in duration.[76] While the act merely requires that applicants complete two years of residency training to obtain a license, the CPME reports that, as of 2013, all of its approved residency programs are three-year programs.[77] So, because any board-approved residency must first be approved by CPME, there is effectively a three-year requirement in California unless CPME changes its standards.

Examination

An applicant for a DPM license must have passed Parts I, II, and III of the APMLE for the board to approve their application.[78] Because Part III is typically completed during postgraduate residency, a resident license only requires Parts I and II, which are typically attempted during

[67] *See generally* Council on Podiatric Med. Ed. (CPME), *CPME 120: Standards and Requirements for Accrediting Colleges of Podiatric Medicine* (Apr. 2023).
[68] PMBC, *Sunset Review Report 2025*, at 20.
[69] Council on Podiatric Med. Ed. (CPME), *CPME 130: Procedures for Accrediting Colleges of Podiatric Medicine*, at 15-17 (Apr. 2023).
[70] BPC § 2475.3.
[71] BPC §§ 2475, 2486.
[72] *See* BPC § 2475.3.
[73] *Id.*
[74] *See* 16 CCR § 1399.667.
[75] *Id.*
[76] *CPME FAQs – Residency Programs*, COUNCIL ON PODIATRIC MED. ED., https://www.cpme.org/residencies/cpme-faqs-residency-programs/ (last visited Mar. 6, 2025).
[77] *Compare* BPC § 2484 *with id.*
[78] BPC § 2486(b).

podiatric medical school, and are often requirements for graduation.[79] Part II itself contains two exam parts: a written portion and the Clinical Skills Patient Encounter (CSPE), which was added in 2015. The CSPE is a practical exam designed to test students' knowledge of and proficiency in the clinical tasks needed during residency. All parts of the exam are administered by the National Board of Podiatric Medical Examiners (NBPME).[80]

The act also allows license applicants to complete an exam that the board recognizes as equivalent in content to the APMLE.[81] Board regulations define equivalent examinations to include the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX), the examinations for medical doctors and doctors of osteopathy, respectively.[82]

The board closely tracks the performance of its licensed residents on Part III of the APMLE, as regulations require that residency programs have a passage rate of at least 75% to maintain board approval.[83] The following table illustrates statewide passage rates for Part III since FY 2020-21:

Year	Candidates	Pass %
FY 2020-21	52	100%
FY 2021-22	50	94%
FY 2022-23	65	98%
FY 2023-24	61	95%

Continuing Education

Professions and practices can change over time. For instance, new technology, research, or ethical requirements may increase the level of minimum competence needed to protect consumers. Therefore, some licensing boards require licensees to complete additional training or classes to maintain minimum competence post-licensure. This is usually accomplished through continuing education (CE) or continuing competence requirements at the time of renewal.

The PMBC requires 50 hours of CE every two years to ensure that its licensees receive current information about new concepts, procedures, and practices relevant to the practice of podiatry.[84] The PMBC accepts CE courses directly related to patient care as follows:[85]

- Courses approved by the California Podiatric Medical Association or the American Podiatric Medical Association and their affiliates.

[79] BPC § 2475.1; PMBC, *Sunset Review Report 2025*, at 19.
[80] PMBC, *Sunset Review Report 2025*, at 19.
[81] BPC § 2486(b).
[82] 16 CCR § 1399.660(c).
[83] *See* 16 CCR § 1399.667.
[84] 16 CCR § 1399.669.
[85] 16 CCR § 1399.670.

- Courses certified for Category 1 credit by the American Medical Association, the California Medical Association, or their affiliates.

- Courses certified for Category 1 credit by the American Osteopathic Association or the California Osteopathic Association, or their affiliates.

- Courses offered by approved colleges or schools of podiatric medicine, medicine, and osteopathic medicine.

- Courses approved by a government agency.

- Completion of a podiatric residency program or clinical fellowship in a hospital approved by the PMBC are credited for 50 hours of approved CE.

- Courses approved by the PMBC submitted by providers that do not fall under one of the other listed categories, however the PMBC has only received one application for approval under this category since its 2011 sunset review, which it approved in FY 2014-15.

The PMBC verifies compliance with CE by requiring licensees to self-report completion by submitting a signed declaration of compliance under penalty of perjury during each two-year renewal period.[86] It additionally audits compliance up to once per year, requiring a random sample of 5% of licensees who reported compliance to submit verification.

