State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

July 28-29, 2016

Board Meeting

Legislative Packet

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MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
July 14, 2016

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1244	Gray	Worker's Compensation: Providers	Sen. Approps	Reco: Support	6/22/16
AB 1306	Burke	Certified Nurse-Midwives: Scope of Practice	Sen. Approps	Oppose Unless Amended	6/20/16
AB 1977	Wood & Waldron	Opioid Abuse Task Force	Sen. Approps	Support	4/13/16
AB 2024	Wood	Critical Access Hospitals: Employment	Sen. Approps	Neutral	6/9/16
AB 2216	Bonta	Primary Care Residency Programs: Grant Program	Sen. Approps	Support	5/27/16
AB 2744	Gordon	Healing Arts: Referrals	Sen. Approps	Neutral	6/16/16
AB 2745	Holden	Healing Arts: Licensing and Certification	Sen. Approps	Sponsor/Support	4/25/16
SB 22	Roth, Cannella & Galgiani	Residency Training: Funding	Assembly	Support	2/29/16
SB 482	Lara	Controlled Substances: CURES Database	Asm. Approps – Suspense	Support	6/21/16
SB 538	Hueso	Naturopathic Doctors	Asm. Approps	Oppose	6/29/16
SB 563	Pan	Workers' Compensation: Utilization Review	Asm. Approps	Support	6/23/16
SB 1174	McGuire	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications	Asm. Approps	Support if Amended	6/22/16
SB 1177	Galgiani	Physician and Suregon Health and Wellness Program	Asm. Approps	Support	6/23/16
SB 1189	Pan & Jackson	Postmortem Examinations or Autopsies	Asm. Approps	Support	6/22/16

Pink – Sponsored Bill, Green – For Discussion , Blue – No Discussion Needed

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SB 1261	Stone	Physicians and Surgeons: Licensure Exemption	Asm. Approps	Neutral	5/3/16
SB 1471	Hernandez	Health Professions Development: Loan Repayment	Asm. Approps. - Suspense	Reco: Support	4/21/16
SB 1478	Sen. B&P	Health Omnibus	Assembly	Sponsor/Support MBC Provisions	

Pink – Sponsored Bill, Green – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1244
Author: Gray
Bill Date: June 22, 2016, Amended
Subject: Workers' Compensation: Providers: Suspension
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify the circumstances in which a medical provider must be suspended from participating in the workers' compensation system. This bill would also ensure that the appropriate licensing board is notified of the suspension and provide for communication between various state agencies.

BACKGROUND

The workers' compensation system in California provides benefits to an employee who suffers from an injury or illness that arises out of, and in the course of employment, irrespective of fault. This system requires all employers to secure payment of benefits by either securing the consent of the Department of Industrial Relations to self-insure or by securing insurance against liability from an insurance company authorized by the state. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to utilization review (UR). UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

Existing law requires the director of the Department of Health Care Services (DHCS) to suspend any or all payments to a medical service provider if there is a credible allegation of fraud against the Medi-Cal system or if a provider has been convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of medical services.

ANALYSIS

This bill would require the administrative director (AD) of the Division of Workers' Compensation (DWC) to suspend medical service providers from participating in any capacity in the workers' compensation system if the provider is:

- Convicted of a felony;
- Convicted of a misdemeanor involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system;
- Convicted of a misdemeanor involving fraud or abuse of any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Suspended from the federal Medicare or Medicaid programs due to fraud or abuse; or
- Lost or surrendered a license, certificate, or approval to provide health care.

This bill would require the AD to provide written notice to the medical provider who has been identified as eligible for suspension. This bill would require the DWC to hold a hearing on the suspension of a medical provider within 30 days of a request. Such a request would stay any suspension of a medical provider. If, during the hearing, the AD finds that the medical provider is eligible for suspension due to the reasons listed above, the AD must suspend the medical provider immediately. Upon suspension, the AD must notify the relevant licensing, certification, or registration board, including the Medical Board. This bill would also require the director of DHCS to notify the AD of the DWC if a medical provider is added to the Suspended or Ineligible Provider List (this notification from DHCS is already required to be provided to the Medical Board).

This bill seeks to combat workers' compensation fraud by changing the incentives facing medical providers in the California workers' compensation system. Specifically, this bill would create a suspension process for medical providers who commit serious crimes or are involved in fraudulent activity that is modeled after the suspension process for Medi-Cal, including requiring notification to the appropriate licensing board. This bill will ensure that the Medical Board is notified when a physician is suspended by the DWC, which will help to ensure consumer protection. This bill will also provide for communication between the DWC and DHCS, which will also help to protect consumers. For these reasons, Board staff is suggesting that the Board support this bill.

FISCAL: None to the Board

SUPPORT: Association of California Insurance Companies; California Chamber of Commerce; California Conference Board of the Amalgamated Transit Union; California Conference of Machinists; California Professional Firefighters; California State Association of Counties; California Teamsters Public Affairs Council; Engineers & scientists of CA, IFPTE Local 20, AFL-CIO; International Longshore & Warehouse Union; Professional & Technical Engineers, IFPTE Local 21, AFL-CIO; UNITE-HERE, AFL-CIO; Utility Workers Union of America, AFL-CIO

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE JUNE 22, 2016

AMENDED IN SENATE MAY 10, 2016

AMENDED IN ASSEMBLY JANUARY 26, 2016

AMENDED IN ASSEMBLY JANUARY 4, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1244

Introduced by Assembly Member Gray

February 27, 2015

An act *to amend Section 139.2 of, and* to add Section ~~5307.15 to~~ *139.21 to,* the Labor Code, and to amend Section 14123 of the Welfare and Institutions Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1244, as amended, Gray. Workers' compensation: providers: ~~suspension and revocation.~~ *suspension.*

Under existing law, the Director of Health Care Services is authorized, for purposes of administering the Medi-Cal program, to suspend a provider of service from further participation under the program for specified reasons, including conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Existing law requires the director, upon receipt of written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid programs, to promptly suspend the practitioner from participation in the Medi-Cal program.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury.

Existing law authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for the provision of medical treatment to injured employees and requires the administrative director to contract with individual physicians or an independent medical review organization to perform medical provider network independent medical reviews. Existing law also requires the administrative director to appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. *Existing law requires the administrative director to terminate from the list of medical evaluators a physician who has been subject to disciplinary action by the relevant licensing board or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice.*

~~This bill would require the Director of Health Care Services to notify the administrative director of a suspension imposed pursuant to the above provisions and would require the administrative director, upon that notification, to promptly suspend the physician or practitioner from participating in the workers' compensation system in any capacity, including, but not limited to, participation as a qualified medical examiner, a treating provider in a medical provider network, or an independent medical reviewer. The bill would require the administrative director to adopt regulations establishing criteria for revocation of a suspended physician's or practitioner's participation in the workers' compensation system, subject to specified notice and hearing requirements.~~

This bill would require the administrative director to *promptly suspend any physician or practitioner from participating in the workers' compensation system in any capacity when the individual or entity meets specified criteria, including when that individual has been convicted of a felony or any one of specified misdemeanors involving fraud or abuse, when that individual's license, certificate, or approval to provide health care has been surrendered or revoked, or when that individual or entity has been suspended, due to fraud or abuse, from participation*

in the Medicare or Medicaid programs. The bill would require the administrative director to adopt regulations for suspending a physician's or practitioner's participation in the workers' compensation system pursuant to these provisions, as specified, and would require the administrative director to furnish to the physician or practitioner written notice of the right to a hearing regarding the suspension and the procedure to follow to request that hearing. If a physician is a qualified medical examiner, and the department finds that the physician meets the criteria for suspension pursuant to these provisions, the bill would require the administrative director to terminate the physician from the list of medical evaluators. The bill would also require the administrative director to notify the appropriate state licensing entity of a physician's or practitioner's suspension ~~or revocation~~ and to update relevant provider databases of qualified medical evaluators and medical provider networks. The bill would prohibit *a provider of services from submitting or pursuing* claims for payment for services or supplies provided by a ~~provider~~ *physician or practitioner* whose participation in the workers' compensation system has been ~~suspended or revoked, except under specified circumstances.~~ *suspended, unless that claim for payment has been reduced to final judgment or the services or supplies are unrelated to a violation of the laws governing workers' compensation.*

The bill would also require the Director of Health Care Services to notify the administrative director of a suspension of a physician from participation in the Medi-Cal program imposed pursuant to the provisions described above authorizing the director to suspend a provider of services from participation.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 5307.15 is added to the Labor Code, to read:~~

~~5307.15. (a) (1) Whenever the administrative director receives written notification from the Director of Health Care Services pursuant to Section 14123 of the Welfare and Institutions Code that a physician or other individual practitioner has been suspended from participation in the Medi-Cal program, the administrative director shall promptly suspend the physician or practitioner from participating in the workers' compensation system in any capacity,~~

~~including, but not limited to, participation as a qualified medical examiner, a treating provider in a medical provider network, or a medical provider network independent medical reviewer.~~

~~(2) The administrative director also shall exercise due diligence to identify physicians and practitioners who have been suspended as described in subdivision (a) by accessing the quarterly updates to the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.~~

~~(b) (1) The administrative director shall adopt regulations establishing criteria for revocation of a suspended physician's or practitioner's participation in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).~~

~~(2) The administrative director shall serve the physician or practitioner with written notice of the specific basis for revocation of his or her participation in the workers' compensation system and shall set a hearing within 30 days of the date of service on the physician or practitioner. The hearing proceedings shall be conducted pursuant to Chapter 4 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(c) The administrative director shall promptly notify the physician's or practitioner's state licensing, certifying, or registering authority of a suspension or revocation imposed pursuant to this section and shall update the department's qualified medical evaluator and medical provider network databases, as appropriate.~~

~~(d) A provider of services, whether an individual, clinic, group, corporation, or other association, may not submit a claim for payment to a payor for any services or supplies provided by a physician or practitioner whose participation in the workers' compensation has been suspended or revoked pursuant to this section. This subdivision does not apply with respect to services or supplies provided prior to the date of the suspension or revocation.~~

SECTION 1. Section 139.2 of the Labor Code is amended to read:

139.2. (a) The administrative director shall appoint qualified medical evaluators in each of the respective specialties as required

for the evaluation of medical-legal issues. The appointments shall be for two-year terms.

