COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2025 Sunset Review

Medical Practice Act

October 15, 2025

COLORADO
Department of
Regulatory Agencies
Executive Director's Office

October 15, 2025

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado General Assembly established the sunset review process in 1976 as a way to analyze and evaluate regulatory programs and determine the least restrictive regulation consistent with the public interest. Pursuant to section 24-34-104(5)(a), Colorado Revised Statutes (C.R.S.), the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) at the Department of Regulatory Agencies (DORA) undertakes a robust review process culminating in the release of multiple reports each year on October 15.

A national leader in regulatory reform, COPRRR takes the vision of their office, DORA and more broadly of our state government seriously. Specifically, COPRRR contributes to the strong economic landscape in Colorado by ensuring that we have thoughtful, efficient, and inclusive regulations that reduce barriers to entry into various professions and that open doors of opportunity for all Coloradans.

As part of this year's review, COPRRR has completed an evaluation of the Medical Practice Act. I am pleased to submit this written report, which will be the basis for COPRRR's oral testimony before the 2026 legislative committee of reference.

The report discusses the question of whether there is a need for the regulation provided under Article 240 of Title 12, C.R.S. The report also discusses the effectiveness of the Colorado Medical Board in carrying out the intent of the statutes and makes recommendations for statutory changes for the review and discussion of the General Assembly.

To learn more about the sunset review process, among COPRRR's other functions, visit coprrr.colorado.gov.

Sincerely,

Patty Salazar
Executive Director

Medical Practice Act

Background

What is regulated?

Physicians work in a variety of both clinical and non-clinical settings, including hospitals, physician offices, insurance companies, and government agencies and they work to address injuries, illness, and health maintenance through diagnosis and treatment.

Physician assistants examine, diagnose, and treat patients, sometimes under the supervision of a physician, and may work in teams with physicians, surgeons, or other healthcare professionals.

Anesthesiologist assistants help with the coordination and implementation of care as a part of an anesthesia care team before, during, and after surgical procedures.

Why is it regulated?

Physicians, physician assistants, and anesthesiologist assistants hold positions of trust with the patients that they work with. Medical treatment, if performed improperly, can cause significant damage to a patient, and in instances where the patient's life is at risk, improper treatment can lead to death.

Who is regulated?

At the end of fiscal year 23-24, there were 40,796 total active licenses administered by the Colorado Medical Board (Medical Board), which is housed in the Division of Professions and Occupations.

How is it regulated?

The Medical Board oversees the licensure and regulation of physicians, physician assistants, and anesthesiologist assistants in Colorado as specified in the Medical Practice Act (Act). The Medical Board is tasked with the issuance of licenses and is required by statute to establish an application process for examination, initial licensure, and license renewal, as well as imposing discipline for violations of the Act.

What does it cost?

In fiscal year 23-24, expenditures associated with the Act amounted to $3,974,013 and 8.75 full-time equivalent employees were allocated to the program.

What disciplinary activity is there?

During the sunset review period of fiscal years 19-20 through 23-24, a total of 1,721 complaints were filed and 117 disciplinary actions were taken against licensees.

Key Recommendations

- **Continue the Medical Practice Act for nine years, until 2035.**
- **Allow the President of the Board to serve as a full member at licensing panel meetings.**
- **Amend the composition of the Board to include three physician assistants and five public members.**

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Background

Sunset Criteria

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) within the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are guided by statutory criteria and sunset reports are organized so that a reader may consider these criteria while reading. While not all criteria are applicable to all sunset reviews, the various sections of a sunset report generally call attention to the relevant criteria. For example,

- In order to address the first criterion and determine whether the program under review is necessary to protect the public, it is necessary to understand the details of the profession or industry at issue. The Profile section of a sunset report typically describes the profession or industry at issue and addresses the current environment, which may include economic data, to aid in this analysis.
- To address the second sunset criterion--whether conditions that led to the initial creation of the program have changed--the History of Regulation section of a sunset report explores any relevant changes that have occurred over time in the regulatory environment. The remainder of the Legal Framework section addresses the fifth sunset criterion by summarizing the organic statute and rules of the program, as well as relevant federal, state and local laws to aid in the exploration of whether the program's operations are impeded or enhanced by existing statutes or rules.
- The Program Description section of a sunset report addresses several of the sunset criteria, including those inquiring whether the agency operates in the public interest and whether its operations are impeded or enhanced by existing statutes, rules, procedures and practices; whether the agency or the agency's board performs efficiently and effectively and whether the board, if applicable, represents the public interest.
- The Analysis and Recommendations section of a sunset report, while generally applying multiple criteria, is specifically designed in response to the fourteenth criterion, which asks whether administrative or statutory changes are necessary to improve agency operations to enhance the public interest.

[1] Criteria may be found at § 24-34-104, C.R.S.

These are but a few examples of how the various sections of a sunset report provide the information and, where appropriate, analysis required by the sunset criteria. Just as not all criteria are applicable to every sunset review, not all criteria are specifically highlighted as they are applied throughout a sunset review. While not necessarily exhaustive, the table below indicates where these criteria are applied in this sunset report.

Table 1
Application of Sunset Criteria

Sunset Criteria	Where Applied
(I) Whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare.	• Profile of the Profession • History of Regulation • Recommendation 1
(II) Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less, or the same degree of governmental oversight.	• History of Regulation • Recommendation 6
(III) If the program is necessary, whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms.	• Legal Summary • Recommendation 6
(IV) If the program is necessary, whether agency rules enhance the public interest and are within the scope of legislative intent.	• Legal Summary • Recommendation 4
(V) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters.	• Legal Summary • Program Description and Administration • Recommendations 2 & 5
(VI) Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively.	• Program Description and Administration • Recommendations 2 & 4
(VII) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.	• Program Description and Administration • Legal Summary • Recommendation 3
(VIII) Whether regulatory oversight can be achieved through a director model.	• Complaints
(IX) The economic impact of the program and, if national economic information is not available, whether the agency stimulates or restricts competition.	• Profile of the Profession

Sunset Criteria	Where Applied
(X) If reviewing a regulatory program, whether complaint, investigation, and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.	• Complaints • Disciplinary Activity
(XI) If reviewing a regulatory program, whether the scope of practice of the regulated occupation contributes to the optimum use of personnel.	• Licensing • Examinations • Recommendations 4 & 5
(XII) Whether entry requirements encourage equity, diversity, and inclusivity.	• Licensing • Examinations
(XIII) If reviewing a regulatory program, whether the agency, through its licensing, certification, or registration process, imposes any sanctions or disqualifications on applicants based on past criminal history and, if so, whether the sanctions or disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subsection (5)(a) of this section must include data on the number of licenses, certifications, or registrations that the agency denied based on the applicant's criminal history, the number of conditional licenses, certifications, or registrations issued based upon the applicant's criminal history, and the number of licenses, certifications, or registrations revoked or suspended based on an individual's criminal conduct. For each set of data, the analysis must include the criminal offenses that led to the sanction or disqualification.	• Collateral Consequences
(XIV) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.	• Recommendations 1-6

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review on COPRRR's website at coprrr.colorado.gov.

The functions of the Colorado Medical Board (Board) as enumerated in Article 240 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on September 1, 2026, unless continued by the General Assembly. During the year prior to this date, it is the duty of COPRRR to conduct an analysis and evaluation of the Board pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation should be continued and to evaluate the performance of the Board. During this review,

the Board must demonstrate that the program serves the public interest. COPRRR's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, COPRRR staff interviewed Division of Professions and Occupations staff, practitioners, and officials with state and national professional associations; and reviewed Colorado statutes and rules.

The major contacts made during this review include, but are not limited to:

- American Academy of Pediatrics – Colorado Chapter
- American College of Emergency Physicians – Colorado Chapter
- American College of Obstetricians & Gynecologists – Colorado
- Attorney General's Office
- Colorado Academy of Family Physicians
- Colorado Academy of Physician Associates
- Colorado Center for Personalized Education for Professionals
- Colorado Hospital Association
- Colorado Medical Board members
- Colorado Medical Society
- Colorado Orthopedic Society
- Colorado Physician Health Program
- Colorado Psychiatric Society
- Colorado Radiological Society
- Colorado Society of Anesthesiologists
- Colorado Society of Eye Physicians & Surgeons
- Colorado Society of Osteopathic Medicine
- COPIC Medical Professional Liability Insurance
- Division of Professions and Occupations

Profile of the Profession

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), C.R.S. The first criterion asks whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare.

To understand the need for regulation, it is first necessary to recognize what the profession does, where they work, who they serve and any necessary qualifications.

Generally, the practice of medicine is defined as,[2]

> …the art or science of restoring or preserving health or due physical condition, as by means of drugs, surgical operations or appliances, or manipulations: often divided into medicine proper, surgery, and obstetrics.

Further, medicine may also include,

> …the art or science of treating disease with drugs or curative substances, as distinguished from surgery or obstetrics.

The Medical Practice Act, which is the subject of this sunset review, creates the regulatory framework for physicians, physician assistants and anesthesiologist assistants.

Physicians work in a variety of both clinical and non-clinical settings, including hospitals, physician offices, insurance companies, and government agencies,[3] and they work to address injuries, illness, and health maintenance through diagnosis and treatment.[4]

Tasks performed by physicians may include, but are not limited to:[5]

- Performing physical examinations and noting the patient's medical history;
- Recommending, designing, and implementing treatment plans for patients;
- Documenting and updating charts regarding patient information in order to demonstrate findings and specific treatments;
- Ordering consultations and patient tests; and
- Reviewing test results to identify findings.

[2] Dictionary.com. *Medicine*. Retrieved June 30, 2025, from http://www.dictionary.com/browse/medicine
[3] U.S. Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons*. Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm
[4] U.S. Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons*. Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-2
[5] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons*. Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-2

Physicians may specialize in specific areas of medicine including, but not limited to:[6]

- Anesthesiology,
- Cardiology,
- Dermatology,
- Emergency medicine,
- Family medicine,
- General internal medicine,
- Neurology,
- Obstetrics,
- Ophthalmology,
- Orthopedics,
- Pediatrics, and
- Radiology.

In order to become a physician, a bachelor's degree and a degree from a medical school or school of osteopathy is typically required. Physicians may obtain a degree as either a medical doctor (M.D.) or as a doctor of osteopathic medicine (D.O.).[7] Depending upon the physician's area of specialization, there may also be a requirement for an additional three to nine years of internship and residency programs.