The PMBC reports conducting two CE audits in the last four FYs. It did not conduct audits during FY 2020-21 due to DCA waivers of CE requirements during the COVID pandemic, which were in effect for healing arts licenses expiring between March 4, 2020, and October 31, 2021.[87] Between the two audits, the PMBC reports that seven licensees failed for a less than 8% failure rate.

Enforcement

The PMBC is responsible for enforcing the requirements of the Medical Practice Act related to DPMs. The purpose of enforcement is to ensure that licensees adhere to licensing requirements and protect the public from the licensees and unlicensed practitioners who do not. To that end, the PMBC is required to investigate potential violations of the act. Due to the PMBC's small staff size, it contracts with the Medical Board of California (MBC) under a "shared services agreement" to handle all complaint intake, desk investigation, and disciplinary action processing.

Like other licensing boards, the PMBC relies on complaints and other information submitted by consumers, licensees, employers, and relevant organizations and governmental entities, including

[86] 16 CCR § 1399.669.
[87] DCA Waivers DCA-20-01, DCA-20-02, DCA-20-27, DCA-20-53, DCA-20-69, DCA-20-89, DCA-21-117, DCA-21-134, DCA-21-152, DCA-21-175, and DCA-21-194 pursuant to Governor's Executive Order N-39-20.

arrest and conviction notices from law enforcement. The PMBC may also open a case based on internal information reviewed by enforcement staff.

Cases without sufficient evidence or that do not allege a violation of either practice act are closed without further action. If the PMBC finds there was a violation, it may take several types of actions depending on the severity of the violation.

For minor violations, the PMBC may send a letter of reprimand, a cease and desist letter, or a notice of warning letter. It may also issue a citation, which may include a maximum fine of up to $5,000, an order of abatement, or both. For more significant violations, it may seek formal disciplinary actions against a license, including probation, suspension, or ultimately revocation. The PMBC can initiate formal disciplinary action by referring the matter to the Office of the Attorney General (OAG) to prepare a case for prosecution in an administrative proceeding. For violations that also involve criminal conduct, the DCA's Division of Investigation (DOI) can also refer the case to law enforcement.

The PMBC reports that it received an average of 141 complaints per FY since FY 2021-22. Approximately 74% of those complaints were from the public. The PMBC referred an average of 139 of the complaints to investigation and closed an average of 132 cases by the end of each FY, although the number of pending cases at the close of FY increased from 49 to 83 during that period.

Cite and Fine. The PMBC uses its cite and fine authority for violations that can be remedied or deterred through an order of abatement or a fine. The PMBC does not issue citations in cases that involve patient harm or otherwise require restrictions on the license to ensure consumer protection. The PMBC has only issued citations to nine licensees in the last four FYs, although some licensees were cited for multiple code violations. The violations in those nine citations were:

1) Five unprofessional conduct violations
2) Two CE audit failures
3) Two failures to maintain adequate records
4) Two failures to comply with records requests
5) One each of aiding unlicensed practice, false or misleading advertising, and violation of condition or term of probation

Enforcement Timelines. Both consumers and licensees benefit from the efficient resolution of investigations and disciplinary proceedings. In FY 2009-10, the PMBC implemented the DCA's Consumer Protection Enforcement Initiative (CPEI), which introduced performance measures and set target cycle timelines with the aim of resolving investigations and disciplinary proceedings in a timely manner.

The CPEI timelines track quarterly statistics for various stages of the enforcement process. The PMBC's primary targets are as follows:

- PM 2—Intake: the average number of days to close a complaint or assign it for an investigation (target average of 10 days).
- PM 3—Investigations: the average number of days to complete the entire enforcement process for cases not transmitted to the OAG for formal discipline (target average of 125 days).
- PM 4—Formal Disciplinary Actions: the average number of days to complete a disciplinary action (target average of 540 days).

Since FY 2021-22, the PMBC reports that it has met its PM 1 and 2 cycle time performance targets but not its PM 3 or 4 targets. PM 3 measures the time it takes to complete investigations for cases that do not result in formal discipline from complaint to disposition, including those that are closed or result in a form of informal discipline. PM 4 measures the time it takes to complete investigations that are referred to the OAG for formal discipline.

	Target Average	FY 2021-22	FY 2022-23	FY 2023-24
PM3 Cycle Time	125	173	154	106
PM4 Cycle Time	540	1,314	1,242	1,017

Because the MBC, DCA, and the OAG handle the PMBC's investigative and prosecutorial duties, these timelines are largely out of the PMBC's control. Still, the PMBC reports that its coordinating staff regularly communicates with the Division of Investigation and the OAG on case status and timelines. The target timelines are discussed further on pages 24–25 under Current Sunset Review Issues, Issue #3: Formal Discipline Timelines.