(b) The administrative director shall appoint or reappoint as a qualified medical evaluator a physician, as defined in Section 3209.3, who is licensed to practice in this state and who demonstrates that he or she meets the requirements in paragraphs (1), (2), (6), and (7), and, if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5).

(1) Prior to his or her appointment as a qualified medical evaluator, passes an examination written and administered by the administrative director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the administrative director. The administrative director shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.

(2) Devotes at least one-third of total practice time to providing direct medical treatment, or has served as an agreed medical evaluator on eight or more occasions in the 12 months prior to applying to be appointed as a qualified medical evaluator.

(3) Is a medical doctor or doctor of osteopathy and meets one of the following requirements:

(A) Is board certified in a specialty by a board recognized by the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California.

(B) Has successfully completed a residency training program accredited by the Accreditation Council for Graduate Medical Education or the osteopathic equivalent.

(C) Was an active qualified medical evaluator on June 30, 2000.

(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.

(4) Is a doctor of chiropractic and has been certified in California workers' compensation evaluation by a provider recognized by the administrative director. The certification program shall include instruction on disability evaluation report writing that meets the standards set forth in paragraph (1).

(5) Is a psychologist and meets one of the following requirements:

(A) Is board certified in clinical psychology by a board recognized by the administrative director.

(B) Holds a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, from a university or professional school recognized by the administrative director and has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

(6) Does not have a conflict of interest as determined under the regulations adopted by the administrative director pursuant to subdivision (o).

(7) Meets any additional medical or professional standards adopted pursuant to paragraph (6) of subdivision (j).

(c) The administrative director shall adopt standards for appointment of physicians who are retired or who hold teaching positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify under paragraph (2) of subdivision (b). A physician whose full-time practice is limited to the forensic evaluation of disability shall not be appointed as a qualified medical evaluator under this subdivision.

(d) The qualified medical evaluator, upon request, shall be reappointed if he or she meets the qualifications of subdivision (b) and meets all of the following criteria:

(1) Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director.

(2) Has not had more than five of his or her evaluations that were considered by a workers' compensation administrative law

judge at a contested hearing rejected by the workers' compensation administrative law judge or the appeals board pursuant to this section during the most recent two-year period during which the physician served as a qualified medical evaluator. If the workers' compensation administrative law judge or the appeals board rejects the qualified medical evaluator's report on the basis that it fails to meet the minimum standards for those reports established by the administrative director or the appeals board, the workers' compensation administrative law judge or the appeals board, as the case may be, shall make a specific finding to that effect, and shall give notice to the medical evaluator and to the administrative director. Any rejection shall not be counted as one of the five qualifying rejections until the specific finding has become final and time for appeal has expired.

(3) Has completed within the previous 24 months at least 12 hours of continuing education in impairment evaluation or workers' compensation-related medical dispute evaluation approved by the administrative director.

(4) Has not been terminated, suspended, placed on probation, or otherwise disciplined by the administrative director during his or her most recent term as a qualified medical evaluator.

If the evaluator does not meet any one of these criteria, the administrative director may in his or her discretion reappoint or deny reappointment according to regulations adopted by the administrative director. A physician who does not currently meet the requirements for initial appointment or who has been terminated under subdivision (e) because his or her license has been revoked or terminated by the licensing authority shall not be reappointed.

(e) The administrative director may, in his or her discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under subdivision (k) or (*l*) whenever either of the following conditions occurs:

(1) The evaluator's license to practice in California has been suspended by the relevant licensing authority so as to preclude practice, or has been revoked or terminated by the licensing authority.

(2) The evaluator has failed to timely pay the fee required by the administrative director pursuant to subdivision (n).

(f) The administrative director shall furnish a physician, upon request, with a written statement of its reasons for termination of, or for denying appointment or reappointment as, a qualified medical evaluator. Upon receipt of a specific response to the statement of reasons, the administrative director shall review his or her decision not to appoint or reappoint the physician or to terminate the physician and shall notify the physician of its final decision within 60 days after receipt of the physician's response.

(g) The administrative director shall establish agreements with qualified medical evaluators to ensure the expeditious evaluation of cases assigned to them for comprehensive medical evaluations.

(h) (1) When requested by an employee or employer pursuant to Section 4062.1, the medical director appointed pursuant to Section 122 shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. Preference in assigning panels shall be given to cases in which the employee is not represented. If a panel is not assigned within 20 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice within a reasonable geographic area. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type requested by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall promulgate a form that shall notify the employee of the physicians selected for his or her panel after a request has been made pursuant to Section 4062.1 or 4062.2. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: "You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will

consider the evaluation prepared by the doctor you select to decide your claim."

(3) When compiling the list of evaluators from which to select randomly, the medical director shall include all qualified medical evaluators who meet all of the following criteria:

(A) He or she does not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision (o).

(B) He or she is certified by the administrative director to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence. An evaluator shall not conduct qualified medical evaluations at more than 10 locations.

(C) He or she has not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the administrative director pursuant to subdivision (n) or for any other reason.

(4) When the medical director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122 shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) (A) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. The administrative director shall develop regulations governing the provision of extensions of the 30-day period in both of the following cases:

(i) When the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline.

(ii) To extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause.

(B) For purposes of subparagraph (A), "good cause" means any of the following:

(i) Medical emergencies of the evaluator or evaluator's family.

(ii) Death in the evaluator's family.

(iii) Natural disasters or other community catastrophes that interrupt the operation of the evaluator's business.

(C) The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Section 4062.1. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury in a manner consistent with Sections 4660 and 4660.1.

(3) Procedures governing the determination of any disputed medical treatment issues in a manner consistent with Section 5307.27.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental

disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(5) Guidelines for the range of time normally required to perform the following:

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

(B) Any treatment procedures that have not been defined and valued pursuant to Section 5307.1.

(C) Any other evaluation procedure requested by the Insurance Commissioner, or deemed appropriate by the administrative director.

(6) Any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator.

(k) Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (*l*), determines, based on substantial evidence, that a qualified medical evaluator:

(1) Has violated any material statutory or administrative duty.

(2) Has failed to follow the medical procedures or qualifications established pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).

(3) Has failed to comply with the timeframe standards established pursuant to subdivision (j).

(4) Has failed to meet the requirements of subdivision (b) or (c).

(5) Has prepared medical-legal evaluations that fail to meet the minimum standards for those reports established by the administrative director or the appeals board.

(6) Has made material misrepresentations or false statements in an application for appointment or reappointment as a qualified medical evaluator.

A hearing shall not be required prior to the suspension or termination of a physician's privilege to serve as a qualified medical evaluator when the physician has done either of the following:

(A) Failed to timely pay the fee required pursuant to subdivision (n).

(B) Had his or her license to practice in California suspended by the relevant licensing authority so as to preclude practice, or had the license revoked or terminated by the licensing authority.

(*l*) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

(m) The administrative director shall terminate from the list of medical evaluators any physician ~~where~~ *whose* licensure has been terminated by the relevant licensing board, or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice, or of a crime of moral turpitude. The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board. *The administrative director shall terminate as a medical evaluator any physician who is a person described in paragraph (3) of subdivision (b) of Section 139.21.* If a physician is suspended or terminated as a qualified medical evaluator under this subdivision, a report prepared by the physician that is not complete, signed, and furnished to one or more of the parties prior to the date of conviction or action of the licensing board, whichever is earlier, shall not be admissible in any proceeding before the appeals board nor shall there be any

liability for payment for the report and any expense incurred by the physician in connection with the report.

(n) A qualified medical evaluator shall pay a fee, as determined by the administrative director, for appointment or reappointment. These fees shall be based on a sliding scale as established by the administrative director. All revenues from fees paid under this subdivision shall be deposited into the Workers' Compensation Administration Revolving Fund and are available for expenditure upon appropriation by the Legislature, and shall not be used by any other department or agency or for any purpose other than administration of the programs of the Division of Workers' Compensation related to the provision of medical treatment to injured employees.

(o) An evaluator shall not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code. The administrative director, after consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt regulations to implement this subdivision.

SEC. 2. Section 139.21 is added to the Labor Code, immediately following Section 139.2, to read:

139.21. (a) (1) The administrative director shall promptly suspend any physician or practitioner from participating in the workers' compensation system in any capacity when the individual or entity meets any of the following criteria:

(A) The individual has been convicted of a felony.