Physician training programs are highly competitive academic environments, and applicants must typically provide transcripts, letters of recommendation, and submission of examination scores from the Medical College Admission Test (MCAT). Schools may also consider an applicant's personality, participation in extra-curricular activities, and leadership qualities. Further, most schools require that applicants be interviewed by members of the school's admissions committee.[8]

Upon acceptance, the initial phase of training is often conducted in classrooms, laboratories, and small groups. Subject matter of initial coursework typically includes study of courses such as biochemistry, anatomy, psychology, pharmacology, and medical ethics. In addition, students gain a variety of skills during this first phase, including patient examinations, medical history intake, and the diagnosis of medical conditions.[9]

During the second phase of training, students work with patients under the supervision of physicians in clinics or hospital settings. Through these experiences, students learn to diagnose and treat illnesses through what are referred to as "rotations" or

[6] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-2
[7] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4
[8] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4
[9] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4

"clerkships" in a variety of areas, including, but not limited to pediatrics, surgery, or internal medicine.[10]

Upon the completion of schooling, most graduates enter into a residency program that relates to their specific area of interest for three to nine years, which typically takes place in either a clinic or hospital setting. Some subspecialties may require additional years of residency for one to three years, such as hand surgery or infectious diseases.[11]

All states require physicians to be licensed, although specific requirements may vary by state. In order to be licensed, applicants must complete an accredited training program and complete any required residency. Additional licensure requirements include the passage of national licensure examinations, [12] including the U.S. Medical Licensing Examination (USMLE) for those with an M.D., or the Comprehensive Osteopathic Medical Licensing Examination (COMPLEX-USA) for those with a D.O.

Similarly, physician assistants also examine, diagnose, and treat patients, sometimes under the supervision of a physician, and may work in teams with physicians, surgeons, or other healthcare professionals.[13]

Tasks performed by physician assistants may include, but are not limited to:[14]

- Examining patients,
- Logging and reviewing patients' medical history,
- Diagnosing a patient's injury or medical condition,
- Providing treatment, and
- Prescribing medication.

Physician assistants may also specialize in specific areas of medicine, such as:[15]

- Emergency medicine,
- Family medicine, and
- Psychiatry.

In order to become a physician assistant, a master's degree from an accredited educational program is typically required. Applicants for these types of programs typically possess a bachelor's degree as well as additional experience caring for

[10] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4
[11] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4
[12] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-4
[13] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-2
[14] Bureau of Labor Statistics. *Physician Assistants: Occupational Outlook Handbook.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-2
[15] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants.* Retrieved June 30, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-2

patients. All states currently require physician assistants to be licensed, and related educational programs typically require a minimum of two years to complete.[16]

Educational programs for physician assistants may include laboratory and classroom instruction in a variety of subjects, including pharmacology, human anatomy, and clinical medicine. Further, supervised clinical training may be required in several specialty areas, such as emergency medicine, family medicine, and internal medicine.[17]

All states and the District of Columbia require physician assistants to be licensed. In order to become licensed, applicants are required to pass an examination (the Physician Assistant National Certifying Examination (PANCE), which is administered by the National Commission on Certification of Physician Assistants). The credential that may be utilized by licensed physician assistants is "PA-C."[18]

Anesthesiologist assistants help with the coordination and implementation of care as a part of an anesthesia care team before, during, and after surgical procedures.[19]

Work performed by anesthesiologist assistants, includes, but is not limited to:[20]

- Performing physical examinations and collecting a patient's medical history;
- Applying and interpreting monitoring techniques in advance of a procedure;
- Securing the patient's airway;
- Securing and recording the status of a patient, including physiological and pharmacological aspects; and
- Providing post-operative continuity of care.

The American Academy of Anesthesiologist Assistants also offers a certification process for anesthesiologist assistants known as "CAA." In order to become certified, applicants must complete any required premedical education and must obtain a master's degree from an accredited anesthesiology program. Specific coursework for CAAs requires at least two full years to complete.[21]

Currently, anesthesiologist assistants are regulated and may be required to obtain either a license or certification in 14 states, the District of Columbia and Guam.

[16] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants*. Retrieved July 1, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-4
[17] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants*. Retrieved July 1, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-4
[18] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants*. Retrieved July 1, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-4
[19] American Academy of Anesthesiologist Assistants. *Certified Anesthesiologist Assistants (CAAs)*. Retrieved July 1, 2025, from https://www.anesthetist.org/_files/ugd/b88fea_6130aad98ba04cd99c6646c027c8c94c.pdf
[20] American Academy of Anesthesiologist Assistants. *About CAAs*. Retrieved July 1, 2025, from https://www.anesthetist.org/about-caas
[21] American Academy of Anesthesiologist Assistants. *About CAAs*. Retrieved July 1, 2025, from https://www.anesthetist.org/about-caas

Additionally, four states have granted anesthesiologist assistants the ability to practice through physician delegation.[22]

The ninth sunset criterion questions the economic impact of the program and, if national economic information is not available, whether the agency stimulates or restricts competition. One way this may be accomplished is to review the projected salary and growth of the profession.

There are approximately 23,600 openings projected each year for physicians in the U.S., with an expected three percent increase projected between 2024 and 2034.[23] The annual median wage for physicians was equal to or greater than $239,200 as of May 2024.[24]

Regarding physician assistants, a 20 percent growth rate is anticipated between 2024 and 2034, and an average of 12,000 job openings per year are anticipated within the next decade. [25] As of May 2024, the median pay for physician assistants was $133,260 per year.[26]

Although economic data is not as readily available for anesthesiologist assistants, it is estimated that they typically earn an average annual salary of $121,730 per year in Colorado.[27]

[22] University of Colorado, Anschutz Medical Campus. *Anesthesiologist Assistant Program*. Retrieved July 1, 2025, from https://medschool.cuanschutz.edu/anesthesiology/education/anesthesiologist-assistant-program/aa-profession
[23] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons*. Retrieved on September 2, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-6
[24] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physicians and Surgeons*. Retrieved on September 2, 2025, from https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-5
[25] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants*. Retrieved on September 2, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-6
[26] Bureau of Labor Statistics. *Occupational Outlook Handbook: Physician Assistants*. Retrieved on September 2, 2025, from https://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-1
[27] Career Explorer. *Anesthesiology assistant salary in Colorado*. Retrieved on September 2, 2025, from https://www.careerexplorer.com/careers/anesthesiologist-assistant/salary/colorado/#:~:text=Anesthesiologist%20assistants%20earn%20an%20average,and%20go%20up%20to%20$164%2C620.

Legal Framework

History of Regulation

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The first and second sunset criteria question:

> Whether regulation or program administration by the agency is necessary to protect the public health, safety, and welfare; and
>
> Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less or the same degree of governmental oversight.

One way that COPRRR addresses this is by examining why the program was established and how it has evolved over time.

The Colorado Medical Board (Board), formerly known as the Colorado State Board of Medical Examiners, was established in 1881 in order to protect the public health, safety, and welfare by enforcing minimum competency standards through licensure, complaint investigation, and disciplinary action where appropriate. Since then, the Medical Practice Act (Act) has undergone numerous amendments.

In 1969, the General Assembly enacted the Child Health Associate Law, which provided regulatory requirements for physician assistants who worked with physicians, primarily in the field of Pediatrics.[28]

In 1990, certified child health associates were granted licensure as physician assistants with the authority to provide services to patients under the age of 21, since the Board no longer certified that category of health professional.[29]

In 2009, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) conducted a sunset review of the Board, and the General Assembly enacted several of the report's recommendations, including, but not limited to:

- Establishment of a two-year waiting period for licenses that have been revoked or surrendered in lieu of disciplinary action;
- Creation of a pro bono license type for physicians; and
- Authorization of the Board to enter into confidential agreements with licensees who agree to voluntarily address health conditions, allowing the licensee to continue to work without reducing patient safety.

[28] Dean, Winston J. *State Legislation for Physicians Assistants: A Review and Analysis.* Center for Disease Control Stacks, January 1973, Vol. 88, No.1.
[29] § 12-240-109, C.R.S.

During the same legislative session, the General Assembly passed several additional amendments to the Act, including a definitional change to physician responsibilities regarding recommending marijuana to patients, which included laws relating to medical marijuana as well as the definition of unprofessional conduct.

In 2018, the most recent sunset review was conducted, which made a variety of recommendations for statutory amendments to the Act which were passed by the General Assembly, including, but not limited to:

- Continuation of the Board for seven years, until 2026;
- Elimination of the 60-day limit for pro bono licenses; and
- Removal of the requirement that letters of admonition be sent by certified mail.

Senate Bill 19-228 was then enacted by the General Assembly, which prohibited a physician or physician assistant from receiving any direct or indirect benefit from pharmaceutical manufacturers or representatives for prescribing specific medications to patients.

Also during the 2019 legislative session, the General Assembly recodified Title 12, C.R.S. At that time, Article 36 was repealed and reenacted as Article 240. Though there were changes in the manner in which the law reads and many provisions of law were combined with common elements of other laws, none of those changes affected the implementation or enforcement of the Act.

In 2023, the General Assembly enacted Senate Bill 23-083 (SB 23-083), which provided additional clarification regarding the relationship between physician assistants and physicians or podiatrists by removing the supervision requirement, except in specific instances. Further, SB 23-083 clarified specific requirements regarding collaborative agreements for physician assistants with physicians or physician groups.

In 2024, the General Assembly enacted the Physician Assistant Licensure Compact through Senate Bill 24-018 which enables physician assistants with a license in a compact state to be more easily authorized to practice in other compact states. That same year, House Bill 24-1153, established a continuing education requirement for physicians of 30 credit hours within the 24 months preceding license renewal, reactivation, or reinstatement.

Legal Summary

The third, fourth, fifth and seventh sunset criteria question:

> Whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms;
>
> Whether agency rules enhance the public interest and are within the scope of legislative intent;
>
> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters; and
>
> Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

A summary of the current statutes and rules is necessary to understand whether regulation is set at the appropriate level and whether the current laws are impeding or enhancing the agency's ability to operate in the public interest.

The Act is located in section 12-240-101, *et seq.*, C.R.S., and it governs the practice of medicine in Colorado, including the regulation of physicians, physician assistants and anesthesiologist assistants. The Board is housed in the Division of Professions and Occupations (Division) in the Colorado Department of Regulatory Agencies, and the Board is charged with rulemaking, licensing and enforcement of the Act.

The Governor appoints the members of the Board as follows:[30]

- Eight medical doctors,
- Three osteopathic doctors,
- Two physician assistants, and
- Four members of the public who have no financial or professional association with the medical profession.

Members are appointed to four-year staggered terms.[31] The professional members must be actively engaged in the practice of medicine and hold licenses in good standing.[32]

[30] § 12-240-105(1)(a), C.R.S.
[31] § 12-240-105(1)(b), C.R.S.
[32] § 12-240-105(2), C.R.S.

Additionally, the Board may conduct investigations, hold hearings, and collect evidence regarding all matters relating to the Board's powers and duties.[33]

In order to facilitate the licensure of a physician from another state, the Board is authorized to obtain fingerprints from an applicant for licensure under the Interstate Medical Licensure Compact Act for a state and national fingerprint-based criminal history record check and receive the results.[34]

The Board is divided into three panels: a licensing panel and two inquiry panels.