Additional Background

For additional information regarding the PMBC's responsibilities, operations, and functions, please see the PMBC's *Sunset Review Report 2024*. The report is available on the Assembly Committee on Business and Professions website: abp.assembly.ca.gov/publications/reports.

PRIOR SUNSET REVIEWS: CHANGES AND IMPROVEMENTS

The PMBC was last reviewed in 2020. A total of 9 issues were raised by the Committees at that time. In the PMBC's *Sunset Review Report 2025* and responses to the previous background paper, the PMBC describes actions it has taken to address the recommendations made in the staff background paper for the review. The issues that have not been fully addressed or may still be of concern to the Committees are discussed under "Current Sunset Review Issues."

- **Prior Issue #1: What is the impact of DCA pro rata on PMBC's fund condition?** As in this review cycle, the board faced a structural deficit during its last review. In response to Committee inquiry about DCA pro rata, the board detailed its reliance on DCA services for human resources, contracts, budgets and accounting, IT, and legal services, concluding that the board lacks the staffing to independently meet these demands. The board estimated that, at the time, approximately 15% of their budget was spent on DCA pro rata. In this review cycle, the board averaged expenditure of roughly 12% on DCA pro rata.

- **Prior Issue #2: How much does PMBC pay for MBC enforcement services, and does this shared services agreement increase efficiency?** When PMBC became independent from MBC, the two boards developed a shared services agreement by which MBC completes certain tasks for payment. In the disciplinary context, MBC handles tasks related to complaint intake, initial case review, and document processing. During the last review cycle, PMBC spent an average of $40,000 per year on shared services. According to PMBC estimates, if it completed these tasks independently, it would cost "four to five" times more, as it would require hiring additional staff.

- **Prior Issue #3: Are increased fees the only option to address PMBC's budget shortfalls?** At the end of last review cycle, a temporary $200 fee increase for permanent license renewal was about to expire. The board was proposing to make the temporary increase permanent, plus an additional $218 for a total of $1,318, pursuant to the recommendations of a third-party fee study. This $1,318 figure was ultimately signed into law in a separate bill. The board supported its passage as a necessary compensation for inflation, as renewal fees had not been permanently raised since 2004. However, the board also indicated its willingness to evaluate methods of cost reduction through internal means and discussions with DCA. This fee discussion is continued on page X under Current Sunset Review Issues, Issue #X: License Fee Increases.

- **Prior Issue #4: Does the new test for employment status from the *Dynamex* decision and AB 5 create any complications for licensees working as independent contractors?** The 2018 *Dynamex* decision created a new test for whether a worker is an employee or an independent contractor. Subsequently, AB 5 (Gonzalez), Chapter 296, Statutes of 2019, codified the test, while providing clarifications and carve-outs for certain professions. The board indicates no complications in the field of podiatry, as podiatrists are explicitly exempted from the requirements of AB 5.

- **Prior Issue #5: What is the status of PMBC's implementation of the Fair Chance Licensing Act, and are any statutory changes needed to carry out the Act's intent?** In 2018, AB 2138 (Chiu/Low), Chapter 995, Statutes of 2018, made substantial reforms to the licensing process for individuals with criminal records. This bill, known as the Fair Chance Licensing Act, prevented boards from denying an application for licensure based on past criminal convictions unless the crime was substantially related to the duties of the licensed professional. During the prior review cycle, the board reported that regulations were being developed with OAL to implement the requirements of AB 2138. These regulations have since been finalized and took effect in August 2021.[88] The board did not request any statutory changes to promote the effectiveness of AB 2138.

- **Prior Issue #6: What level of disclosure to patients is appropriate for DPMs subject to probationary status?** Healing arts licensing boards often place licensees on probation as an initial action during disciplinary proceedings for moderate to severe offenses. In 2018, SB 1448

[88] 16 CCR §§ 1399.659.1–2.

(Hill), Chapter 570, Statutes of 2018, required DPMs, among other licensed professionals, to disclose if the licensee has been placed on probation, the length of probation, the alleged reason for probation, and any practice restrictions placed on the licensee. The probation disclosure requirements are narrower for doctors of osteopathy and medical doctors, for whom gross negligence and incompetence are not grounds for mandatory disclosure. PMBC requested in the prior sunset review that DPMs, as surgeons who operate in hospitals alongside DOs and MDs, should be held to the narrower standard. Amendments to this effect were passed and became effective in 2023.