(B) The individual has been convicted of a misdemeanor involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system.

(C) The individual has been convicted of a misdemeanor involving fraud or abuse of any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(D) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.

(E) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(2) The administrative director shall exercise due diligence to identify physicians and practitioners who have been suspended as described in subdivision (a) by accessing the quarterly updates to

the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

(b) (1) The administrative director shall adopt regulations for suspending a physician's or practitioner's participation in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician or practitioner written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the department is required to suspend the physician or practitioner pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the physician or practitioner requests a hearing and, in that hearing, the physician or practitioner provides proof that paragraph (1) of subdivision (a) is not applicable. The physician or practitioner may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the department finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician or practitioner.

(3) If a physician is a qualified medical examiner, and the department finds, in accordance with the notice and hearing requirements of this section, that paragraph (1) of subdivision (a) is applicable to that physician, the physician shall be terminated from the list of medical evaluators pursuant to subdivision (m) of Section 139.2.

(c) The administrative director shall promptly notify the physician's or practitioner's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the department's qualified medical evaluator and medical provider network databases, as appropriate.

(d) A provider of services, whether an individual, clinic, group, corporation, or other association, may not submit a claim for payment to, or pursue a claim for payment from, a payor for any services or supplies provided by a physician or practitioner whose participation in the workers' compensation system has been

suspended pursuant to this section, unless that claim for payment has been reduced to final judgment or the services or supplies are unrelated to a violation of the laws governing workers' compensation.

~~SEC. 2.~~

SEC. 3. Section 14123 of the Welfare and Institutions Code is amended to read:

14123. Participation in the Medi-Cal program by a provider of service is subject to suspension in order to protect the health of the recipients and the funds appropriated to carry out this chapter.

(a) (1) The director may suspend a provider of service from further participation under the Medi-Cal program for violation of any provision of this chapter or Chapter 8 (commencing with Section 14200) or any rule or regulation promulgated by the director pursuant to those chapters. The suspension may be for an indefinite or specified period of time and with or without conditions, or may be imposed with the operation of the suspension stayed or probation granted. The director shall suspend a provider of service for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.

(2) If the provider of service is a clinic, group, corporation, or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization, of a crime described in paragraph (1) shall result in the suspension of that organization and the individual convicted if the director believes that suspension would be in the best interest of the Medi-Cal program. If the provider of services is a political subdivision of the state or other government agency, the conviction of the person in charge of the facility of a crime described in paragraph (1) may result in the suspension of that facility. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of the fact that the conviction occurred. A plea or verdict of guilty, or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(3) After conviction, but before the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, the director, if he or she believes that suspension would be in the best

interests of the Medi-Cal program, may order the suspension of a provider of service. When the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence irrespective of any subsequent order under Section 1203.4 of the Penal Code allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment, the director shall order the suspension of a provider of service. The suspension shall not take effect earlier than the date of the director's order. Suspension following a conviction is not subject to the proceedings required in subdivision (c). However, the director may grant an informal hearing at the request of the provider of service to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension provided for in this subdivision.

(4) If the provider of service appeals the conviction and the conviction is reversed, the provider may apply for reinstatement to the Medi-Cal program after the conviction is reversed. Notwithstanding Section ~~14126.6,~~ *14124.6,* the application for reinstatement shall not be subject to the one-year waiting period for the filing of a reinstatement petition pursuant to Section 11522 of the Government Code.

(b) Whenever the director receives written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or medicaid programs, the director shall promptly suspend the practitioner from participation in the Medi-Cal program and notify the Administrative Director of the Division of Workers' Compensation of the suspension, in accordance with paragraph (2) of subdivision (e). This automatic suspension is not subject to the proceedings required in subdivision (c). No payment from state or federal funds may be made for any item or service rendered by the practitioner during the period of suspension.

(c) The proceedings for suspension shall be conducted pursuant to Section 100171 of the Health and Safety Code. The director may temporarily suspend any provider of service prior to any hearing when in his or her opinion that action is necessary to

protect the public welfare or the interests of the Medi-Cal program. The director shall notify the provider of service of the temporary suspension and the effective date thereof and at the same time serve the provider with an accusation. The accusation and all proceedings thereafter shall be in accordance with Section 100171 of the Health and Safety Code. Upon receipt of a notice of defense by the provider, the director shall set the matter for hearing within 30 days after receipt of the notice. The temporary suspension shall remain in effect until such time as the hearing is completed and the director has made a final determination on the merits. The temporary suspension shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. This subdivision does not apply where the suspension of a provider is based upon the conviction of any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare program. In those instances, suspension shall be automatic.

(d) (1) The suspension by the director of any provider of service shall preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies the provider has provided under the program, except for services or supplies provided prior to the suspension. No clinic, group, corporation, or other association which is a provider of service shall submit claims for payment to the Medi-Cal program for any services or supplies provided by a person within the organization who has been suspended or revoked by the director, except for services or supplies provided prior to the suspension.

(2) If the provisions of this chapter, Chapter 8 (commencing with Section 14200), or the regulations promulgated by the director are violated by a provider of service that is a clinic, group, corporation, or other association, the director may suspend the organization and any individual person within the organization who is responsible for the violation.

(e) (1) Notice of the suspension shall be sent by the director to the provider's state licensing, certifying, or registering authority, along with the evidence upon which the suspension was based.

(2) At the same time notice is provided pursuant to paragraph (1), the director shall provide written notification of the suspension

to the Administrative Director of the Division of Workers' Compensation, for purposes of Section ~~5307.15~~ *139.21* of the Labor Code.

(f) In addition to the bases for suspension contained in subdivisions (a) and (b), the director may suspend a provider of service from further participation under the Medi-Cal dental program for the provision of services that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. The suspension shall be subject to the requirements contained in subdivisions (a) to (e), inclusive.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1306
Author: Burke
Bill Date: June 30, 2016, Amended
Subject: Certified Nurse Midwives: Scope of Practice
Sponsor: California Nurse Midwives Association
Current Position: Oppose Unless Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would remove the physician supervision requirement for certified nurse midwives (CNMs) working in specified settings, would increase educational requirements, and would establish a Nurse-Midwifery Advisory Committee within the Board of Registered Nursing (BRN), among other changes.

BACKGROUND:

CNMs are registered nurses with a certificate to practice midwifery, who have acquired additional training in the field of obstetrics and are certified by the American College of Nurse Midwives. Like licensed midwives (LMs), CNMS can practice in homes, birth centers and clinics; however, CNMs can also practice in hospital settings. In 2012, CNMs attended approximately 8.5 percent of all births in California, the majority of these births took place in a hospital, and the remainder took place in free-standing birthing centers. It is estimated that ninety percent of CNM attended births take place in a hospital setting. CNMs are required to practice under the supervision of a physician; California is one of six states that require physician supervision of CNMs.

Existing law authorizes a CNM, under physician supervision, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother, and immediate care for the newborn. Existing law authorizes a CNM to furnish and order drugs or devices incidental to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the CNM's education, and in accordance with standardized procedures and protocols with the supervising physician. Existing law also authorizes a CNM to perform and repair episiotomies and repair first-degree and second degree lacerations of the perineum in a licensed acute care hospital and licensed alternate birth center, if performed pursuant to protocols developed and approved by the supervising physician.

AB 1308 (Bonilla, Chapter 665) was signed into law in 2013 and removed the physician supervision requirement for LMs. There were specific requirements on what type of patients LMs can accept, which are those that meet the criteria for normal pregnancy and

childbirth, as specified. If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM must refer that client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk factors are not likely to significantly affect the course of pregnancy and childbirth. AB 1308 also allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to the practice of midwifery and consistent with the LMs' scope of practice. AB 1308 was very narrow on what services could be provided and what patients an LM could accept. It also included other provisions related to hospital transfers and education program requirements.

ANALYSIS

This bill would subject CNMs to the anti-kickback and referral prohibitions in Business and Professions Code Section 650.01 and the exemptions in 650.02 and would add an exemption for a referral to a licensed alternative birth center or nationally accredited alternative birth center.

This bill would require a CNM applicant to provide evidence of current advanced level national certification by a certifying body that meets standards established and approved by the BRN.

This bill would require the BRN to create and appoint a Nurse-Midwifery Advisory Committee (Committee), similar to the Medical Board of California's (Board) Midwifery Advisory Council (MAC), which would consist of CNMs in good standing with experience in hospital settings, alternative birth center settings, and home settings; a nurse-midwife educator, as specified; a consumer of midwifery care; and at least two qualified physicians, including an obstetrician that has experience working with nurse-midwives. The Committee membership must consist of a majority of CNMs who shall make recommendations to BRN on all matters related to nurse-midwifery practice, education, and other matters specified by BRN, and would require the Committee to meet regularly, but at least twice a year.

This bill would authorize a CNM to manage a full range of primary gynecological and obstetric care services for women from adolescence to beyond menopause, consistent with the Core Competencies for Basic Midwifery Practice promulgated by the American College of Nurse-Midwives, as approved by BRN. These services include, but are not limited to: primary health care; gynecologic and family planning services; preconception care; care during pregnancy, childbirth, and postpartum period; immediate care of the newborn; and treatment of male partners for sexually transmitted infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services, as indicated.