The licensing panel consists of one licensed physician with a degree in medicine, one licensed physician with a degree in osteopathy, one public member, and one physician assistant. [35] The licensing panel reviews and makes determinations regarding applications for licensure, and resolves issues related to the unlicensed practice of medicine.[36]

The inquiry panels consist of two separate panels totaling six members each, four of whom must be physician members. Each inquiry panel performs, among other things, inquiries and hearings regarding complaint investigations.[37]

At present, the inquiry panels do not contain the same composition. For example, Panel A currently consists of three medical doctors, one doctor of osteopathy, one public member, and one physician assistant. Panel B currently consists of three medical doctors, one doctor of osteopathy, two public members, and no physician assistants.

Practice of Medicine

The practice of medicine is defined in the Act as:[38]

> Holding out one's self to the public within this state as being able to diagnose, treat, prescribe for, palliate or prevent any human disease; ailment; pain; injury; deformity; physical condition; or behavioral, mental health, or substance use disorder, whether by the use of drugs, surgery, manipulation, electricity, telemedicine, the interpretation of tests, including primary diagnosis of pathology specimens, images or photographs, or any physical, mechanical or other means whatsoever;
>
> Suggesting, recommending, prescribing or administering any form of treatment, operation or healing for the intended palliation, relief or cure

[33] § 12-240-106(1)(b), C.R.S.
[34] § 12-240-106(3), C.R.S.
[35] § 12-240-116(1)(a), C.R.S.
[36] §§ 12-240-116(2) and (3), C.R.S.
[37] § 12-240-125(1), C.R.S.
[38] § 12-240-107(1), C.R.S.

> of a person's physical disease; ailment; injury; condition; or behavioral, mental health or substance use disorder;… [.]

Further, this statutory definition also includes other clarifications such as title protections, the ability for all physicians to perform any kind of surgical operation, and authorization to provide telemedicine.[39]

A physician who is licensed in another state or U.S. territory is exempt from the Act's licensure requirement if the practice in Colorado is limited to only the occasional case or consultation.[40] A commissioned medical officer in the U.S. armed forces, the U.S. public health service, or the U.S. veteran's administration is likewise exempt.[41] Finally, the Act exempts anyone who renders services in case of an emergency.[42]

Licensing

The Board issues several types of physician licenses:

- Training licenses,
- Full physician licenses,
- Distinguished foreign teaching licenses,
- Reentry licenses, and
- Pro bono licenses.

In addition to physician licenses, the Board also licenses anesthesiologist assistants and physician assistants.

Professional Liability Insurance

All physicians and most physician assistants must maintain professional liability insurance of at least $1 million per incident and $3 million aggregate per year.[43] The Board may establish lower amounts of financial responsibility requirements for specified classes of physicians or physician assistants, including those who are:[44]

- Employed by the U.S. government,
- Provide limited or occasional medical services,
- Perform less than full-time medical services, and
- Provide only uncompensated care for patients.

[39] § 12-240-107(1), C.R.S.
[40] § 12-240-107(3)(b)(VI), C.R.S.
[41] § 12-240-107(3)(i), C.R.S.
[42] § 12-240-107(3)(a), C.R.S.
[43] § 13-64-301(1)(a.5)(I), C.R.S.
[44] § 13-64-301(1)(a.5)(II), C.R.S.

Foreign Medical School Graduates

The Board may license a physician applicant with a foreign medical degree if the applicant meets all the other requirements for licensure and holds a specialty board certification. The Board must consider the following when considering the qualifications of a foreign medical school graduate:[45]

- The information available to the Board relating to the medical school of the applicant, and
- The nature and length of the postgraduate training completed by the applicant.

Training License

A training license may be issued to any person who is not otherwise licensed to practice medicine in Colorado and who is serving in an approved internship, residency, or fellowship in a hospital.[46] The holder of a training license may practice medicine only under the supervision of a fully licensed physician,[47] may not delegate medical functions to a person who is not a licensed physician and may not supervise physician assistants.[48] An individual may not hold a training license for more than six years.[49]

Full License

To obtain a full physician license, an applicant must have demonstrated:[50]

- Passage of an examination approved by the Board,
- Reaching the age of 21,
- Graduation from an approved medical school, and
- Completion of an internship of at least one year or one year of postgraduate training.

Additionally, if an applicant already holds a license issued by another state or U.S. territory, the Board may issue a license by endorsement, as long as the applicant satisfies the requirements of the Occupational Credential Portability Program.[51]

Distinguished Foreign Teaching License

A distinguished foreign teaching license may be issued to an applicant "of noteworthy and recognized professional attainment" who is a graduate of a foreign medical school and who is licensed in a foreign jurisdiction, provided the candidate has been invited by a Colorado medical school as a full-time member of its academic faculty and so long

[45] § 12-240-114(1), C.R.S.
[46] § 12-240-128(1), C.R.S.
[47] § 12-240-128(7)(a), C.R.S.
[48] § 12-240-128(7)(c), C.R.S.
[49] § 12-240-128(1), C.R.S.
[50] §§ 12-240-110(1) and (2), C.R.S.
[51] § 12-240-110(1)(d), C.R.S.

as the candidate's medical practice is limited to that required by the academic position.[52]

Reentry License

A reentry license may be issued by the Board to a physician, physician assistant or an anesthesiologist assistant who has not actively practiced for the previous two years or who has not maintained continued competency during that period.[53] The Board may require an applicant for a reentry license to complete an educational program, evaluations, and assessments.[54]

The Board may also issue a reentry license with a requirement of supervised practice.[55] Upon completion of any requirements imposed by the Board, the reentry license may be converted to a full physician license.[56]

A reentry license may be valid for no more than three years and may not be renewed.[57]

Pro Bono License

A pro bono license may be issued by the Board for a physician to practice medicine in this state as long as the applicant:[58]

- Either does not charge fees for services or works for a facility that does not charge fees for its services;
- Holds an active, unrestricted license to practice medicine in Colorado or another state or U.S. territory;
- Has not been on inactive status for more than two years;
- Has never had a license suspended or revoked in Colorado or another state or U.S. territory; and
- Does not have any unresolved complaints against their license.

Anesthesiologist Assistant License

An anesthesiologist assistant license may be issued to an applicant who has:[59]

- Successfully completed an anesthesiologist assistant educational program approved by the Board,
- Passed a national examination administered by the National Commission for Certification of Anesthesiologist Assistants or successor organization, and

[52] § 12-240-111(1), C.R.S.
[53] § 12-240-119(1)(a)(I), C.R.S.
[54] § 12-240-119(2)(a), C.R.S.
[55] § 12-240-119(2)(b)(I), C.R.S.
[56] § 12-240-119(2)(b)(II), C.R.S.
[57] § 12-240-119(3), C.R.S.
[58] § 12-240-118(1), C.R.S.
[59] § 12-240-112(1), C.R.S.

- Is at least 21 years of age.

PHYSICIAN ASSISTANT LICENSE

A physician assistant license may be issued to an applicant who:[60]

- Has completed a physician assistant educational program approved by the Board,
- Has passed a national examination administered by the National Commission on Certification of Physician Assistants or successor organization, and
- Is at least 21 years of age.

Physician assistants enter into collaborative agreements with a physicians or physician groups. The physician entering into the collaborative agreement must be actively practicing in Colorado with a regular and reliable physical presence in the state. The collaborative agreement must include:[61]

- The physician assistant's name, license number, and primary location of practice;
- The signature of both the physician assistant and the physician or physician group involved in the collaborative agreement; and
- A description of the collaboration process engaged in by the physician assistant, which must be based on the physician assistant's primary location and area of practice.

PROBATIONARY LICENSE

The Board may deny a license, or it may grant a probationary license, to any applicant who:[62]

- Does not meet the required qualifications,
- Has engaged in unprofessional conduct,
- Has been disciplined in another jurisdiction, or
- Has not actively practiced for the two-year period prior to submitting an application or has not otherwise maintained continued competency during such period.

[60] § 12-240-113(1), C.R.S.
[61] § 12-240-114.5(2)(a), C.R.S.
[62] § 12-240-120(1), C.R.S.

Unprofessional Conduct

The Act defines unprofessional conduct as including, but not being limited to:[63]

- Resorting to fraud, misrepresentation or deception in obtaining a license, professional liability insurance, or privileges at a hospital;
- Having been convicted of an offense of moral turpitude, a felony, or any crime that would constitute a violation of the Act;
- Administering, dispensing or prescribing any habit-forming drug or a controlled substance other than in the course of legitimate professional practice;
- Having been convicted of violating any federal or state law regulating the possession, distribution, or use of a controlled substance;
- Habitual or excessive use or abuse of alcohol, a habit-forming drug, or a controlled substance;
- Aiding or abetting an unlicensed person in the practice of medicine;
- Practicing medicine as a partner, agent or employee of, or in joint venture with, any person who does not hold a license to practice medicine in this state;
- Violating, or attempting to violate, any provision of the Act;
- Failing to notify the Board of a physical or mental condition that impacts the licensee's ability to practice with reasonable skill and safety and failing to act within the limitations created by the condition or agreed to under a confidential agreement with the Board;
- Engaging in any act or omission that fails to meet generally accepted standards of medical practice;
- Engaging in a sexual act with a patient during the course of patient care or within six months immediately following the termination of the professional relationship;
- Violating any valid Board order or rule;
- Dispensing, injecting or prescribing an anabolic steroid that is intended to increase muscle mass or weight without medical necessity;
- Prescribing, distributing, or giving to a family member or to oneself except on an emergency basis, a Schedule II controlled substance;
- Failing to report to the Board, within 30 days, an adverse action taken by another licensing agency;
- Failing to report to the Board, within 30 days, the surrender of a license or other authorization to practice medicine in another jurisdiction;
- Committing a fraudulent insurance act;
- Failing to maintain professional liability insurance;
- Failing to respond in an honest, materially responsive and timely manner to a complaint submitted to the Board; and
- Advertising in a manner that is misleading, deceptive or false.

[63] § 12-240-121(1), C.R.S.

Enforcement Authority

The Board may revoke, suspend or place on probation any license belonging to an individual it determines has engaged in unprofessional conduct or has otherwise violated any provision of the Act or the Board rules.[64]

If the Board determines that a complaint does not warrant formal action but should not be dismissed as being without merit, it may issue a letter of admonition.[65] If the Board determines that a complaint should be dismissed but the Board notices indications of possible errant conduct that could lead to serious consequences if not corrected, it may issue a letter of concern.[66] The Board may also impose a fine of not more than $5,000.[67]

Additionally, the Board may issue a cease-and-desist order to any licensee that it determines is an imminent threat to the health and safety of the public, or to any person who is practicing medicine without a license.[68]

[64] § 12-240-125(5)(c)(III), C.R.S.
[65] § 12-240-125(4)(c)(IV), C.R.S.
[66] § 12-240-125(4)(c)(III), C.R.S.
[67] § 12-240-125(5)(c)(III), C.R.S.
[68] § 12-240-125(12), C.R.S.

Program Description and Administration

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The fifth, sixth and seventh sunset criteria question:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters;
>
> Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively; and
>
> Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

In part, COPRRR utilizes this section of the report to evaluate the agency according to these criteria.