- **Prior Issue #7: What is the status of enforcement efforts by the Division of Investigation's Health Quality Investigation Unit (HQIU) and the Office of the Attorney General (OAG)?** During the prior review cycle, HQIU had faced significant vacancy rates and other administrative issues that greatly increased investigation times. Additionally, OAG significantly increased its per-hour rates for investigations and prosecutions. The board reports that, by the close of the review cycle, HQIU had become adequately staffed and the rate of investigation had improved. Additionally, the board had stopped utilizing OAG for the investigation phase of enforcement actions. Instead, the board only uses OAG for prosecution, which improves cost-effectiveness, especially in light of OAG's recently increased rates.

- **Prior Issue #8: Are there any technical changes that would improve the effectiveness of the laws governing podiatric medicine?** PMBC requested certain technical changes to the code section relating to fees.[89] First, PMBC requested the elimination of the word "wall" from subdivision (f). Second, the board requested deletion of two fees, the duplicate renewal receipt and the endorsement fee, as they are duplicative and not used.

[89] Located in BPC § 2499.5.

CURRENT SUNSET REVIEW ISSUES

This section covers new and unresolved issues relating to the PMBC. It includes background information and committee staff recommendations for each issue. Committee staff has provided this paper to the PMBC and other interested parties, including the professions, so that they may respond to the issues and recommendations.

BUDGET ISSUES

ISSUE #1: LICENSE FEE INCREASES. ***The PMBC reports that its statutory fees are currently insufficient to cover its ongoing expenditures. Should the PMBC be authorized to charge additional or increased fees for license applications and renewals, and if so, in what amounts?***

Background: This issue is a continuation of fees issues discussed in the PMBC's last two sunset reviews, Issue #1 from the PMBC's 2016 sunset review Issue #3 from the PMBC's 2020 sunset review.[90] As discussed on pages 6–7, the PMBC continues to operate at a deficit relative to its authorized budget. Additionally, as discussed on pages 7–8, the PMBC relies entirely on fee revenue, and 90% of fee revenue is generated by the biennial license renewal fee.[91]

Recent Budget & Fee History. Between 1989 and 2001, the biennial license renewal fee was statutorily set at $800.[92] In 2001, the legislature enacted a temporary increase to $900, which was then made permanent in 2004.[93] The renewal fee and all other ancillary fees remained at their 2004 levels through the 2016 sunset review. In the 2016 sunset report, the board attached the results of a fee audit which found that service-based fees had not kept pace with the actual cost of providing those services, such as issuing letters of good standing or duplicate certificates.[94] In response, these service fees were then increased in 2017 to match the estimated cost of providing the service associated with each fee.[95]

By FY 2017-18, board expenditures had significantly eclipsed its fee revenues, leading to yearly declines in reserve funds. From FY 2015-16 to FY 2017-18, the reserve balance declined from 12.4 months in reserve to a mere 6.6 months.[96] Thus, in 2018, the legislature passed SB 1480 (Hill, Chapter 571, Statutes of 2018) which deleted an obsolete fee for an oral examination and

[90] Senate Comm. on Bus., Pros., & Econ. Dev. & Assembly Comm. on Bus. & Pros., *Background Paper for the Board of Podiatric Medicine* (2016), at 18; Senate Comm. on Bus., Pros., & Econ. Dev. & Assembly Comm. on Bus. & Pros., *Background Paper for the Podiatric Medical Board of California* (2020), at 17.
[91] For detailed budget and fee data, *see* PMBC, *Sunset Review Report 2025*, at 10–12, Attachment E–PMBC: Sustainable Fund Condition Options (Oct. 2024).
[92] *Compare* SB 1330 (Presley), Chapter 801, Statutes of 1989, *with* SB 724 (Figueroa et al.), Chapter 728, Statutes of 2001.
[93] SB 724 (Figueroa et al.), Chapter 728, Statutes of 2001; SB 1549 (Figueroa), Chapter 691, Statutes of 2004.
[94] PMBC, *Sunset Review Report 2016*, at Exhibit C–PMBC Draft Fee Audit Report.
[95] SB 547 (Hill), Chapter 429, Statutes of 2017.
[96] PMBC, *Sunset Review Report 2020*, at 13.