This bill would allow a CNM to practice without physician supervision in the following settings:

- A licensed clinic.

- A licensed health facility (this includes a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, etc.).
- A county medical facility.
- A medical group practice, including a professional medical corporation, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.
- A licensed alternative birth center or a nationally accredited alternative birth center.
- A nursing corporation.
- A home setting.

This bill would allow a CNM to be employed in these settings; however the entity shall not interfere with, control, or otherwise direct the professional judgment of a CNM.

This bill would only allow a CNM to attend normal and low-risk pregnancy and childbirth in the home setting when all of the following conditions apply:

- There is an absence of all of the following:
    - Any preexisting maternal disease or condition creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.
    - Disease arising from or during the pregnancy creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.
    - Prior caesarean delivery.
- There is a singleton fetus.
- There is cephalic presentation at the onset of labor.
- The gestational age of the fetus is greater than 37 0/7 weeks and less than 42 0/7 completed weeks of pregnancy at the onset of labor.
- Labor is spontaneous or induced in an outpatient setting.

If a potential CNM client meets all of the above conditions, but has had a prior caesarean delivery, and the woman still desires to be a client of the CNM, the CNM shall provide the woman with a referral for an examination by a physician trained in obstetrics and gynecology. A CNM may assist the woman in pregnancy and childbirth only if an examination by a physician trained in obstetrics and gynecology is obtained and, based upon review of the client's medical file, the CNM determines that the risk factors presented by the woman's condition do not increase the woman's risk beyond that of a normal, low-risk pregnancy and birth. A CNM may continue care of the client during a reasonable interval between the referral and the initial appointment with the physician.

This bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the

client and the resources of the medical personnel available in the setting of care. This bill would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care and early detection and referral of a complication to a physician. This bill would require CNMs working in a hospital setting to collaboratively care for women with more complex health needs.

This bill would require a CNM to be subject to all credentialing and quality standards held by the facility in which he or she practices. This bill would require the peer review body to include CNMs as part of the peer review body that reviews CNMS. This bill would require the peer review body of that facility to impose standards that assure quality and patient safety and these standards must be approved by the relevant governing body unless found by a court to be arbitrary and capricious.

This bill would delete requirements in existing law that drugs or devices must be furnished or ordered by a CNM in accordance with standardized procedures and protocols. This bill would require CNMs to only furnish Schedule II controlled substances in a nonhospital setting during labor and delivery and only after a consultation with a physician. This bill would authorize a CMN to: furnish and order drugs or devices in connection with care rendered in a home; directly procure supplies and devices; order, obtain, and administer drugs and diagnostic tests; order laboratory and diagnostic testing; and receive reports that are necessary to his or her practice as a CNM and that are consistent with nurse-midwifery education preparation.

This bill would authorize a CNM to perform and repair episiotomies and to repair first degree and second degree lacerations of the perineum in a nationally accredited birth center or in a patient's home, as specified, and would delete all requirements that those procedures be performed pursuant to protocols developed and approved by a supervising physician.

This bill would state that a consultative relationship between a CNM and a physician shall not, by itself, provide the basis for finding a physician liable for any act or omission of the CNM.

This bill has been significantly amended and the amendments address the concerns previously raised by the Board. This bill now would require two physician members on the Committee, is very restricted on what types of patients a CNM can accept, and requires a physician examination for patients that have had a prior caesarean delivery. Although the CNM is allowed to make the determination regarding the risk factors for patients that have had a prior caesarean delivery, the CNM is still held to the standard of care and subject to discipline if that standard is not met. Although this bill does not include a ban on the corporate practice of medicine for CNMs, the type of settings where CNMs are allowed to work without physician supervision are limited, and for the most part they are licensed facilities overseen by the California Department of Public Health. Although this bill now includes parameters on independent CNM practice, this bill does expand the scope of a CNM to include primary health care as part of the gynecological and obstetric care services that a CNM can provide. If the

reference to primary health care is removed, Board staff believes this bill has the necessary protections in place to ensure consumer protection. As such, Board staff is recommending that the Board change its position from oppose unless amended to neutral if amended.

FISCAL: None to the Board

SUPPORT: California Nurse Midwives Association (Sponsor); Association of Healthcare Districts; and AARP
7/1/15 Version
American Association of Birth Centers; American College of Nurse-Midwives; American Nurses Association/California; Beach Cities Midwifery & Women's Health Care; Beachside Birth Center; Black Women for Wellness; California Association of Midwives; California Association of Nurse Anesthetists; Center on Reproductive Rights and Justice at the University of California, Berkley School of Law; County of Santa Cruz Board of Supervisors; Inland Midwife Service; Maternal and Child Health Access; South Coast Midwifery & Women's Healthcare, Inc.; United Nurses Associations of California/Union of Health Care Professionals; and numerous individuals

OPPOSITION: Adventist Health; California Association for Nurse Practitioners; California Hospital Association; and Sutter Health
7/1/15 Version
California Association of Clinical Nurse Specialists; Ceders-Sinai; Coalinga Regional Medical Center; Community Hospital of the Monterey Peninsula; El Camino Hospital; Henry Mayo Newhall Hospital; Lodi Health; Loma Linda University Health; Lompoc Valley Medical Center; Mammoth Hospital; Medical Board of California; Natividad Medical Center; Ridgecrest Regional Hospital; San Antonio Regional Hospital; San Benito Health Care District; San Gorgonio Memorial Hospital; Sharp Healthcare; St. Helena Hospital Napa Valley; Sutter Health; and Watsonville Community Hospital

POSITION: Recommendation: Neutral if Amended

AMENDED IN SENATE JUNE 30, 2016

AMENDED IN SENATE JUNE 20, 2016

AMENDED IN SENATE JULY 1, 2015

AMENDED IN ASSEMBLY MAY 28, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1306

Introduced by Assembly Member Burke
(Coauthor: Assembly Member Mark Stone)

February 27, 2015

An act to amend Sections *510,* 650.01, 650.02, 2725.1, 2746.2, 2746.5, 2746.51, 2746.52, 4061, 4076, and 4170 of, and to add Section 2746.6 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1306, as amended, Burke. Healing arts: certified nurse-midwives: scope of practice.

(1) Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and authorizes the board to issue a certificate to practice nurse-midwifery to a person who meets educational standards established by the board or the equivalent of those educational standards. The act makes the violation of any of its provisions a misdemeanor punishable upon conviction by imprisonment in the county jail for not less than 10 days nor more than one year, or by a fine of not less than $20 nor more than $1,000, or by both that fine and imprisonment.

This bill would additionally require an applicant for a certificate to practice nurse-midwifery to provide evidence of current advanced level

national certification by a certifying body that meets standards established and approved by the board. The bill would also require the board to create and appoint a Nurse-Midwifery Advisory Committee consisting of certified nurse-midwives in good standing with experience in hospital settings, alternative birth settings, and home settings, a nurse-midwife educator, as specified, 2 qualified physicians, and a consumer of midwifery care. ~~This~~ *The* bill would require the committee to consist of a majority of certified nurse-midwives and would require the committee to make recommendations to the board on all matters related to nurse-midwifery practice, education, disciplinary actions, standards of care, and other matters specified by the board, and would require the committee to meet regularly, but at least twice a year. ~~This bill would prohibit corporations and other artificial legal entities from having professional rights, privileges, or powers under the act, except as specified. The bill would authorize specified entities to employ a certified nurse-midwife and charge for professional services rendered by that certified nurse-midwife, as provided.~~

(2) The act authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal.

This bill would delete those provisions and would instead authorize a certified nurse-midwife to manage a full range of gynecological and obstetric care services for women from adolescence beyond menopause, as provided. The bill would authorize a certified nurse-midwife to practice *under that gynecological and obstetric care services authorization without supervision of a physician and surgeon* in certain settings, including, but not limited to, a home setting, as specified. ~~This~~ *The bill would prohibit entities described in those specified settings from interfering with, controlling, or otherwise directing the professional judgment of such a certified nurse-midwife, as specified. The* bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the client and the resources of the medical personnel available in the setting of care, and would provide that the practice of

nurse-midwifery emphasizes informed consent, preventive care, and early detection and referral of complications to a physician and surgeon.

(3) The act authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the certified nurse-midwife's educational preparation in specified facilities and clinics, and only in accordance with standardized procedures and protocols, as specified.

This bill would delete the requirement that drugs or devices are furnished or ordered in accordance with standardized procedures and protocols. The bill would authorize a certified nurse-midwife to furnish and order drugs or devices in connection with care rendered in a home, and would authorize a certified nurse-midwife to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and that are consistent with nurse-midwifery education preparation.

(4) The act also authorizes a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a licensed acute care hospital and a licensed alternate birth center, if certain requirements are met, including, but not limited to, that episiotomies are performed pursuant to protocols developed and approved by the supervising physician and surgeon.

This bill would also authorize a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a home, and would delete all requirements that those procedures be performed pursuant to protocols developed and approved by the supervising physician and surgeon. The bill would require a certified nurse-midwife to provide emergency care to a patient during times when a physician and surgeon is unavailable.