The Medical Practice Act (Act) is located in section 12-240-101, *et seq.*, Colorado Revised Statutes (C.R.S.), and it governs the practice of medicine in Colorado, including the regulation of physicians, physician assistants and anesthesiologist assistants. The Colorado Medical Board (Board) is housed in the Division of Professions and Occupations (Division) in the Colorado Department of Regulatory Agencies, and is charged with rulemaking, licensing and enforcement of the Act.

The Governor appoints the members of the Board as follows:[69]

- Eight medical doctors,
- Three osteopathic doctors,
- Two physician assistants, and
- Four members of the public who have no financial or professional association with the medical profession.

Members are appointed to four-year staggered terms.[70] The professional members must be actively engaged in the practice of medicine and hold licenses in good standing.[71]

[69] § 12-240-105(1)(a), C.R.S.
[70] § 12-240-105(1)(b), C.R.S.
[71] § 12-240-105(2), C.R.S.

Additionally, the Board may conduct investigations, hold hearings, and collect evidence regarding all matters relating to the Board's powers and duties.[72] Full Board meetings are conducted in a virtual format on a quarterly basis, with meetings scheduled in February, May, August and November.

The Board is divided into three panels: a licensing panel and two inquiry panels.

The licensing panel consists of one licensed physician with a degree in medicine, one licensed physician with a degree in osteopathy, one public member, and one physician assistant. The licensing panel reviews and makes determinations regarding applications for licensure, and resolves issues related to the unlicensed practice of medicine.[73]

The inquiry panels consist of two separate panels totaling six members each, four of whom must be physician members. Each inquiry panel performs, among other things, inquiries and hearings regarding complaint investigations.[74] Panel meetings are conducted in a virtual format on a monthly basis.

At present, the inquiry panels do not contain the same composition. For example, Panel A currently consists of three medical doctors, one doctor of osteopathy, one public member, and one physician assistant. Panel B currently consists of three medical doctors, one doctor of osteopathy, two public members, and no physician assistants.

Table 2 highlights the total program expenditures and the number of full-time equivalent (FTE) employees dedicated to the Board for fiscal year 19-20 through fiscal year 23-24.

Table 2
Program Expenditures and FTE

Fiscal Year	Total Program Expenditure	FTE
19-20	$ 3,780,813	9.66
20-21	$ 3,271,189	9.75
21-22	$ 2,847,595	8.75
22-23	$ 3,090,883	8.75
23-24	$ 3,974,013	8.75

The table above demonstrates that expenditures continued to increase from fiscal years 21-22 through 23-24, while FTE remained stable. Since 2019, the Division has centralized services to include requests made under the Colorado Open Records Act (CORA), rulemaking, and an intake team.

[72] § 12-240-106(1)(b), C.R.S.
[73] § 12-240-116, C.R.S.
[74] § 12-240-125(1), C.R.S.

Fluctuations in expenditures may have occurred due to the Division's efforts to centralize services, which led to the reallocation of three positions for the intake team and regulatory team to include rulemaking and CORA requests.

The number of FTE reflected in the table does not include employees in the centralized offices of the Division that provide management, licensing, administrative, technical, and investigative support to the Board. However, the cost of those FTE is reflected in the total program expenditures.

In fiscal year 24-25, the Division allocated a combined total of 7.0 FTE to support the Board, apportioned in the following manner:

- Program Management II – 1.0 FTE (Program Director) - Manages and supervises all Board related matters which include policy development, administration, licensing, enforcement, and Board meetings.
- Technician V – 1.0 FTE (Enforcement Program Manager) - Assists the Program Director with analysis and prioritization of complaints; initiates and monitors investigations; issues orders for mental or physical evaluations; provides analysis, preparation and distribution of materials to the inquiry panels as well as the full Board; and implements Board decisions regarding complaints.
- Technician IV – 1.0 FTE (Licensing Manager) - Provides Board support during meetings, prepares Board correspondence and reports, prepares and distributes materials to the licensing panel, maintains Board records, and provides additional administrative support.
- Technician IV – 1.0 FTE (Enforcement Specialist) - Oversees and monitors disciplinary processes, issues peer health assistance program orders and processes all final agency orders and Board orders.
- Technician III – 2.0 FTE (Program Specialists) - Oversees, monitors, and provides follow up regarding daily Board operations and prepares information for the Board's review, as well as any duties that impact the efficiency of processes within the work unit.
- Technician III – 1.0 FTE (Licensing Specialist) - Responsible for application review as well as the processing and issuing licenses and cease and desist orders.

The program is cash funded by the various fees paid by licensees.

Table 3 highlights initial license fees for physicians, physician assistants, anesthesiologist assistants, and physicians in training during fiscal years 19-20 through 23-24.

Table 3
Initial Fees

Fiscal Year	Initial Physician	Initial Physician Assistants	Initial Anesthesiologist Assistants	Initial Physician in Training
19-20	$240	$100	$100	$10
20-21	$275	$100	$100	$15
21-22	$275	$80	$80	$15
22-23	$173	$80	$80	$15
23-24	$173	$10	$10	$15

The decrease in physician assistant and anesthesiologist assistant license fees in fiscal year 23-24 was due to an effort to balance the cash fund, as there were residual funds available.

Table 4 highlights renewal license fees for physicians, physician assistants, anesthesiologist assistants, and physicians in training during fiscal years 19-20 through 23-24.

Table 4
Renewal License Fees

Fiscal Year	Renewal Physician	Renewal Physician Assistant	Renewal Physician in Training	Renewal Anesthesiologist Assistant
19-20	$219	$5	$10	$5
20-21	$219	$5	$10	$5
21-22	$238	$3	$15	$3
22-23	$238	$3	$15	$3
23-24	$150	$3	$9	$3

The table above demonstrates that all renewal fees decreased during the years under review. During each renewal period, the Division's budget team analyzes the budget and reviews the need to increase or decrease renewal fees. As a result of the COVID-19 pandemic, costs associated with Board meetings and staff office expenses decreased due to remote work causing a residual in the operation fund, which led to the decrease in fees.

Table 5 highlights initial and renewal license fees relating to licensure compacts during fiscal years 19-20 through 23-24.

Table 5
Initial and Renewal Fees - Compacts

Fiscal Year	Initial Compact Physician Home State	Initial Compact Physician Member State	Renewal Compact Home State	Renewal Compact Member State
19-20	$300	$250	$219	$219
20-21	$300	$250	$219	$219
21-22	$330	$275	$238	$238
22-23	$238	$275	$238	$238
23-24	$208	$173	$150	$150

A "Compact Physician Home State" license refers to a compact license where the physician's primary license is issued in Colorado. In the same manner as other license renewal fees, the Division's budget team analyzes the budget each renewal period and reviews the need to increase or decrease renewal fees.

Licensing

The eleventh and twelfth sunset criteria question whether the scope of practice of the regulated occupation contributes to the optimum use of personnel and whether entry requirements encourage equity, diversity and inclusivity.

In part, COPRRR utilizes this section of the report to evaluate the program according to these criteria.

Requirements for Licensure

The Board issues several types of physician licenses:

- Training licenses,
- Full physician licenses,
- Distinguished foreign teaching licenses,
- Reentry licenses, and
- Pro bono licenses.

In addition to physician licenses, the Board also licenses anesthesiologist assistants and physician assistants.

Most physician licenses expire on April 30 of odd-numbered years, physician assistant licenses expire on January 31 of even-numbered years, and anesthesiologist assistant

licenses expire on January 31 of even-numbered years. In addition, physician training licenses are valid for three years, and may only renew one time (for a total of six years).

An individual applying for a license to practice medicine must complete an application which must be submitted to the Board along with the applicable license fee and any required supporting documentation.

Table 6 provides the total number of all initial, endorsement, and renewal licenses, as well as the total number of all active licenses administered by the Board for fiscal years 19-20 through 23-24. See Appendix A for tables regarding the number of licenses issued by license type.

Table 6
Total Licenses Issued

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	3,759	923	4,018	33,499
20-21	3,837	860	25,130	36,283
21-22	4,394	953	4,595	36,428
22-23	5,013	1,053	27,738	40,062
23-24	5,093	1,107	5,413	40,796

The "total" category in the table represents the overall total number of active licenses for the fiscal years indicated, while the initial, endorsement and renewals demonstrated for each fiscal year represent the number of such licenses that were processed during that fiscal year.

Training License

A training license may be issued to any person who is not otherwise licensed to practice medicine in Colorado and who is serving in an approved internship, residency or fellowship in a hospital.[75] The holder of a training license may practice medicine only under the supervision of a fully licensed physician,[76] may not delegate medical functions to a person who is not a licensed physician, and may not supervise physician assistants.[77] An individual may not hold a training license for more than six years.[78]

[75] § 12-240-128(1), C.R.S.
[76] § 12-240-128(7)(a), C.R.S.
[77] § 12-240-128(7)(c), C.R.S.
[78] § 12-240-128(1), C.R.S.

FULL LICENSE

To obtain a full physician license, an applicant must have demonstrated:[79]

- Passage of an examination approved by the Board,
- Reaching the age of 21,
- Graduation from an approved medical school, and
- Completion of an internship of at least one year or one year of postgraduate training.

Additionally, if an applicant already holds a license issued by another state or U.S. territory, the Board may issue a license by endorsement, as long as the applicant for licensure by endorsement satisfies the requirements of the Occupational Credential Portability Program.[80]

In order to be eligible for licensure with a foreign medical degree, the applicant must meet all other Board requirements for licensure and hold a specialty board certification. The Board must consider the following when considering the qualifications of a foreign medical school graduate:[81]

- The information available to the Board relating to the medical school of the applicant, and
- The nature and length of the postgraduate training completed by the applicant.

CONTINUING MEDICAL EDUCATION

With the passage of House Bill 24-1153, physicians will be required to complete 30 hours of Continuing Medical Education (CME) within the previous 24 months in order to receive license renewal, reinstatement, or reactivation, starting with the beginning of the 2027 renewal cycle.

To qualify a program as eligible for CME, the program must:[82]

- Be accredited by the Accreditation Council for Continuing Medical Education;
- Qualify for prescribed credit from the American Academy of Family Physicians;
- Be approved by the American Osteopathic Association; or
- Be a program that is required in order to obtain national certification.

[79] § 12-240-110(1), C.R.S.
[80] § 12-240-110(1)(d), C.R.S.
[81] § 12-240-114(1), C.R.S.
[82] § 12-240-130.5(3)(d) C.R.S.

Unless selected to participate in a Board audit of CME, physicians must provide an attestation upon renewal, reinstatement, or reactivation that all required CME has been completed.[83]

Distinguished Foreign Teaching License

A distinguished foreign teaching license may be issued to an applicant "of noteworthy and recognized professional attainment" who is a graduate of a foreign medical school and who is licensed in a foreign jurisdiction, provided the candidate has been invited by a Colorado medical school as a full-time member of its academic faculty and so long as the candidate's medical practice is limited to that required by the academic position.[84] This license type must be renewed annually.