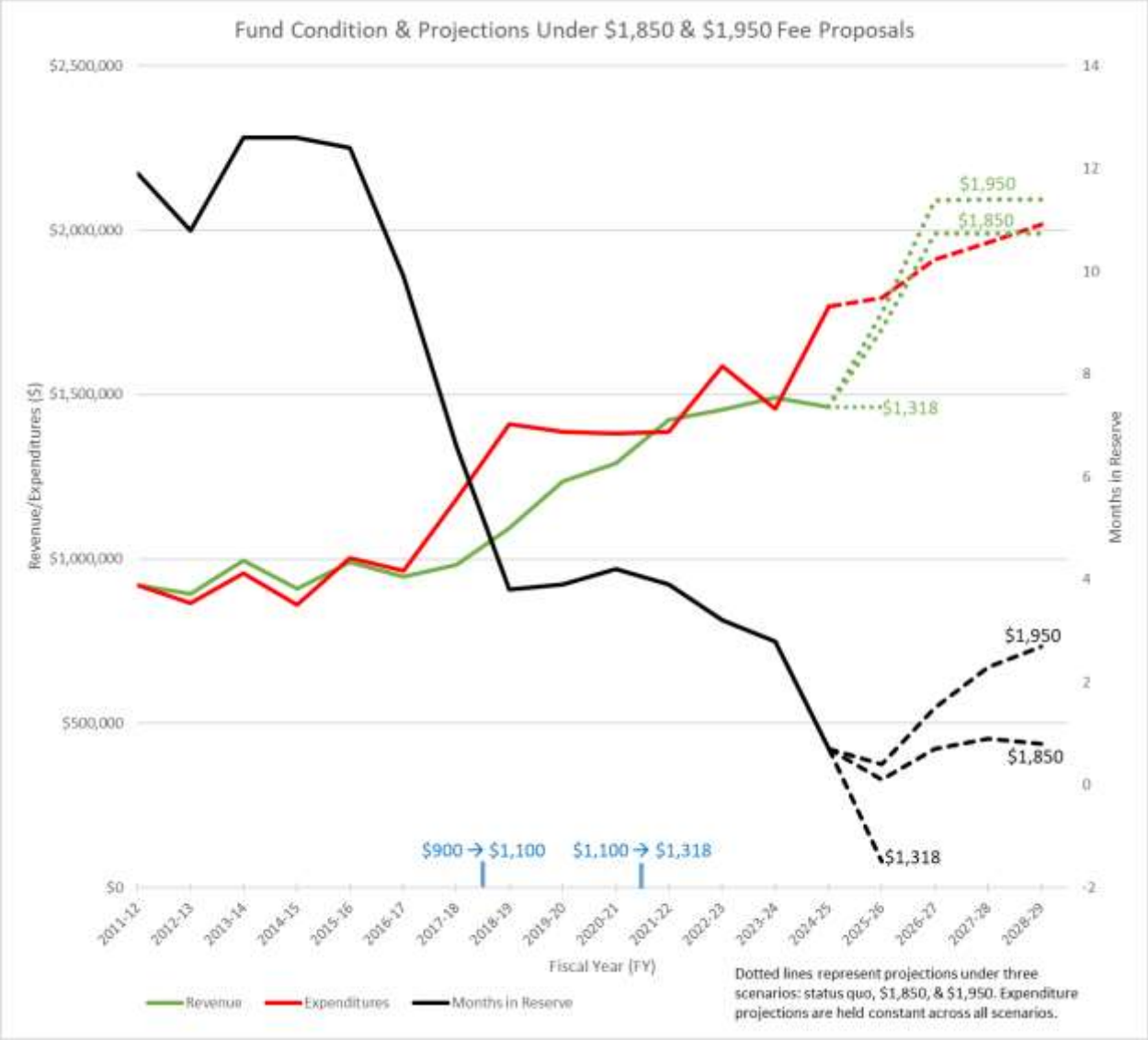
temporarily increased renewal fees from $900 to $1,100 for two years. However, this temporary increase did little to offset the rapidly rising costs, as outlined in a 2019 fee audit included in the board's 2020 sunset review.[97]

The 2019 fee audit, completed by Monetary Resources Group (MRG), concluded that the PMBC's fund reserve remained in decline and that approximately half of the board's expenditures remained out of its control. In response, MRG proposed two fee scenarios to avoid insolvency. MRG suggested that, at a minimum, the board should make the temporary $1,100 renewal fee permanent, which would provide near-term solvency.[98] MRG further recommended that, to begin replenishing the depleted fund reserve, the board should consider increasing the renewal fee to $1,318. In MRG's estimation, this would raise about $300,000 each year to provide long-term stability and allow the board to reach the standard DCA target of 12 months in reserve.[99] The board elected to pursue the latter path, and following the 2020 sunset review, AB 3330 (Calderon, Chapter 359, Statutes of 2020) was passed to codify the recommended $1,318 renewal fee, effective in 2021.