This bill would provide that a consultative relationship between a certified nurse-midwife and a physician and surgeon by ~~it self~~ *itself* is not a basis for finding the physician and surgeon liable for any acts or omissions on the part of the certified nurse-midwife. The bill would also update cross-references as needed.

(5) Because the act makes a violation of any of its provisions a misdemeanor, this bill would expand the scope of an existing crime and therefore this bill would impose a state-mandated local program.

(6) Existing law provides prescribed protection against retaliation for health care practitioners who advocate for appropriate health care for their patients. Existing law defines "health care practitioner" for those purposes to mean a person who engages in acts that are the subject of licensure or regulation under specific law or initiative act and who is either a licentiate, as defined, a party to a contract with a payer whose decision, policy, or practice is subject to such advocacy, or an individual designated in a contract with a payer whose decision, policy, or practice is subject to such advocacy, where the individual is granted the right to appeal denials of payment or authorization for treatment under the contract.

This bill would expand that protection against retaliation to certified nurse-midwives.

~~(6)~~

(7) Existing law prohibits a licensee, as defined, from referring a person for laboratory, diagnostic, nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or entity that receives the referral, and makes a violation of that prohibition punishable as a misdemeanor. Under existing law, the Medical Board of California is required to review the facts and circumstances of any conviction for violating the prohibition, and to take appropriate disciplinary action if the licensee has committed unprofessional conduct. Existing law provides that, among other exceptions, this prohibition does not apply to a licensee who refers a person to a health facility if specified conditions are met.

This bill would include a certified nurse-midwife under the definition of a licensee, which would expand the scope of an existing crime and therefore impose a state-mandated local program. The bill would require the Board of Registered Nursing to review the facts and circumstances of any conviction of a certified nurse-midwife for violating that prohibition, and would require the board to take appropriate disciplinary action if the certified nurse-midwife has committed unprofessional conduct. The bill would additionally authorize a licensee to refer a person to a licensed alternative birth center, as defined, or a nationally accredited alternative birth center.

~~(7)~~

(8) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 510 of the Business and Professions Code is amended to read:

510. (a) The purpose of this section is to provide protection against retaliation for health care practitioners who advocate for appropriate health care for their patients pursuant to Wickline v. State of California 192 Cal. App. 3d 1630.

(b) It is the public policy of the State of California that a health care practitioner be encouraged to advocate for appropriate health care for his or her patients. For purposes of this section, "to advocate for appropriate health care" means to appeal a payer's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the health care practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care, reasonably believes impairs the health care practitioner's ability to provide appropriate health care to his or her patients.

(c) The application and rendering by any individual, partnership, corporation, or other organization of a decision to terminate an employment or other contractual relationship with or otherwise penalize a health care practitioner principally for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care violates the public policy of this state.

(d) This section shall not be construed to prohibit a payer from making a determination not to pay for a particular medical treatment or service, or the services of a type of health care practitioner, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body acting pursuant to Section 809.05, or payer from enforcing reasonable peer review or utilization review protocols or determining whether a health care practitioner has complied with those protocols.

(e) (1) Except as provided in paragraph (2), appropriate health care in a hospital licensed pursuant to Section 1250 of the Health and Safety Code shall be defined by the appropriate hospital committee and approved by the hospital medical staff and the governing body, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care.

(2) To the extent the issue is under the jurisdiction of the medical staff and its committees, appropriate health care in a hospital licensed pursuant to Section 1250 of the Health and Safety Code shall be defined by the hospital medical staff and approved by the governing body, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care.

(f) Nothing in this section shall be construed to prohibit the governing body of a hospital from taking disciplinary actions against a health care practitioner as authorized by Sections 809.05, 809.4, and 809.5.

(g) Nothing in this section shall be construed to prohibit the appropriate licensing authority from taking disciplinary actions against a health care practitioner.

(h) For purposes of this section, "health care practitioner" means *either* a person who is described in subdivision (f) of Section 900 and who is either (1) a licentiate as defined in Section 805, or (2) a party to a contract with a payer whose decision, policy, or practice is subject to the advocacy described in subdivision (b), or (3) an individual designated in a contract with a payer whose decision, policy, or practice is subject to the advocacy described in subdivision (b), where the individual is granted the right to appeal

denials of payment or authorization for treatment under the ~~contract.~~ *contract, or a person who is described in Section 2746.2.*

(i) Nothing in this section shall be construed to revise or expand the scope of practice of any health care practitioner, or to revise or expand the types of health care practitioners who are authorized to obtain medical staff privileges or to submit claims for reimbursement to payers.

(j) The protections afforded health care practitioners by this section shall be in addition to the protections available under any other law of this state.

~~SECTION 1.~~

SEC. 2. Section 650.01 of the Business and Professions Code is amended to read:

650.01. (a) Notwithstanding Section 650, or any other law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) "Diagnostic imaging" includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For

purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of his or her research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for his or her ongoing services in making refinements to his or her medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, "immediate family" includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) "Licensee" means a physician as defined in Section 3209.3 of the Labor Code, and a certified nurse-midwife as defined in Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code.

(5) "Licensee's office" means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall

be licensed or certified when licensure or certification is required by law.

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

~~SEC. 2.~~

SEC. 3. Section 650.02 of the Business and Professions Code is amended to read:

650.02. The prohibition of Section 650.01 shall not apply to or restrict any of the following:

(a) A licensee may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 650.01 if the licensee's regular practice is located where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. If an alternative provider commences furnishing the good or service for which a patient was referred pursuant to this subdivision, the licensee shall cease referrals under this subdivision within six months of the time at which the licensee knew or should have known that the alternative provider is furnishing the good or service. A licensee who refers to or seeks consultation from an organization in which the licensee has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A licensee, when the licensee or his or her immediate family has one or more of the following arrangements with another licensee, a person, or an entity, is not prohibited from referring a patient to the licensee, person, or entity because of the arrangement:

(1) A loan between a licensee and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a licensee and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) Ownership of corporate investment securities, including shares, bonds, or other debt instruments that may be purchased on terms generally available to the public and that are traded on a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the licensee's referral

of persons to the corporation, do not have a separate class or accounting for any persons or for any licensees who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous three fiscal years, stockholder equity exceeding seventy-five million dollars ($75,000,000).

(4) Ownership of shares in a regulated investment company as defined in Section 851(a) of the federal Internal Revenue Code, if the company had, at the end of the company's most recent fiscal year, or on average during the previous three fiscal years, total assets exceeding seventy-five million dollars ($75,000,000).

(5) A one-time sale or transfer of a practice or property or other financial interest between a licensee and the recipient of the referral if the sale or transfer is for commercially reasonable terms and the consideration is not affected by either party's referral of any person or the volume of services provided by either party.

(6) A personal services arrangement between a licensee or an immediate family member of the licensee and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the licensee or an immediate family member of the licensee.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A person who is referred by a licensee or an immediate family member of the licensee is informed in writing of the personal services arrangement that includes information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A licensee may refer a person to a health facility, as defined in Section 1250 of the Health and Safety Code, a licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or to any facility, or nationally accredited alternative birth center, owned or leased by a health facility, if the recipient of the referral does not compensate the licensee for the patient referral, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a licensee solely because the licensee has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A licensee may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code.

(4) A licensee may refer a person to any organization that owns or leases a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code if the licensee is not compensated for the patient referral, the licensee does not receive any payment from the recipient of the referral that is based or determined on the number or value of any patient referrals, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b). For purposes of this paragraph, the ownership may be through stock or membership, and may be represented by a parent holding company that solely owns or controls both the health facility organization and the affiliated organization.

(d) A licensee may refer a person to a nonprofit corporation that provides physician services pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code if the nonprofit corporation is controlled through membership by one or more health facilities or health facility systems and the amount of compensation or other transfer of funds from the health facility or nonprofit corporation to the licensee is fixed annually, except for adjustments caused by physicians joining or leaving the groups during the year, and is not based on the number of persons utilizing goods or services specified in Section 650.01.

(e) A licensee compensated or employed by a university may refer a person for a physician service, to any facility owned or operated by the university, or to another licensee employed by the university, provided that the facility or university does not compensate the referring licensee for the patient referral. In the case of a facility that is totally or partially owned by an entity other than the university, but that is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physicians for those referrals.

(f) The prohibition of Section 650.01 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a licensee's office, or the office of a group practice. Further, the provisions of Section 650.01 shall not alter, limit, or expand a licensee's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice.

(g) The prohibition of Section 650.01 shall not apply to cardiac rehabilitation services provided by a licensee or by a suitably trained individual under the direct or general supervision of a licensee, if the services are provided to patients meeting the criteria for Medicare reimbursement for the services.

(h) The prohibition of Section 650.01 shall not apply if a licensee is in the office of a group practice and refers a person for services or goods specified in Section 650.01 to a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code.

(i) The prohibition of Section 650.01 shall not apply to health care services provided to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(j) The prohibition of Section 650.01 shall not apply to a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, or a request by a radiation oncologist for radiation therapy if those services are furnished by, or under the supervision of, the pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician.

(k) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(*l*) This section shall become operative on January 1, 1995.

~~SEC. 3.~~

SEC. 4. Section 2725.1 of the Business and Professions Code is amended to read:

2725.1. (a) Notwithstanding any other law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon or an order by a certified nurse-midwife, nurse practitioner, or physician assistant issued pursuant to Section 2746.51, 2836.1, or 3502.1, respectively, if the registered nurse is functioning within a licensed primary care clinic as defined in subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b), (c), (h), or (j) of Section 1206 of, the Health and Safety Code.