Reentry License

A reentry license may be issued by the Board to a physician, physician assistant or an anesthesiologist assistant who has not actively practiced for the previous two years or who has not maintained continued competency during that period.[85] The Board may require an applicant for a reentry license to complete an educational program, evaluations, and assessments.[86]

The Board may also issue a reentry license with a requirement of supervised practice.[87] Upon completion of any requirements by the Board, the reentry license may be converted to a full license.[88]

A reentry license may be valid for no more than three years and may not be renewed.[89]

Pro Bono License

A pro bono license may be issued by the Board for a physician to practice medicine in this state as long as the applicant:[90]

- Either does not charge fees for services or works for a facility that does not charge fees for its services,
- Holds an active, unrestricted license to practice medicine in Colorado or another state or U.S. territory,
- Has not been on inactive status for more than two years,
- Has never had a license suspended or revoked in Colorado or another state or U.S. territory, and

[83] § 12-240-130.5(3)(b) C.R.S.
[84] § 12-240-111(1), C.R.S.
[85] § 12-240-119(1)(a)(I), C.R.S.
[86] § 12-240-119(2)(a), C.R.S.
[87] § 12-240-119(2)(b)(I), C.R.S.
[88] § 12-240-119(2)(b)(II), C.R.S.
[89] § 12-240-119(3), C.R.S.
[90] § 12-240-118(1), C.R.S.

- Does not have any unresolved complaints against their license.

MILITARY SPOUSE LICENSE

With the passage of House Bill 24-1097, spouses, dependents, and Gold Star spouses have the option to obtain a temporary license while stationed in Colorado for any profession or occupation under the purview of the Division. This temporary license type is valid for six years with no fees associated with the license.[91]

ANESTHESIOLOGIST ASSISTANT LICENSE

An anesthesiologist assistant license may be issued to an applicant who has:[92]

- Successfully completed an anesthesiologist assistant educational program approved by the Board,
- Passed a national examination administered by the National Commission for Certification of Anesthesiologist Assistants or successor organization, and
- Is at least 21 years of age.

PHYSICIAN ASSISTANT LICENSE

A physician assistant license may be issued to anyone who:[93]

- Has completed a physician assistant educational program approved by the Board,
- Has passed a national examination administered by the National Commission on Certification of Physician Assistants or successor organization, and
- Is at least 21 years of age.

PROBATIONARY LICENSE

The Board may deny a license, or it may grant a probationary license, to any applicant who:[94]

- Does not meet the required qualifications,
- Has engaged in unprofessional conduct,
- Has been disciplined in another jurisdiction, or
- Has not actively practiced for the two-year period prior to submitting an application or has not otherwise maintained continued competency during such period.

[91] Colorado Division of Professions and Occupations. *Military Spouse Licenses.* Retrieved September 10, 2025, from https://dpo.colorado.gov/Military/Spouse
[92] § 12-240-112(1), C.R.S.
[93] § 12-240-113(1), C.R.S.
[94] § 12-240-120(1), C.R.S.

License Renewal

In order to qualify for license renewal, licensees must:[95]

- Successfully complete the Board's renewal questionnaire,
- Pay the renewal fee, and
- Provide proof of compliance with any financial responsibility requirements.

License Reinstatement

Once a license expires, it must be reinstated by the Board in order for a licensee to continue to practice.

In order to be reinstated, the licensee must complete the Board's requirements for reinstatement, including, but not limited to: [96]

- Successfully complete the Board's application for reinstatement, including the renewal questionnaire;
- Pay the reinstatement fee; and
- Provide proof of compliance with any financial responsibility requirements.

If the individual has a matter pending before one of the inquiry or hearings panels, the Board may defer the application for reinstatement in order to proceed with any disciplinary action, and the Board may also determine whether to deny reinstatement.

The Board may require the licensee to undertake a competency assessment or evaluation, undertake a period of supervised practice, or complete an educational program if the individual has not practiced medicine within the preceding two years of the Board's consideration of the reinstatement application.

Reentry License

At the discretion of the Board, a reentry license may be issued in order to allow the licensee the opportunity to complete specific training and/or education requirements. Once issued, the reentry license is valid for a single period not to exceed three years from the date of issuance. The reentry license can be administratively deactivated if the licensee fails to complete the required education and training.[97]

[95] 3 CCR § 713-1-1.8-C. Colorado Medical Board, Medical Rules and Regulations.
[96] 3 CCR § 713-1-1.8-D. Colorado Medical Board, Medical Rules and Regulations.
[97] 3 CCR § 713-1-1.8-F. Colorado Medical Board, Medical Rules and Regulations.

Examinations

The eleventh and twelfth sunset criteria question whether the scope of practice of the regulated occupation contributes to the optimum use of personnel and whether entry requirements encourage equity, diversity and inclusivity.

In part, COPRRR utilizes this section of the report to evaluate the program according to these criteria.

One of the qualifications necessary to obtain a medical license in Colorado is the passage of a national examination.

Physicians

The Board has authorized the following examinations to satisfy physician licensure requirements:[98]

- The United States Medical Licensing Examination (USMLE), administered by the National Board of Medical Examiners;
- The Osteopathic Medical Licensing Examination, administered by the National Board of Osteopathic Medical Examiners;
- The Federal Licensure Examination, administered by the Federation of State Medical Boards; and
- The Medical Council of Canada Qualifying Examination, along with the conferral of the Licentiate of the Medical Council of Canada.

Of these examination mechanisms, the USMLE is the most prevalently utilized so it is the only examination discussed here.

The USMLE is available to all candidates seeking licensure to practice medicine in the United States. The examination includes the separate steps meant to assess a variety of related skills:[99]

- Step 1 – Assesses basic scientific knowledge related to the practice of medicine;
- Step 2 – Assesses clinical knowledge and the ability to apply key clinical concepts in patient care; and
- Step 3 – Assesses abilities related to the application of knowledge regarding clinical and biomedical science utilized in unsupervised practice.

Each step utilizes computer-based testing, which is administered by Prometric at approximately 335 Prometric testing centers throughout the United States and Canada, as well as approximately 100 international Prometric testing locations. Steps 1 and 2

[98] 3 CCR §§ 713-1-1.5-C and D. Colorado Medical Board, Medical Rules and Regulations.
[99] United States Medical Licensing Examination. *Exam Day Information*. Retrieved October 8, 2025 from https://www.usmle.org/what-to-know/exam-day-information

are administered worldwide. However, step 3 is only administered within the United States.[100]

In order to complete an examination, applicants must schedule an appointment at the testing location, and test scores are reported on a weekly basis.

Physician Assistants

Physician assistants are required to pass the Physician Assistant National Certifying Examination (PANCE).

The National Commission on the Certification of Physician Assistants (NCCPA) administers PANCE, which is a five-hour, multiple-choice examination that consists of five blocks of 60 questions in 60-minute blocks.[101]

As of 2025, the PANCE examination registration fee is $550.[102]

Anesthesiologist Assistants

Anesthesiologist assistants must pass the Certifying Examination for Anesthesiologist Assistants (CEAA) in order to be licensed.

The CEAA is developed by the National Commission for the Certification of Anesthesiologist Assistants in order to test for entry-level knowledge related to the practice of an anesthesiologist assistant.[103] The CEAA is a multiple-choice, computer-based examination, which contains 180 items divided into two blocks of 90 items, with 235 minutes to complete the examination.[104]

As of 2024, the CEAA examination registration fee is $1,400.

Complaints

The eighth and tenth sunset criteria require COPRRR to examine whether regulatory oversight can be achieved through a director model, and whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.

[100] United States Medical Licensing Examination. *Performance Data.* Retrieved October 8, 2025, from https://www.usmle.org/performance-data
[101] NCCPA. *What to Expect on Test Day.* Retrieved September 4, 2025, from https://www.nccpa.net/become-certified/test-day/
[102] NCCPA. *How do I apply for PANCE?* Retrieved September 4, 2025, from https://www.nccpa.net/become-certified/
[103] National Commission for Certification of Anesthesiologist Assistants. *Certification Examination Handbook*. Retrieved on September 4, 2025, from https://nccaa.org/certexamhandbook
[104] National Commission for Certification of Anesthesiologist Assistants. *Certification Examination Handbook*. Retrieved on September 4, 2025, from https://nccaa.org/certexamhandbook

In part, COPRRR utilizes this section of the report to evaluate the program according to these criteria.

The Board reviews complaints and takes disciplinary actions resulting from violations of the Act. Table 7 details the total number of alleged violation types received from complaints for fiscal years 19-20 through 23-24. See Appendix B for tables regarding complaints received by license type.

Table 7
Total Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Aiding and Abetting Unlicensed Practice	3	2	0	0	0
Continuing Education Violation	1	8	0	10	2
Criminal Conviction	4	6	0	2	1
Drug or Alcohol Abuse	20	14	2	8	5
Failure to Report	4	0	1	7	2
False Advertising	6	16	1	3	0
False Billing/Abuse of Health Insurance	28	5	26	23	35
Improper Supervision	6	4	3	1	4
Outside of the Scope of Practice	2	1	1	3	1
Physical or Mental Disability	8	2	1	6	4
Prescribing Administering Drugs Improperly	115	59	29	25	12
Sexual Relations with a Patient	15	4	1	3	1
Substandard Care	907	715	823	995	1184
Unlicensed Practice	23	19	27	71	29
Unprofessional Conduct	331	408	555	414	439
Violation of Stipulation of Board Order	4	2	3	6	2
Total	**1477**	**1265**	**1473**	**1577**	**1721**

There is no known reason for the decrease in false billing complaints in fiscal year 20-21, although this reduction occurred during the COVID-19 pandemic.

Further, the upward trend in complaints for unlicensed practice during the years under review may possibly be attributed to the cross collaboration with other programs for cases that cross over for unlicensed practice in several programs.

Disciplinary Activity

The tenth sunset criterion requires COPRRR to examine whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession or regulated entity.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

Table 8 displays the final agency actions of the Board for all license types from fiscal year 19-20 through 23-24. See Appendix C for tables regarding final agency actions by license type.

Table 8
Total Final Agency Actions

Final Agency Actions	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Agreement - Cannot Practice	0	0	1	1	0
Application Denied	0	0	0	2	1
Application Expired	0	1	18	9	23
Application Withdrawn	0	5	25	17	19
Cease & Desist Order	5	8	3	8	4
Combined w/other case for action	17	11	9	10	1
Confidential Agreement	2	1	2	1	1
Court Judgement	0	0	1	0	0
Final Agency Order	2	5	3	1	0
Letter of Admonition	29	36	19	28	27
Probation	0	0	0	1	0
Revocation	1	0	1	0	6
Stipulation	37	26	23	23	27
Stipulation - Cannot Practice	0	0	0	1	0
Suspension	1	0	1	1	0
Voluntary Surrender	13	10	14	9	8
Total Disciplinary Actions	**107**	**103**	**120**	**112**	**117**
Dismiss with Confidential Letter of Concern	95	77	157	198	191
Dismiss with Letter of Guidance	4	0	1	0	0
Dismissed	1,045	1,059	1,094	1,158	1,235
Dismissed Application	0	0	2	5	0
Total Dismissals	**1,144**	**1,136**	**1,254**	**1,361**	**1,426**

The decrease in the number of letters of admonition (LOAs) during fiscal year 21-22 may be due, in part, to the changeover in Board members as well as an increased focus on approaching violations of substandard care with LOA stipulations to add continuing education. Further, the increase in dismissals coincides with the increase in complaints.