Current Budget & Fee Proposals. Despite the 2021 fee increases, the board's current fiscal data indicate deficits in two of the past four fiscal years and projected deficits this year and next.[100] Additionally, the decline in reserve funds that occurred between FY 2015-16 and FY 2019-20 was not remediated by the 2021 fee increase.[101] The fund reserve remains around 3 months and is projected to fall in the near future, resulting in insolvency by FY 2025-26.[102] As the board is primarily funded through fee revenue, and roughly 90% of fee-based revenue comes from the biennial license renewal fee, the board is requesting increased renewal fees during this sunset review process.

PMBC proposes two scenarios for increasing the $1,318 biennial license renewal fee: $1,850 and $1,950.[103] Under the $1,850 scenario, factoring in projected increased costs, the board expects to stabilize the declining fund reserve before the board reaches insolvency. However, under this scenario, the board projects that revenues will remain roughly equal to expenditures, so the fund reserve will not be replenished and will remain below 2 months.[104] On the other hand, the $1,950 proposal, evaluated under the same expenditure projections, will create a surplus of around $100,000 per year to begin replenishing the dwindling fund reserve.[105] See chart below for historical and projected fund conditions.

[97] *See* PMBC, *Sunset Review Report 2020*, at Attachment C–PMBC Final Fee Audit Report (Nov. 2019).
[98] *Id.*
[99] *Id.*
[100] *See* PMBC, *Sunset Review Report 2025*, at 10.
[101] *See id.*
[102] *Id.*
[103] S*ee Id.* at Attachment E–PMBC: Sustainable Fund Condition Options (Oct. 2024).
[104] *Id.*
[105] *Id.*



Staff Recommendation: ***The PMBC should continue to work with the committees on ensuring fees are set at the appropriate amounts.***

EDUCATION ISSUES

ISSUE #2: EXAM FOR OUT-OF-STATE APPLICANTS. ***Should the 10-year limitation on Part III exam validity be eliminated for out-of-state license applicants?***

Background: Current statute provides that podiatrists licensed in another state may receive a license in California under specified conditions, through a process known as "credentialing." One condition for credentialing is that the applicant must have passed Part III of the APMLE, the

clinical skills exam administered by the National Board, within the past 10 years.[106] As such, a podiatrist licensed in another state who has passed the national exam and practiced for over a decade would be required to retake Part III of the APMLE if they wish to be certified in California. However, newly-licensed podiatrists in another state, having passed the APMLE within the past 10 years, have an easier time securing a license in California. Stakeholders have expressed concern that this 10-year requirement is unduly restrictive to experienced podiatrists, discouraging them from establishing their practice in California, and that the rationale under which it was originally created has lost relevance.

History of Credentialing. The 10-year Part III exam requirement for credentialing was introduced alongside a series of licensing reforms in the early 2000s.[107] Earlier versions of the licensing statute had neither a credentialing provision nor a 10-year limitation on exam validity. It merely required that all applicants, both in-state and credential, had passed the national exam at some time after 1958.[108] However, by 2000, podiatric medicine and education had advanced significantly beyond its scope in the 1960s.[109] To ensure competence in modern podiatry, the licensing statute was amended to require passage of Parts I-III of the APMLE within the 10 years preceding an application.[110] Because there was still no provision for credentialing, this update would force decade-long practitioners in another state to retake the entire exam upon applying for a California license. To relax this burden, the legislature enacted the credentialing provision that remains in effect today, which mandates passage of only Part III of the APMLE within the past 10 years.[111]

Parity Between In-state Renewal & Credentialing. At the time of its passage in 2003, the 10-year Part III exam requirement for out-of-state licensees imposed a burden roughly equal to that of in-state licensees seeking a renewal. To secure in-state license renewal at that time, statute required fulfillment of one continuing competence criterion from a list of eight options.[112] Like the 10-year exam validity for out-of-state credential licenses, these in-state renewal criteria were passed to ensure competence in an era when "some DPMs were surgically trained, and others were not, dependent upon their year of graduation from podiatric medical school."[113] In fact, one of the eight options to demonstrate competence for in-state renewal was completion of Part III of the APMLE within the past 10 years, mirroring the credentialing requirement for out-of-state licensees.[114] As such, the exam requirement for credentialing did not make out-of-state licensure significantly more