(b) No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(c) This section shall not be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section 2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

(d) This section shall not be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

~~SEC. 4.~~

SEC. 5. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) Each applicant shall show by evidence satisfactory to the board that he or she has met the educational standards established by the board or has at least the equivalent thereof, including evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board.

(b) The board shall create and appoint a Nurse-Midwifery Advisory Committee consisting of certified nurse-midwives in good standing with experience in hospital settings, alternative birth center settings, and home settings, a nurse-midwife educator who has demonstrated familiarity with educational standards in the delivery of maternal-child health care, a consumer of midwifery care, and at least two qualified physicians, including an obstetrician that has experience working with nurse-midwives. The committee membership shall consist of a majority of certified nurse-midwives and shall make recommendations to the board on all matters related to nurse-midwifery practice, education, and other matters as specified by the board. The committee shall meet regularly, but at least twice a year.

~~(c) Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Board of Registered Nursing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.~~

~~(d) Notwithstanding subdivision (c), the following entities may employ a certified nurse-midwife and charge for professional services rendered by a certified nurse-midwife; however, the entity shall not interfere with, control, or otherwise direct the professional judgment of a certified nurse-midwife:~~

~~(1) A clinic operated under subdivision (h) or (p) of Section 1206 of the Health and Safety Code.~~

~~(2) A hospital owned and operated by a health care district pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code.~~

~~(3) A clinic operated primarily for the purpose of medical education or nursing education by a public or private nonprofit university medical school, which is approved by the Medical Board or the Osteopathic Medical Board of California, provided the certified nurse-midwife holds an academic appointment on the faculty of the university, including, but not limited to, the University of California medical schools and hospitals.~~

~~(4) A licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or a nationally accredited alternative birth center owned or operated by a nursing corporation, as defined in Section 2775 of the Business and Professions Code.~~

~~(5) A health facility described in Section 1250 of the Health and Safety Code if the certified-nurse midwife is practicing under the supervision of a physician and surgeon.~~

~~(6) A clinic operated under subdivision (a) of Section 1204 of the Health and Safety code.~~

~~(e) As used in this section, supervision shall not be construed to require the physical presence of a supervising physician and surgeon. A facility described in paragraphs (1) to (4), inclusive, of subdivision (d) that employs a certified-nurse midwife shall not require supervision by a physician and surgeon of the certified-nurse midwife.~~

~~SEC. 5.~~

SEC. 6. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) The certificate to practice nurse-midwifery authorizes the holder to manage a full range of primary gynecological and obstetric care services for women from adolescence to beyond menopause, consistent with the Core Competencies for Basic Midwifery practice promulgated by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. These services include, but are not limited to, primary health care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth, and the postpartum period, immediate care of the newborn, and treatment of male partners for sexually

transmitted infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services, as indicated.

(b) A certified nurse-midwife may practice *under this section without supervision of a physician and surgeon* in the following settings:

(1) A licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) A facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(3) A facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(4) A medical group practice, including a professional medical corporation, a medical partnership, a medical foundation exempt from licensure pursuant to Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

(5) A licensed alternative birth center, as described in Section 1204 of the Health and Safety Code, or nationally accredited birth center.

(6) A nursing corporation, as defined in Section 2775 of the Business and Professions Code.

(7) A home setting.

(A) Except as provided in subparagraph (B), a certified nurse-midwife shall only attend during normal, low-risk pregnancy and childbirth in the home setting when all of the following conditions apply:

(i) There is the absence of all of the following:

(I) Any preexisting maternal disease or condition creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.

(II) Disease arising from or during the pregnancy creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.

(III) Prior caesarean delivery.

(ii) There is a singleton fetus.

(iii) There is cephalic presentation at the onset of labor.

(iv) The gestational age of the fetus is greater than 370/7 weeks and less than 420/7 completed weeks of pregnancy at the onset of labor.

(v) Labor is spontaneous or induced in an outpatient setting.

(B) If a potential certified nurse-midwife client meets the conditions specified in subclauses (I) and (II) of clause (i) and clauses (ii) to (v), inclusive, of subparagraph (A), but fails to meet the condition specified in subclause (III) of clause (i) of subparagraph (A), and the woman still desires to be a client of the certified nurse-midwife, the certified nurse-midwife shall provide the woman with a referral for an examination by a physician and surgeon trained in obstetrics and gynecology. A certified nurse-midwife may assist the woman in pregnancy and childbirth only if an examination by a physician and surgeon trained in obstetrics and gynecology is obtained and, based upon review of the client's medical file, the certified nurse-midwife determines that the risk factors presented by the woman's condition do not increase the woman's risk beyond that of a normal, low-risk pregnancy and birth. The certified nurse-midwife may continue care of the client during a reasonable interval between the referral and the initial appointment with the physician and surgeon.

(c) An entity described in subdivision (b) shall not interfere with, control, or otherwise direct the professional judgment of a certified nurse-midwife functioning pursuant to this section in a manner prohibited by Section 510 or any other law.

~~(c)~~

(d) As used in this chapter, the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. The practice of nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications to physicians and surgeons. While practicing in a hospital setting, the certified nurse-midwife shall collaboratively care for women with more complex health needs.

~~(d)~~

(e) A certified nurse-midwife practicing under subdivision (a) shall be subject to all credentialing and quality standards held by the facility in which he or she practices. The peer review body shall include nurse-midwives as part of the peer review body that

reviews nurse-midwives. The peer review body of that facility shall impose standards that ensure quality and patient safety in their facility. The standards shall be approved by the relevant governing body unless found by a court to be arbitrary and capricious.

~~(e)~~

(f) The practice of nurse-midwifery does not include the assisting of childbirth by any forcible or mechanical means or the performance of a version.

~~(f)~~

(g) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

~~(g)~~

(h) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board and the Nurse-Midwifery Advisory Committee.

~~SEC. 6.~~

SEC. 7. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when the drugs or devices are furnished or ordered related to the provision of any of the following:

(1) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(2) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(3) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health

and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(4) Care rendered in a home pursuant to subdivision (a) of Section 2746.5.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) when the drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (1) to (3), inclusive, of subdivision (b). In a nonhospital setting, a Schedule II controlled substance shall be furnished by a certified nurse-midwife only during labor and delivery and only after a consultation with a physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of a physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(f) A certified nurse-midwife is authorized to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and consistent with nurse-midwifery education preparation.

~~SEC. 7.~~

SEC. 8. Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, in a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or a nationally accredited birth center, and in a home pursuant to paragraph (7) of subdivision (b) of Section 2746.5.

(b) The certified nurse-midwife performing and repairing first-degree and second-degree lacerations of the perineum shall do both of the following:

(1) Ensure that all complications are referred to a physician and surgeon immediately.

(2) Ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or provide emergency care for times when a physician and surgeon is not available.

~~SEC. 8.~~

SEC. 9. Section 2746.6 is added to the Business and Professions Code, to read:

2746.6. A consultative relationship between a certified nurse-midwife and a physician and surgeon shall not, by itself, provide the basis for finding a physician and surgeon liable for any act or omission of the certified nurse-midwife.

~~SEC. 9.~~

SEC. 10. Section 4061 of the Business and Professions Code is amended to read:

4061. (a) A manufacturer's sales representative shall not distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by a nurse practitioner, certified nurse-midwife, physician assistant, or naturopathic doctor, shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant

to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor.

~~SEC. 10. Section 4076 of the Business and Professions Code is amended to read:~~

~~4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:~~

~~(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.~~

~~(2) The directions for the use of the drug.~~

~~(3) The name of the patient or patients.~~

~~(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.~~

~~(5) The date of issue.~~

~~(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.~~

~~(7) The strength of the drug or drugs dispensed.~~

~~(8) The quantity of the drug or drugs dispensed.~~

~~(9) The expiration date of the effectiveness of the drug dispensed.~~

~~(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.~~

~~(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:~~

~~(i) Prescriptions dispensed by a veterinarian.~~

~~(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.~~

~~(iii) Dispensed medications for which no physical description exists in any commercially available database.~~

~~(B) This paragraph applies to outpatient pharmacies only.~~

~~(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.~~

~~(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.~~

~~(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.~~

~~(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who~~

~~functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.~~

~~(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.~~

SEC. 11. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor

who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose

containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

(e) A pharmacist shall use professional judgment to provide a patient with directions for use that enhance the patient's understanding of those directions, consistent with the prescriber's instructions.

~~SEC. 11.~~

SEC. 12. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) A prescriber shall not dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon, if applicable, a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the

Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state.

~~SEC. 12.~~

SEC. 13. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1977
Author: Wood and Waldron
Bill Date: April 13, 2016, Amended
Subject: Opioid Abuse Task Force
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish an Opioid Abuse Task Force (Task Force) to develop recommendations regarding the abuse and misuse of opioids.