Additionally, the Board is authorized to impose a fine of up to $5,000 for violations of the Act. It imposed only two fines during the five-year review period: one each in fiscal year 19-20 and 20-21. Each was for $1,500 and both were issued to physicians.

Table 9 depicts the average number of days for case processing time during fiscal years 19-20 through 23-24 for all cases. Each case lifespan is tabulated from the filing of the initial complaint through the final agency action taken. See Appendix D for tables regarding average case processing by license type.

Table 9
Total Average Case Processing

Fiscal Year	Number of Days
19-20	108
20-21	123
21-22	98
22-23	94
23-24	79

The table highlights the average number of days needed to close a jurisdictional complaint, as calculated from the date the complaint is received until the date of the final agency action. This consistent decrease is a reflection of the Division's commitment to the reduction of average case closure timeframes.

Collateral Consequences – Criminal Convictions

The thirteenth sunset criterion requires COPRRR to examine whether the agency, through its licensing, certification or registration process, imposes any sanctions or disqualifications on applicants based on past criminal history and, if so, whether the sanctions or disqualifications serve public safety or commercial or consumer protection interests.

COPRRR utilizes this section of the report to evaluate the program according to this criterion.

The Board may deny or take disciplinary action based upon criminal history. Table 10 provides specific information relating to the total number of sanctions imposed on licensees for fiscal years 19-20 through 23-24 for collateral consequences.

Table 10
Collateral Consequences of Criminal Activity
Sanctions Imposed

Nature of Sanction or Disqualification	FY 19-20	FY 20-21	FY 21-22	FY22-23	FY 23-24
Denials	0	0	0	0	0
Suspensions	0	0	0	0	0
Revocations	0	1	0	0	0
Other*	1	1	1	1	1
Total	**1**	**2**	**1**	**1**	**1**

The criminal activities related to actions are as follows:

- Fiscal year 19-20 – Sexual assault on a child;
- Fiscal year 20-21 – Menacing with a real or simulated weapon and paying/offering and soliciting/receiving illegal kickbacks and bribes;
- Fiscal year 21-22 – Mail fraud;
- Fiscal year 22-23 – Misdemeanor harassment; and
- Fiscal year 23-24 – Healthcare fraud.

The "Other" category listed above reflects the following actions:

- Relinquishments that occurred in fiscal years 19-20 and 20-21;
- Interim Cessation Practice Agreement in fiscal year 21-22;
- Final agency order with conditions in fiscal year 22-23; and
- Non-permanent relinquishment (or voluntary license surrender) in fiscal year 23-24.

Analysis and Recommendations

The final sunset criterion questions whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest. The recommendations that follow are offered in consideration of this criterion, in general, and any criteria specifically referenced in those recommendations.

Recommendation 1 — Continue the Medical Practice Act for nine years, until 2035.

The Medical Practice Act (Act) regulates a variety of professionals, including physicians, physician assistants, and anesthesiologist assistants, who work in both clinical and non-clinical settings, including hospitals, physician offices, insurance companies, and government agencies. Each profession works within their scope of practice to address injuries, illness, pain management, and health maintenance through diagnosis and/or treatment.

Physicians, physician assistants, and anesthesiologist assistants hold a position of trust with the patients with whom they work. Medical treatment, if performed improperly, can cause significant damage to a patient, and in instances where the patient's life is at risk, improper treatment can lead to death.

The field of medicine requires high levels of training to ensure that healthcare professionals are skilled in their areas of expertise in order to ensure minimal competency in their work with patients.

The Act protects consumers from harm by imposing educational and licensure requirements to ensure that licensees receive proper training and maintain competency in their field. The Colorado Medical Board (Board) administers and enforces the Act by reviewing complaints and may discipline licensees for violations of the Act including potential revocation for severe violations.

The first sunset criterion asks if regulation is necessary to protect the public health, safety, and welfare. Through the application of the regulatory framework established in the Act, the Board provides effective oversight in order to protect the public interest. Given the number of structural recommendations made in this review, the General Assembly should continue the Act and the Board for nine years, until 2035.

It is worth noting that concurrently with this sunset review, the Division of Professions and Occupations (Division) also underwent a sunset review. Recommendations in the sunset report of the Division will likely impact the administration of the Act, as those recommendations will have Division-wide impact. Such recommendations were made in the sunset report of the Division, as opposed to individual programmatic reports, to ensure consistency and cohesion in policy implementation across the Division.

Recommendation 2 — Authorize the President of the Board to serve as a full member at licensing panel meetings.

The Board currently consists of 17 total members and is structured into three separate sub-panels that each complete specific tasks: two inquiry panels (which each complete tasks including the reviewing of complaints, investigations, and conducting hearings) and one licensing panel (which completes tasks including reviewing license applications and addressing instances of unauthorized practice). Each inquiry panel currently has six members, while the licensing panel currently has four members.

On the licensing panel, two members of a panel must be present in order to constitute a quorum to hold panel meetings, and three members of the panel must be present in order for the panel to go into executive session. On either of the inquiry panels, three members constitute a quorum for meetings related to inquiries or hearings.

Section 12-240-116(1)(b), Colorado Revised Statutes (C.R.S.), further allows the President of the Board to rotate membership on the various panels so that all Board members, including the President, have the ability to serve on each panel. Additionally, section 12-240-125 (1)(b), C.R.S., allows the President to serve as a full member on the two inquiry panels, and thus, to be able to vote on related matters as established under this section of statute. However, section 12-240-116, C.R.S., does not directly state that the President has full membership on the licensing panel, which is in contrast to the statute regarding the inquiry panels.

Therefore, the President retains full voting membership on both inquiry panels but is not a voting member on the licensing panel. As a result, even if the President is in attendance at a licensing panel meeting, they cannot be considered for the establishment of a quorum to convene a meeting, which can delay licensing panel business in the event that there are not enough members to constitute a quorum. [105] In recent years, there have been challenges with the establishment of quorums due to scheduling issues and Board member vacancies.

The fifth and sixth sunset criteria ask,

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures, and practices and any other circumstances, including budgetary, resource, and personnel matters; and
>
> Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively.

[105] § 12-240-125(6), C.R.S.

Allowing the President to participate as a full member of the licensing panel would help to ensure that the business of the Board can run as effectively and efficiently as possible, which is in the public interest. Therefore, the General Assembly should authorize the President of the Board to serve as a full member at licensing panel meetings.

Recommendation 3 – Amend the composition of the Board to include three physician assistants and five public members.

Section 12-240-105, C.R.S., states that the Board must consist of 17 members, including two physician assistants and four public members. To conduct its licensing and investigatory duties, the Board is divided into one licensing panel and two inquiry panels.

The licensing panel consists of one licensed physician with a degree in medicine, one licensed physician with a degree in osteopathy, one public member, and one physician assistant. The licensing panel reviews and makes determinations regarding applications for licensure, and resolves issues related to the unlicensed practice of medicine.[106]

The inquiry panels consist of two separate panels totaling six members each, four of whom must be physician members. Each inquiry panel performs, among other things, inquiries and hearings regarding complaint investigations.[107] The Act does not presently list each required member for the inquiry panels. However, the current makeup of members on each panel is as follows:

- Panel A – One physician assistant, one public member, one doctor of osteopathy, and three medical doctors.
- Panel B – Two public members, one doctor of osteopathy, and three medical doctors.

In sum, the composition of the full Board renders the composition of the two inquiry panels unbalanced. One inquiry panel currently contains one member of the public and one physician assistant, while the other inquiry panel currently has two members of the public and no physician assistant.

Public membership on the Board is an important voice and should not be diminished. Therefore, by increasing the public membership on Panel A by adding one public member and adding one physician assistant to Panel B, both panels would have equal representation consisting of two public members and one physician assistant on each panel.

[106] § 12-240-116, C.R.S.
[107] § 12-240-125(1), C.R.S.

The seventh sunset criterion asks whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

By changing both the number of public members and the number of physician assistants on the full Board by a net increase of two members (adding one public member to Panel A and one physician assistant to Panel B), the number of public members and physician assistants serving on each panel will be balanced, which is in the public interest. For this reason, the General Assembly should amend the composition of the Board to include three physician assistants and five public members.

Recommendation 4 – Create an administrative license category for physicians consistent with the stipulations currently utilized by the Board.

In order to renew, reinstate, or reactivate an existing license, a physician applicant must complete 30 hours of Continuing Medical Education (CME) within a timeframe established by the Board.[108]

Presently, if an individual is applying for reinstatement after an extended period of professional absence, the Board may offer a stipulated agreement to the applicant to obtain a "restricted license" in which the applicant may provide professional work in a limited capacity, with an exemption from the CME requirement.

Such stipulations typically contain specific elements of allowable practice if a restricted license is granted, including, but not limited to:

- Evidence-based medicine protocol design,
- Participation in activities related to quality management,
- Development of patient safety protocols, and
- Research design and analysis.

However, one holding such a restricted license is prohibited from engaging in certain aspects of medical practice including, but not limited to:

- Prescribing;
- Ordering tests;
- Patient contact, including assessment of a patient's medical history, current medical condition, or personal physical examinations; and
- Administration or interpretation of patient tests, evaluations, and data.

These same limitations may also be used for physicians engaged in purely administrative work, providing an exemption from the CME requirement.

[108] § 12-240-130.5(3)(a), C.R.S.

This license category is provided only in limited circumstances in which an individual has demonstrated that they may have the ability to work in the medical field in a unique manner, such as medical research or other roles that may require a medical license but that do not involve treating patients. In these instances, the Board may waive the CME requirement to allow the individual to utilize their license in a strictly administrative capacity (not treating patients or prescribing medications).

However, the Board may only provide this option through a stipulated agreement since no such license category is authorized in statute. Furthermore, stipulations are often reserved for resolution in lieu of disciplinary action, and these types of stipulations often appear disciplinary in nature. Stipulations are also frequently reported to a variety of national databases, furthering the appearance that the restricted license was punitive in nature.

If the Act authorized the Board to issue an administrative license, physician applicants who do not intend to in any way treat or prescribe medications to patients may still have the ability to work in their field of expertise without the stigma of discipline.

The fourth, sixth, eleventh, and fourteenth sunset criteria ask,

> Whether agency rules enhance the public interest and are within the scope of legislative intent;
>
> Whether an analysis of agency operations indicates that the agency or the agency's board or commission performs its statutory duties efficiently and effectively;
>
> Whether the scope of practice of the regulated occupation contributes to the optimum use of personnel; and
>
> Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Allowing for an administrative license that provides physicians who wish to work in a strictly administrative capacity with a means of continuing work in the field of medicine enables well-trained professionals to continue providing their expertise, which is in the public interest. Therefore, the General Assembly should amend the Act to include an administrative license category for physicians consistent with the stipulations currently utilized by the Board.