[106] BPC § 2488(b) (applicants may also have completed, within the past 10 years, an exam the Board has deemed "equivalent," which is defined in 16 CCR § 1399.660(c) to include the relevant parts of the national exams for medical doctors and doctors of osteopathy).
[107] SB 363 (Figueroa), Chapter 874, Statutes of 2003; *See also* AB 2888 (Comm. on Consumer Prot., Gov. Efficiency, & Econ. Dev.), Chapter 568, Statutes of 2000; SB 1981 (Greene), Chapter 736, Statutes of 1998; SB 1955 (Figueroa), Chapter 1150, Statutes of 2002.
[108] *See* AB 2743 (Frazee), Chapter 1289, Statutes of 1992.
[109] Assembly Comm. on Bus. & Pros., *AB 826 (Chen) Bill Analysis* (2023).
[110] AB 2888 (Comm. on Consumer Prot., Gov. Efficiency, & Econ. Dev.), Chapter 568, Statutes of 2000.
[111] SB 363 (Figueroa), Chapter 874, Statutes of 2003; BPC § 2488(b).
[112] SB 1955 (Figueroa), Chapter 1150, Statutes of 2002.
[113] Assembly Comm. on Bus. & Pros., *AB 826 (Chen) Bill Analysis* (2023).
[114] SB 1955 (Figueroa), Chapter 1150, Statutes of 2002.

difficult than qualifying for in-state renewal. The only difference was that, where in-state licensees seeking renewal had eight options to demonstrate continuing competence, credential license applicants could only fulfill option (h) from that list, completion of APMLE Part III within the past 10 years.[115]

However, the continuing competence measures for in-state renewal were eliminated by AB 826 in 2023, as the PMBC concluded that they had outlived their necessity.[116] In support of the bill, the board wrote, "[t]he concerns from 25 years ago are no longer present and the Podiatric Medical Board of California no longer supports the additional renewal requirements."[117] Since these continuing competence requirements no longer exist, applicants for a credential license now face significantly greater burdens than those of in-state licensees seeking a renewal. And, because the surgical education disparity that justified the in-state renewal requirements has been resolved, the 10-year limitation on exam validity for credential licenses may have similarly outlived its original rationale.

Staff Recommendation: ***The PMBC should evaluate and advise the committees on whether the 10-year exam validity for out-of-state credential applicants remains necessary.***

ENFORCEMENT ISSUES

ISSUE #3: ENFORCEMENT TIMELINES FOR SHARED SERVICES. ***The PMBC, which relies on the MBC for its enforcement services, reports that it is unable to meet its target cycle times for two of its performance measures, Performance Measures 3 (PM3) and 4 (PM4). What could the PMBC do to meet its targets, or should the PMBC revisit the way it tracks and utilizes enforcement data?***

Background: This issue is related to Issue #2 from the PMBC's 2020 sunset review, Shared Services.[118] All licensing boards under the DCA have target enforcement cycle timelines to ensure the timely resolution of complaints and disciplinary cases. As discussed under Enforcement Timelines on pages 16–17, the PMBC is unable to meet its PM3 (125 days) and PM4 (540 days) targets.

The timelines are not significantly off-target compared to other DCA boards, and PM4 is rarely met by any board. Regardless, the PMBC has almost no control over the investigative and probationary timelines. According to PMBC staff, under a shared services agreement, the MBC handles the PMBC's intake and desk investigations while the DCA's Division of Investigation (DOI) handles field investigations. The PMBC's enforcement coordinator just coordinates with MBC, DOI, and, in the event of disciplinary action, the OAG.

[115] *Compare id., with* SB 363 (Figueroa), Chapter 874, Statutes of 2003.
[116] AB 826 (Chen), Chapter 122, Statutes of 2023.
[117] Assembly Comm. on Bus. & Pros., *AB 826 (Chen) Bill Analysis* (2023).
[118] Senate Comm. on Bus., Pros., & Econ. Dev. & Assembly Comm. on Bus. & Pros., *Background Paper for the Podiatric Medical Board of California* (2020), at 16–17.