BACKGROUND

The issue of preventing inappropriate prescribing and misuse and abuse of opioids is of great importance to the Medical Board of California (Board). In September 2014, the Board hosted a free continuing medical education course in Los Angeles on Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy that was developed by the U.S. Food and Drug Administration. In November 2014, after numerous Prescribing Task Force meetings with interested parties, significant public comment, and discussions with experts in the field of pain management, the Board approved a new document entitled *Guidelines for Prescribing Controlled Substances for Pain* (Guidelines). These Guidelines are intended to educate physicians on effective prescribing for pain in California by avoiding under treatment, overtreatment or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. Lastly, the Board produced two public service announcements (PSAs) that address the issue of prescription drug abuse and misuse. One was directed towards physicians and one was directed towards consumers and featured gold medalist Natalie Coughlin. These PSAs have been aired on television stations throughout California and are posted on the Board's website.

ANALYSIS

This bill would make findings and declarations regarding opioid abuse and misuse in California and the number of drug overdose deaths involving prescription opioid pain relievers.

This bill would require, on or before February 1, 2017, health care service plans and health insurer representatives, in collaboration with advocates, experts, health care professionals, and other entities and stakeholders that they deem appropriate, to convene a Task Force. The Task Force would be required to develop recommendations regarding the abuse and misuse of opioids as a serious problem that affects the health, social welfare, and economic welfare of persons in California. The Task Force shall address the following:

- Interventions that have been scientifically validated and have demonstrated clinical efficacy.
- Interventions that have measurable treatment outcomes.
- Collaborative, evidence-based approaches to resolving opioid abuse and misuse that incorporate both the provider and the patient into the solution.
- Education that engages and encourages providers to be prudent in prescribing opioids and to be proactive in defining care plans that include a plan to taper and stop opioid use.
- Review and consideration of medication coverage policies and formulary management and development of an interdisciplinary case management program that addresses quality, fraud, waste, and abuse.

This bill would require the Task Force to submit a report detailing its findings and recommendations to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and Assembly and Senate Health Committees by December 31, 2017. The Task Force is required to be dissolved by June 1, 2018.

This bill furthers the Board's mission of consumer protection and is in line with the Board's work on the important issue of preventing misuse and abuse and inappropriate prescribing of prescription drugs. The issues assigned to the Task Force would be helpful to the Board's work as well, and Board staff plans on participating in the Task Force if this bill is signed into law to ensure the discussions are in line with the Board's Guidelines. For these reasons, the Board took a support position on this bill.

FISCAL: None

SUPPORT: California Council of Community Behavioral Health Agencies; California Dental Association; California District Attorneys Association; California Health+Advocates; California State Sheriffs' Association; County Health Executives Association of California; L.A. Care Health Plan; Medical Board of California; and Mental Health America of California

OPPOSITION: California Department of Public Health

AMENDED IN ASSEMBLY APRIL 13, 2016

AMENDED IN ASSEMBLY MARCH 30, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1977

Introduced by Assembly Members Wood and Waldron

February 16, 2016

An act to ~~add Sections 2241.8 and 4069 to the Business and Professions Code, to add Section 1367.217 to~~ *add and repeal Division 10.10 (commencing with Section 11999.30) to* the Health and Safety Code, ~~and to add Section 10123.203 to the Insurance Code,~~ relating to prescription drugs.

LEGISLATIVE COUNSEL'S DIGEST

AB 1977, as amended, Wood. ~~Healing arts: prescriptions: health coverage: abuse-deterrent opioid analgesics.~~ *Opioid Abuse Task Force.*

~~(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. A violation of specified provisions of the Medical Practice Act is a crime.~~

~~This bill would prohibit a physician and surgeon from prescribing more than a 5-day supply of an opioid analgesic drug product to a patient the first time that physician and surgeon prescribes a patient such an opioid for acute pain due to surgery or injury. The bill would apply that 5-day supply limitation even if the patient has previously been prescribed such an opioid from a different physician and surgeon. Because the violation of those limitation requirements would be a crime under the Medical Practice Act, the bill would impose a state-mandated local program.~~

~~(2) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy.~~

~~This bill would require a pharmacist to inform a patient receiving for the first time an opioid analgesic drug product on proper storage and disposal of the drug. The bill would also require the California State Board of Pharmacy to adopt regulations to implement that requirement.~~

~~Because a knowing violation of these provisions would be a crime, this bill would impose a state-mandated local program.~~

~~(3) Existing~~

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. These provisions require specified services and drugs to be covered by the various health care service plans and health insurers.

This bill would ~~require an individual or group health care service plan or disability insurance policy issued, amended, or renewed after January 1, to provide coverage on its formulary, drug list, or other lists of similar construct for at least one abuse-deterrent opioid analgesic drug product per opioid analgesic active ingredient. The bill would require that the total amount of copayments and coinsurance an enrollee or insured is required to pay for brand name abuse-deterrent opioid analgesic drug products covered pursuant to the bill not exceed the lowest cost-sharing level applied to brand name or generic prescription drugs covered under the applicable health care service plan or insurer, as specified. The bill would prohibit a health care service plan or insurer from requiring an enrollee or an insured to first use a non-abuse-deterrent opioid analgesic drug product before providing coverage for an abuse-deterrent opioid analgesic drug product, subject to uniformly applied utilization review requirements described in the bill.~~ *require health care service plans and health insurers representatives, in collaboration with certain entities, to convene an Opioid Abuse Task Force on or before February 1, 2017, for the purpose of developing recommendations regarding the abuse and misuse of opioids, as specified. The bill would require the task force to submit a report detailing its findings and recommendations to specified government entities on or before December 31, 2017. The bill would require the task force to be dissolved on June 1, 2018. The bill would provide that a violation of these provisions by a health care service plan does not constitute a crime under the Knox-Keene Health*

Care Service Plan Act of 1975. The bill would make related legislative findings and declarations.

~~Because a willful violation of these requirements with respect to health care service plans would be a crime, this bill would impose a state-mandated local program.~~

~~(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~yes~~ *no*. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares as follows:

(a) Abuse and misuse of opioids is a serious problem that affects the health, social, and economic welfare of the state.

(b) After alcohol, prescription drugs are the most commonly abused substances by Americans over 12 years of age.

(c) Almost 2,000,000 people in the United States suffer from substance use disorders related to prescription opioid pain relievers.

(d) Nonmedical use of prescription opioid pain relievers can be particularly dangerous when the products are manipulated for snorting, injection, or combination with other drugs.

(e) Deaths involving prescription opioid pain relievers represent the largest proportion of drug overdose deaths, greater than the number of overdose deaths involving heroin or cocaine.

(f) The number of unintentional overdose deaths involving prescription opioid pain relievers has more than quadrupled since 1999.

~~SEC. 2. Section 2241.8 is added to the Business and Professions Code, to read:~~

~~2241.8. (a) (1) No physician and surgeon shall prescribe more than a five-day supply of an opioid analgesic drug product to a patient the first time that physician and surgeon prescribes a patient such an opioid for acute pain due to surgery or injury.~~

~~(2) The initial prescription in paragraph (1) may be for a non-abuse-deterrent opioid analgesic drug product and the five-day supply limitation shall still apply.~~

~~(3) This subdivision does not apply to an opioid prescription for a patient in chronic pain.~~

~~(b) Subdivision (a) shall apply even if the patient has previously been prescribed such an opioid from a different physician and surgeon.~~

~~(c) For the purposes of this section, "opioid analgesic drug product" has the same meaning as defined in Section 1367.217 of the Health and Safety Code.~~

~~SEC. 3. Section 4069 is added to the Business and Professions Code, to read:~~

~~4069. (a) A pharmacist shall inform a patient receiving for the first time an opioid analgesic drug product on proper storage and disposal of the drug. The board shall adopt regulations to implement this section.~~

~~(b) For the purposes of this section, "opioid analgesic drug product" has the same meaning as defined in Section 1367.217 of the Health and Safety Code.~~

~~SEC. 4. Section 1367.217 is added to the Health and Safety Code, immediately following Section 1367.215, to read:~~

~~1367.217. (a) Notwithstanding any other law, an individual or group health care service plan issued, amended, or renewed on or after January 1, that provides coverage for an opioid analgesic drug product shall comply with all of the following:~~

~~(1) The plan shall provide coverage on its formulary, drug list, or other lists of similar construct for at least one abuse-deterrent opioid analgesic drug product per opioid analgesic active ingredient.~~

~~(2) Notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay for brand name abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to brand name prescription drugs covered under the applicable health care service plan.~~

~~(3) Notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable health care service plan.~~

~~(4) The plan shall not require an enrollee to first use a non-abuse-deterrent opioid analgesic drug product before providing coverage for an abuse-deterrent opioid analgesic drug product. This paragraph shall not be construed to prevent a health care service plan from applying utilization review requirements, including prior authorization, to abuse-deterrent opioid analgesic drug products, provided that those requirements are applied to all opioid analgesic drug products with the same type of drug release, immediate or extended. This paragraph shall not be construed to preclude the use of a non-abuse-deterrent opioid for the initial prescription for a five-day supply.~~

~~(b) The following definitions shall apply for purposes of this section:~~

~~(1) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration (FDA) with abuse-deterrence labeling claims indicating its abuse-deterrent properties are expected to deter or reduce its abuse.~~

~~(2) "Cost sharing" means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.~~

~~(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and that is indicated by the FDA for the treatment of pain, whether in an immediate release or extended release formulation and whether or not the drug product contains any other drug substance.~~