Recommendation 5 — Change the requirement in section 12-240-111, C.R.S., for a distinguished foreign teaching physician to apply for a license every odd-numbered year as opposed to every year.

Section 12-20-202(1)(a), C.R.S., provides the Director of the Division with the authority to establish a renewal schedule for all licenses under the Division's purview. As a part of this schedule, full physician licenses are set to renew every other year.

However, section 12-240-111(3), C.R.S., regarding renewal of the distinguished foreign teaching physician license states,

> A distinguished foreign teaching physician license is effective and in force only while the holder is serving on the academic staff of a medical school. The license expires one year after the date of issuance…

The current renewal schedule for full physician licensure is every other year. However, distinguished foreign teaching physician licensure is required by statute to renew every year.

The fifth, eleventh, and fourteenth sunset criteria ask,

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes…;
>
> …whether the scope of practice of the regulated occupation contributes to the optimum use of personnel; and
>
> Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

By changing the requirement for a distinguished foreign teaching physician to apply for a license every other year, rather than the current requirement of every year, statute would be in greater alignment with the requirements of the full physician license, creating fewer burdens for licensees and the facilities that hire them, which is in the public interest. Therefore, the General Assembly should change the requirement in section 12-240-111, C.R.S., for a distinguished foreign teaching physician to apply for a license every odd-numbered year as opposed to every year.

Recommendation 6 – Exempt from the Act facilitators who are practicing within the scope of their Natural Medicine license.

The Natural Medicine Program was established with the passage of Senate Bill 23-290 and allows the utilization of certain natural medicines (such as Psilocybin or Psilocin) to be utilized as a method of treatment for a variety of mental health conditions.

This program is a director model program which oversees, among other things, the regulatory requirements of the practitioners who provide natural medicine services in the state. There are several categories of practitioners within the Natural Medicine Program, including the categories of facilitator and clinical facilitator.

Individuals who do not hold licensure or other authorization to practice a profession that does not diagnose and treat medical or behavioral health conditions may become licensed as a facilitator.[109] Facilitator licensees are authorized to provide natural medicine services to certain participants.[110]

The Natural Medicine Program also licenses clinical facilitators. Physicians and physician assistants may be licensed as clinical facilitators. A clinical facilitator is a practitioner who,[111]

- Has a license in Colorado which enables them to diagnose and treat physical or behavioral/mental health conditions; and
- Is licensed to perform and supervise natural medicine services for participants whose safety screening does not indicate needing the involvement of a medical or behavioral health provider that treats concerns outside the scope of the clinical facilitator's secondary license.

Natural medicine services include conducting preparation, administration, and integration sessions. Certain aspects of natural medicine services may overlap with the practice of medicine, as defined at section 12-240-107, C.R.S. For example, facilitators and clinical facilitators may recommend and administer natural medicine services, a form of treatment, for certain behavioral, mental health, or substance use disorders. In the absence of an exemption under the Act, a facilitator may run the risk of being alleged to be engaged in the unlicensed practice of medicine.

Clinical facilitators may provide natural medicine services to participants for the purpose of treating physical or behavioral/mental health conditions.[112] They are expected to use the skills gained from their medical training and their natural medicine training during the performance of facilitation services. For example, during a natural medicine preparation session, a clinical facilitator must conduct a safety health screening to ensure participants are able to safely receive natural medicine services.[113] For some participants with underlying health or behavioral health conditions, these safety screenings must be performed by clinical facilitators and may involve more complex medical screening. Similarly, following administration of natural medicine, clinical facilitators will conduct integration sessions for participants with behavioral health conditions, and those integration sessions may reasonably be expected to have

[109] 4 CCR § 755-1-2.2(A)(2), Natural Medicine Licensure Rules and Regulations.
[110] 4 CCR §§ 755-1-2.2(A)(6) and (7), Natural Medicine Licensure Rules and Regulations.
[111] Colorado Department of Regulatory Agencies. *Regulated Natural Medicines: Facilitator and Clinical Facilitator Path*. Retrieved August 11, 2025, from: https://dpo.colorado.gov/NaturalMedicine
[112] 4 CCR § 755-1-2.2(A)(1), Natural Medicine Licensure Rules and Regulations.
[113] 4 CCR § 755-1-2.2(A)(1), Natural Medicine Licensure Rules and Regulations.

some overlap between facilitation and behavioral health treatment that would otherwise fall within the definition of the practice of medicine in the Act at section 12-240-107(1)(b), C.R.S.

"Natural medicine" is defined to include psilocybin and psilocin, and may be expanded to include ibogaine, dimethyltryptamine, and/or mescaline.[114] Each of these substances are Schedule I controlled substances, illegal under federal law but decriminalized under Colorado law. The recommendation or administration of such substances to patients in traditional medical communities is not widespread outside of its use in clinical trials; as a result, generally accepted standards of medical practice are unlikely to support a Board licensee's administration of natural medicines to a patient outside of the Natural Medicine Program. Because the Natural Medicine Program is establishing standards of practice for clinical facilitators and facilitators, at this time it makes more sense for clinical facilitators who also are licensed by the Board to be evaluated on the standards of care being established by the Natural Medicine Program, rather than by the Board.

In other words, while the Natural Medicine Program and the Board regulate licensees when they perform functions that fall under their respective jurisdictions, a clear exemption is needed within the Act for two reasons. First, facilitators who are properly performing services within the scope of their Natural Medicine licensure could be determined to be engaged in the unlicensed practice of medicine. Second, clinical facilitators who provide natural medicine services in accordance with the standards of care established within the Natural Medicine Program may, nevertheless, be determined to be deviating from generally accepted standards of medical practice because of their use of Schedule I controlled substances.

For these reasons, the rendering of natural medicine services by individuals licensed by the Natural Medicine Program (including as a facilitator, clinical facilitator, distinguished educator facilitator, or facilitator in training) should be exempt from the Act while practicing within the scope of their Natural Medicine license.

The second, third, and fourteenth sunset criteria ask,

> Whether the conditions that led to the initial creation of the program have changed and whether other conditions have arisen that would warrant more, less, or the same degree of governmental oversight;
>
> If the program is necessary, whether the existing statutes and regulations establish the least restrictive form of governmental oversight consistent with the public interest, considering other available regulatory mechanisms; and

[114] §§ 12-170-104(12)(a) and (b), C.R.S.

Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Providing an exemption from the Act for facilitators licensed under the Natural Medicine Program will help to provide clarity regarding the regulatory authority between the Board and the Natural Medicine Program, so that practitioners and members of the public alike have a more accurate understanding regarding the boundaries of each regulatory mechanism. Therefore, the General Assembly should add an additional exemption to section 12-240-107(3), C.R.S., regarding facilitators who are licensed to practice natural medicine while performing regulated activities that are within the scope of their Natural Medicine facilitator license.

Appendix A — Number of Licenses by License Type

Table A-1 provides the total number of initial, endorsement, and renewal licenses for physicians, as well as the total number of active physician licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-1
Physician Licenses

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	2,091	923	5	26,000
20-21	2,003	860	23,689	27,728
21-22	2,276	953	2	26,991
22-23	2,339	1,053	24,883	29,011
23-24	2,201	1,107	12	28,096

Table A-2 provides the total number of initial, endorsement, and renewal licenses for military spouse - physicians, as well as the total number of active military spouse - physician licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-2
Military Spouse - Physician Licenses

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	0	0	0	0
20-21	2	0	0	2
21-22	5	0	0	4
22-23	8	0	0	5
23-24	0	0	0	8

Table A-3 provides the total number of initial, endorsement, and renewal licenses for pro bono physicians (a physician license type for physicians who do not charge for their services pursuant to section 12-240-118 Colorado Revised Statutes), as well as the total number of active bro bono physician licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-3
Pro Bono Physician Licenses

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	11	Not applicable	Not applicable	176
20-21	37	Not applicable	136	214
21-22	8	Not applicable	Not applicable	184
22-23	41	Not applicable	158	226
23-24	10	Not applicable	Not applicable	205

Table A-4 provides the total number of initial, endorsement, and renewal licenses for physicians in training, as well as the total number of physicians in training licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-4
Physicians in Training Licenses

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	520	Not applicable	75	1,770
20-21	516	Not applicable	80	1,818
21-22	499	Not applicable	84	1,701
22-23	517	Not applicable	78	1,708
23-24	524	Not applicable	83	1,689

Table A-5 provides the total number of initial, endorsement, and renewal licenses for physician assistants, as well as the total number of active physician assistant licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-5
Physician Assistant Licenses

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	512	Not applicable	3,832	4,197
20-21	518	Not applicable	Not applicable	4,734
21-22	581	Not applicable	4,360	4,816
22-23	572	Not applicable	1	5,425
23-24	671	Not applicable	5,116	5,586

Table A-6 provides the total number of initial, endorsement, and renewal licenses for anesthesiologist assistants, as well as the total number of active licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-6
Anesthesiologist Assistant Licenses

Fiscal Year	Initial	Endorsement	Renewal	Total
19-20	19	Not applicable	102	118
20-21	24	Not applicable	Not applicable	142
21-22	28	Not applicable	138	157
22-23	35	Not applicable	Not applicable	192
23-24	39	Not applicable	180	210

Table A-7 provides the total number temporary initial and endorsement licenses for anesthesiologist assistants, as well as the total number of temporary anesthesiologist licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-7
Temporary Anesthesiologist Licenses

Fiscal Year	Initial	Endorsement	Total
19-20	1	Not applicable	1
20-21	2	Not applicable	Not applicable
21-22	Not applicable	Not applicable	Not applicable
22-23	Not applicable	Not applicable	Not applicable
23-24	Not applicable	Not applicable	Not applicable

The temporary anesthesiologist license was only available during the COVID-19 pandemic.

Table A-8 provides the total number of initial and renewal licenses for compact physicians, as well as the total number of active compact physician licenses administered by the Board for this license type during fiscal years 19-20 through 23-24.

Table A-8
Compact Physician Licenses

Fiscal Year	Initial	Renewal	Total
19-20	360	Not applicable	681
20-21	428	583	789
21-22	657	N/A	1,434
22-23	1,102	1,398	1,962
23-24	1,157	1	3,089

Appendix B — Complaints Received by License Type

Table B-1 details the total number of alleged violation types received for physician licenses for fiscal years 19-20 through 23-24.

Table B-1
Physician Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Aiding and Abetting Unlicensed Practice	3	1	0	0	0
Continuing Education Violation	1	2	0	6	1
Criminal Conviction	3	6	0	2	1
Drug or Alcohol Abuse	16	12	2	5	2
Failure to Report	3	0	0	5	1
False Advertising	6	16	1	2	0
False Billing/Abuse of Health Insurance	22	0	17	17	21
Improper Supervision	4	3	2	1	4
Outside of the Scope of Practice	1	0	0	3	1
Physical or Mental Disability	6	2	1	5	4
Prescribing Administering Drugs Improperly	94	50	25	24	10
Sexual Relations with a Patient	13	3	0	2	1
Substandard Care	772	615	673	768	906
Unlicensed Practice	16	10	9	14	15
Unprofessional Conduct	286	319	443	327	348
Violation of Stipulation of Board Order	2	2	3	5	2
Total	**1248**	**1041**	**1176**	**1186**	**1317**

Table B-2 details the total number of alleged violation types received for foreign teaching physician licenses for fiscal years 19-20 through 23-24.