To the extent the enforcement coordinator is able to refer cases between the various other entities and close cases in a timely manner, it is unclear what more the PMBC could do to meet the targets, which are actually just the MBC's targets. Unlike situations where private contractors can compete for business, the MBC is essentially the only entity that can currently perform the work the PMBC is ultimately responsible for. According to the PMBC, it is too small an organization to handle its own investigations without significant cost. As a result, in the unlikely event the MBC is unable to perform the PMBC's investigations, the PMBC may wish to have alternatives on hand to meet its consumer protection mandates.

Staff Recommendation: ***The PMBC should discuss whether it has considered alternatives to its MBC shared services agreement aside from hiring its own enforcement staff. The PMBC should also discuss how it differentiates time spent by board staff and time spent by staff at other entities.***

PRACTICE ISSUES

ISSUE #4: TREATMENT OF PODIATRY AS MEDICINE. ***As podiatric education and practice continues to grow into alignment with physician education and practice, what meaningful distinctions remain between the professions when providing the same services?***

Background: While existing law limits DPM scope of practice to the foot and ankle, the services commonly provided within that scope are held to the same standard of care as those provided by a physician, including those provided by a podiatric surgeon.[119] Aside from the ability to manage complex conditions that fall outside the DPM scope, there do not appear to be any differences remaining between the specific services provided.

However, stakeholders note that, even if providing the same services in the same settings, podiatrists are still treated as non-physicians. For example, there have been reports of health plans that categorize podiatrists as "ancillary providers" or other types of non-physicians which decreased their reimbursement rate by as much as 50% for the same procedures provided by physicians. Situations like this may serve as disincentive to provide services in these settings or to even enter the profession in the first place.

The issue of DPM parity with physicians and surgeons is not new. In 2011, the California Medical Association, California Orthopaedic Association, and the California Podiatric Medical Association formed a joint task force with the specific goal of aligning podiatric education with physician education, making podiatric graduates simply medical graduates. While that work is ongoing, there may still be instances where podiatrists are treated differently than physicians that may unnecessarily disadvantage providers or impact access to care.

[119] *See* BPC § 2222.

Staff Recommendation: ***The PMBC should share any discussions it may have had on the topic of parity with physicians and surgeons.***

EDITS TO THE PRACTICE ACT

ISSUE #5: TECHNICAL EDITS. ***Are there technical changes to the Practice Act that may improve the PMBC's operations?***

Background: There may be technical changes to the PMBC's Practice Act that are necessary to enhance or clarify the act or assist with consumer protection. For example, PMBC staff have requested technical changes relating to outdated fees.

Staff Recommendation: ***The PMBC should continue to work with the committees on potential changes.***

CONTINUED REGULATION OF THE PROFESSION

ISSUE #6: SUNSET EXTENSION. ***Should DPMs continue to be regulated and licensed under the PMBC?***

Background: Consumers continue to benefit from the licensure of podiatric practice, and the PMBC and its staff continue to work well with the legislature in implementing its consumer protection mission. However, persistent questions remain about the board's long-term sustainability as an independent regulatory agency, given the relatively small licensing population amidst continually rising costs of program administration and operations.

As discussed in earlier sections of this paper, the PMBC is almost entirely funded through licensing fees, and the license population is not showing significant growth. While the PMBC runs a lean program with only five permanent staff members, it also relies on the MBC to achieve cost savings for the majority of its enforcement processes and functions.

Some of the other regulatory programs that have previously relied on MBC infrastructure, such as the Physician Assistant Board (PAB), are now completely independent of MBC and handle their licensing and enforcement processes on their own. The PAB is no longer subject to a shared services agreement with MBC. However, the PAB licenses almost 18,000 physician assistants, as opposed to the PMBC's approximately 2,000 licensees and, while costs have increased for all programs within the DCA, the PAB has functioned without a fee increase for 20 years.

As noted under Prior Issue #2 on page 18, the PMBC would have to hire additional staff if were to take on the enforcement functions provided under the shared services agreement, an option that is clearly unavailable given the current fund condition. The PMBC's smaller staff has been able to meet all of the program's requirements but, as was raised during the prior sunset review, it would be helpful for the Committees to understand what alternatives exist to ensure robust regulation of

DPMs and whether it remains feasible for PMBC as a standalone board to continue to regulate such a small licensing population given the increased costs of doing so.

Still, the PMBC's current regulation of DPMs is necessary to protect consumers. While the question of long-term sustainability and the other outstanding issues noted in this background paper still need to be addressed, the PMBC and its staff are aware and communicating with the committees and their staff on next steps.

Staff Recommendation: ***The PMBC's current regulation of DPMs should be continued and reviewed again on a future date to be determined.***