Table B-2
Foreign Teaching Physician License Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Continuing Education Violation	0	5	0	3	1
Substandard Care	17	2	0	1	1
Unlicensed Practice	0	0	0	2	0
Unprofessional Conduct	1	10	17	12	9
Total	**18**	**17**	**17**	**18**	**11**

Table B-3 details the total number of alleged violation types received for physician training licenses for fiscal years 19-20 through 23-24.

Table B-3
Physician Training License Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Drug or Alcohol Abuse	0	1	0	0	2
Failure to Report	1	0	0	0	0
Physical or Mental Disability	1	0	0	1	0
Prescribing Administering Drugs Improperly	3	0	0	0	0
Substandard Care	9	6	7	5	5
Unprofessional Conduct	2	6	9	10	10
Total	**16**	**13**	**16**	**16**	**17**

Table B-4 details the total number of alleged violation types received for pro bono physician licenses for fiscal years 19-20 through 23-24.

Table B-4
Pro Bono Physician Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Substandard Care	0	0	1	0	0
Unlicensed Practice	0	0	1	0	0
Unprofessional Conduct	0	2	1	2	1
Total	**0**	**2**	**3**	**2**	**1**

Table B-5 details the total number of alleged violation types received from compact physician (home) licenses for fiscal years 19-20 through 23-24.

Table B-5
Compact Physician (Home) Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Drug or Alcohol Abuse	0	0	0	1	0
False Advertising	0	0	0	1	0
Failure to Report	0	0	0	0	1
Prescribing Administering Drugs Improperly	1	0	0	0	0
Substandard Care	9	11	25	24	28
Unprofessional Conduct	6	7	4	8	8
Total	**16**	**18**	**29**	**34**	**37**

Table B-6 details the total number of alleged violation types received for compact physician licenses for fiscal years 19-20 through 23-24.

Table B-6
Compact Physician License Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Aiding and Abetting Unlicensed Practice	0	1	0	0	0
Failure to Report	0	0	0	1	0
Prescribing Administering Drugs Improperly	0	1	0	0	1
Substandard Care	5	4	6	13	18
Unlicensed Practice	0	0	0	0	1
Unprofessional Conduct	0	1	7	4	9
Violation of Stipulation of Board Order	1	0	0	0	0
Total	**6**	**7**	**13**	**18**	**29**

Table B-7 details the total number of alleged violation types received for anesthesiologist assistant licenses for fiscal years 19-20 through 23-24.

Table B-7
Anesthesiologist Assistant License Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Substandard Care	1	1	0	1	1
Unprofessional Conduct	0	0	0	0	2
Total	**1**	**1**	**0**	**1**	**3**

Table B-8 details the total number of alleged violation types received for temporary physician licenses for fiscal years 19-20 through 23-24.

Table B-8
Temporary Physician License Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Unprofessional Conduct	0	0	0	0	1
Total	**0**	**0**	**0**	**0**	**1**

Table B-9 details the total number of alleged violation types received against unlicensed individuals for fiscal years 19-20 through 23-24.

Table B-9
Unlicensed Complaint Information

Alleged Violation	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
False Billing/Abuse of Health Insurance	4	5	6	5	10
Outside of the Scope of Practice	0	1	1	0	0
Prescribing Administering Drugs Improperly	0	1	1	0	0
Substandard Care	34	28	56	81	119
Unlicensed Practice	6	9	15	51	11
Unprofessional Conduct	17	22	24	12	13
Total	**61**	**66**	**103**	**149**	**153**

Appendix C — Final Agency Actions by License Type

Table C-1 details the total number of final agency actions for anesthesiologist assistant licenses for fiscal years 19-20 through 23-24.

Table C-1
Anesthesiologist Assistant - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Dismissed	1	1	1	0	2
Dismiss with Confidential Letter of Concern	1	0	0	0	0
Total Dismissals	2	1	1	0	2

Table C-2 details the total number of final agency actions for compact physicians for fiscal years 19-20 through 23-24.

Table C-2
Compact Physician - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Letter of Admonition	1	0	0	0	2
Stipulation	0	1	0	0	0
Suspension	0	0	0	1	0
Voluntary Surrender	0	0	0	0	3
Total Disciplinary Actions	**1**	**1**	**0**	**1**	**5**
Dismissed	4	6	6	6	13
Dismiss with Confidential LOC	1	0	2	2	5
Total Dismissals	**5**	**6**	**8**	**8**	**18**

Table C-3 details the total number of final agency actions for compact physician (home) licenses for fiscal years 19-20 through 23-24.

Table C-3
Compact Physician (Home) - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Letter of Admonition	0	1	1	0	0
Stipulation	0	1	0	1	0
Total Disciplinary Actions	0	2	1	1	0
Dismissed	9	14	28	27	27
Dismiss with Confidential LOC	1	1	4	4	5
Total Dismissals	10	15	32	31	32

Table C-4 details the total number of final agency actions for physician licenses for fiscal years 19-20 through 23-24.

Table C-4
Physicians - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Agreement - Cannot Practice	0	0	1	1	0
Application Denied	0	0	0	2	1
Application Expired	0	1	18	8	20
Application Withdrawn	0	4	22	13	13
Cease & Desist Order	1	1	2	0	1
Combined w/other cases for action	17	10	9	10	1
Confidential Agreement	2	1	2	0	1
Court Judgement	0	0	1	0	0
Final Agency Order	0	5	2	1	0
Letter of Admonition	28	34	16	27	21
Probation	0	0	0	1	0
Revocation	1	0	1	0	6
Stipulation	31	23	19	20	25
Stipulation - Cannot Practice	0	0	1	0	0
Suspension	1	0	1	0	0
Voluntary Surrender	10	9	13	7	5
Total Disciplinary Actions	91	88	108	90	94
Dismiss with Confidential LOC	83	74	130	160	166
Dismiss with Letter of Guidance	2	0	1	0	0
Dismissed	874	864	892	878	964
Dismissed Application	0	0	2	5	0
Total Dismissals	959	938	1025	1043	1130

Table C-5 details the total number of final agency actions for pro bono physicians for fiscal years 19-20 through 23-24.

Table C-5
Pro Bono Physicians - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Application Withdrawn	0	0	0	1	2
Total Disciplinary Actions	0	0	0	1	2
Dismissed	0	1	3	0	0
Dismiss with Confidential LOC	0	0	2	0	0
Total Dismissals	0	1	5	0	0

Table C-6 details the total number of final agency actions for physician assistant licenses for fiscal years 19-20 through 23-24.

Table C-6
Physician Assistant - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Application Expired	0	0	0	1	2
Application Withdrawn	0	1	3	2	3
Letter of Admonition	0	1	2	1	2
Stipulation	5	1	2	2	2
Suspension	0	0	0	0	0
Voluntary Surrender	3	1	1	2	0
Total Disciplinary Actions	8	4	8	8	9
Dismiss with Confidential LOC	9	1	18	31	15
Dismiss with Letter of Guidance	2	0	0	0	0
Dismissed	67	85	77	109	126
Total Dismissals	78	86	95	140	141

Table C-7 details the total number of final agency actions for distinguished foreign teaching physician licenses for fiscal years 19-20 through 23-24.

Table C-7
Distinguished Foreign Teaching Physician - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Application Withdrawn	0	0	1	0	0
Total Disciplinary Actions	**0**	**0**	**1**	**0**	**0**
Dismissed	19	17	14	19	13
Total Dismissals	**19**	**17**	**14**	**19**	**13**

Table C-8 details the total number of final agency actions for physician training licenses for fiscal years 19-20 through 23-24.

Table C-8
Physician Training - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Application Expired	0	0	0	0	1
Application Withdrawn	0	0	0	0	1
Confidential Agreement	0	0	0	1	0
Letter of Admonition	0	0	0	0	2
Stipulation	1	0	2	0	0
Total Disciplinary Actions	1	0	2	1	4
Dismissed	**11**	**8**	**7**	**15**	**10**
Dismiss with Confidential LOC	0	1	1	1	0
Total Dismissals	**11**	**9**	**8**	**16**	**10**

Table C-9 details the total number of final agency actions for unlicensed individuals for fiscal years 19-20 through 23-24.

Table C-9
Unlicensed - Final Agency Actions

Found Statutory Violations	FY 19-20	FY20-21	FY 21-22	FY 22-23	FY 23-24
Cease & Desist Order	3	5	0	6	3
Combined w/other cases for action	0	1	0	0	0
Final Agency Order	1	0	1	0	0
Total Disciplinary Actions	4	6	1	6	3
Dismissed	57	54	61	100	79
Total Dismissals	**57**	**54**	**61**	**100**	**79**

Appendix D — Average Case Processing Time by License Type

Table D-1 depicts the average number of days for case processing time for anesthesiologist assistant-related cases for fiscal years 19-20 through 23-24.

Table D-1
Anesthesiologist Assistant-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	51
20-21	92
21-22	161
22-23	Not applicable
23-24	107

Table D-2 depicts the average number of days for case processing time for physician-related cases during fiscal years 19-20 through 23-24.

Table D-2
Physician-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	116
20-21	127
21-22	101
22-23	99
23-24	80

Table D-3 depicts the average number of days for case processing time for physician assistant-related cases during fiscal years 19-20 through 23-24.

Table D-3
Physician Assistant-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	97
20-21	117
21-22	97
22-23	90
23-24	75

Table D-4 depicts the average number of days for case processing time for distinguished foreign teaching physician-related cases during years 19-20 through 23-24.

Table D-4
Distinguished Foreign Teaching Physician-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	25
20-21	26
21-22	33
22-23	32
23-24	41

Table D-5 depicts the average number of days for case processing time for physician training license-related cases during fiscal years 19-20 through 23-24.

Table D-5
Physician Training License-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	80
20-21	88
21-22	74
22-23	84
23-24	64

Table D-6 depicts the average number of days for case processing time for physician compact (home)-related cases during fiscal years 19-20 through 23-24.

Table D-6
Physician Compact (Home)-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	82
20-21	161
21-22	81
22-23	98
23-24	92

Table D-7 depicts the average number of days for case processing time for physician compact-related cases during fiscal years 19-20 through 23-24 for all cases.

Table D-7
Physician Compact-Related Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	79
20-21	72
21-22	126
22-23	81
23-24	86

Table D-8 depicts the average number of days for case processing time for unlicensed cases during fiscal years 19-20 through 23-24 for all cases.

Table D-8
Unlicensed Cases
Total Average Case Processing

Fiscal Year	Number of Days
19-20	22
20-21	87
21-22	75
22-23	63
23-24	69