~~SEC. 5. Section 10123.203 is added to the Insurance Code, to read:~~

~~10123.203. (a) Notwithstanding any other law, an insurer issuing, amending, or renewing a policy of individual or group disability insurance on or after January 1, that provides coverage for an opioid analgesic drug product shall comply with all of the following:~~

~~(1) The insurer shall provide coverage on its formulary, drug list, or other lists of similar construct for at least one abuse-deterrent opioid analgesic drug product per opioid analgesic active ingredient.~~

~~(2) Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay for brand name abuse-deterrent opioid analgesic drug products covered~~

~~pursuant to this section shall not exceed the lowest cost-sharing level applied to brand name prescription drugs covered under the applicable policy.~~

~~(3) Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable policy.~~

~~(4) The insurer shall not require an insured to first use a non-abuse-deterrent opioid analgesic drug product before providing coverage for an abuse-deterrent opioid analgesic drug product. This paragraph shall not be construed to prevent an insurer from applying utilization review requirements, including prior authorization, to abuse-deterrent opioid analgesic drug products, provided that those requirements are applied to all opioid analgesic drug products with the same type of drug release, immediate or extended. This paragraph shall not be construed to preclude the use of a non-abuse deterrent opioid for the initial prescription for a five-day supply.~~

~~(b) The following definitions shall apply for purposes of this section:~~

~~(1) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration (FDA) with abuse-deterrence labeling claims indicating its abuse-deterrent properties are expected to deter or reduce its abuse.~~

~~(2) "Cost sharing" means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.~~

~~(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and that is indicated by the FDA for the treatment of pain, whether in an immediate release or extended release formulation and whether or not the drug product contains any other drug substance.~~

~~SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty~~

~~for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

SEC. 2. Division 10.10 (commencing with Section 11999.30) is added to the Health and Safety Code, to read:

DIVISION 10.10. OPIOID ABUSE TASK FORCE

11999.30. (a) On or before February 1, 2017, health care service plans and health insurer representatives, in collaboration with advocates, experts, health care professionals, and other entities and stakeholders that they deem appropriate, shall convene an Opioid Abuse Task Force. The task force shall develop recommendations regarding the abuse and misuse of opioids as a serious problem that affects the health, social welfare, and economic welfare of persons in the state. The task force shall address all of the following:

(1) Interventions that have been scientifically validated and have demonstrated clinical efficacy.

(2) Interventions that have measurable treatment outcomes.

(3) Collaborative, evidence-based approaches to resolving opioid abuse and misuse that incorporate both the provider and the patient into the solution.

(4) Education that engages and encourages providers to be prudent in prescribing opioids and to be proactive in defining care plans that include a plan to taper and stop opioid use.

(5) Review and consideration of medication coverage policies and formulary management and development of an interdisciplinary case management program that addresses quality, fraud, waste, and abuse.

(b) On or before December 31, 2017, the task force shall submit a report detailing its findings and recommendations to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, the Senate Committee on Health, and the Assembly Committee on Health.

(c) The task force shall be dissolved and shall cease to exist on June 1, 2018.

(d) A violation of this section is not subject to Section 1390.

11999.31. This division shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2024
Author: Wood
Bill Date: June 9, 2016, Amended
Subject: Critical Access Hospitals: Employment
Sponsor: Author
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize, until January 1, 2024, a federally certified critical access hospital (CAH) to employ physicians and charge for professional services. This bill would specify that the CAH must not interfere with, control, or otherwise direct the professional judgement of a physician. This bill would require the Office of Statewide Health Planning and Development (OSHPD), on or before July 1, 2023, to provide a report to the Legislature regarding the impact of CAH's and their ability to recruit and retain physicians.

BACKGROUND:

Current law (commonly referred to as the "Corporate Practice of Medicine" – Business & Professions Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

Most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, and certain non-profit organizations. California is one of only a few states that prohibits the employment of physicians by hospitals.

SB 376 (Chesbro, Chapter 411, Statutes of 2003) directed the Board to establish a pilot program to provide for the direct employment of physicians by qualified district hospitals. The bill was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire, and employ physicians as full-time, paid staff in rural or underserved communities meeting specified criteria. The goal of the legislation was to improve the ability of district hospitals to attract physicians. However, participation in the pilot was very limited with only five participating hospitals and six participating physicians. Therefore, the Board was hindered in making a full evaluation due to lack of participation. The pilot expired on January 1, 2011.

ANALYSIS

This bill would establish a pilot program for federally certified CAHs to employ physicians and would require OSHPD to provide a report to the Legislature containing data about the impact of CAH's employing physicians and their ability to recruit and retain physicians. The report would be due on or before July 1, 2023 and the pilot program would end on January 1, 2024. This bill would specify that the CAH shall not interfere with, control, or otherwise direct the professional judgment of a physician in a manner prohibited by the ban on the corporate practice of medicine.

The author states that he is sympathetic to the concerns about interference with the clinical judgment of any health care provider. There are a number of exceptions to the ban on the corporate practice of medicine currently allowed. The 26 CAHs are in rural communities that have difficulty recruiting and retaining physicians. Allowing these CAHs to employ physicians will help to provide economic security adequate to recruit physicians who will have to relocate to these rural communities where CAHs are located.

The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine. That being said, CAHs are in remote, rural areas and this bill would help these hospitals to recruit and retain physicians, which will improve access to care in these rural communities. In addition, this bill is a pilot program that will be evaluated and the bill makes it clear that the CAH must not interfere with, control, or otherwise direct the professional judgement of a physician. As such, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: Alliance of Catholic Health Care
Association of California Healthcare Districts
California Hospital Association
California Special Districts Association
SEIU California
Union of American Physicians and Dentists

OPPOSITION: None on file

AMENDED IN SENATE JUNE 9, 2016

AMENDED IN SENATE MAY 23, 2016

AMENDED IN ASSEMBLY APRIL 11, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2024

Introduced by Assembly Member Wood
(Coauthors: Assembly Members Bigelow, Dahle, Gallagher, and Obernolte)
(Coauthor: Senator Gaines)

February 16, 2016

An act to amend Section 2401 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2024, as amended, Wood. Critical access hospitals: employment.

Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons ~~and~~ *or* doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. *Existing law establishes the Office of Statewide Health Planning and Development, which succeeds to and is vested with all the duties, powers, responsibilities, and jurisdiction of the State Department of Public Health relating to health planning and research development.*

This bill, until January 1, 2024, would also authorize a federally certified critical access hospital to employ those medical professionals and charge for professional services rendered by those medical professionals if the medical staff concur by an affirmative vote that the

professional's employment is in the best interest of the communities served by the hospital and the hospital does not direct or interfere with the professional judgment of a physician and surgeon, as specified. The bill would require the ~~board,~~ *office,* on or before July 1, 2023, to provide a report to the Legislature containing data on the impact of this authorization on federally certified critical access hospitals and their ability to recruit and retain physicians and surgeons, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed

licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(e) (1) Notwithstanding Section 2400, until January 1, 2024, a federally certified critical access hospital may employ licensees and charge for professional services rendered by those licensees to patients, provided both of the following conditions are met:

(A) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(B) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(2) (A) On or before July 1, 2023, the ~~board~~ *Office of Statewide Health Planning and Development* shall provide a report to the Legislature containing data about the impact of paragraph (1) on federally certified critical access hospitals and their ability to recruit and retain physicians and surgeons between January 1, 2017, and January 1, 2023, inclusive. This report shall be submitted in compliance with Section 9795 of the Government Code.

(B) The requirement for submitting a report imposed under subparagraph (A) is inoperative on July 1, 2027.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 2216
Author:	Bonta
Bill Date:	May 27, 2016, Amended
Subject:	Primary Care Residency Programs: Grant Program
Sponsor:	California Health+ Advocates California Primary Care Association (CPCA)
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Teaching Health Center Primary Care Graduate Medical Education Fund (Fund) for purposes of funding primary care residency programs. This bill would specify that implementation is subject to an appropriation in the Budget Act.

BACKGROUND

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

The Teaching Health Center Graduate Medical Education Program (THCGME) has been funded since 2011, and is set to expire in 2015. The THCGME has increased the number of primary care physicians and dentists training to care for underserved populations nationwide. Teaching Health Centers (THCs) were created under the Patient Protection and Affordable Care Act and since their creation, six THCs have opened in California. They are located in Modesto, Fresno, San Bernardino, Redding, Bakersfield, and San Diego. Without continued federal funding, most of the Teaching Health Centers (THCs) report they would be unlikely to continue current residency recruitment and enrollment, threatening the viability of the THCGME.

ANALYSIS

This bill would establish the Fund in the State Treasury and would require the Director of the Office of Statewide Health Planning and Development (OSHPD) to award planning and development grants from the Fund to THC's for the purpose of establishing new accredited or expanded primary care residency programs. This bill would provide that the grants awarded must not be for more than three years and that the maximum award to a THC must not be more

than $500,000. This bill would specify that grants be used to cover the costs of establishing or expanding a primary care residency training program, including costs associated with curriculum development, recruitment, training, retention of residents and faculty, accreditation, faculty salaries during the development phase, and technical assistance. This bill would define a sustaining grant as a grant awarded to ensure the continued operation of an accredited THC, whether that accreditation was first awarded by this bill or prior to the enactment of this bill. This bill would require OSHPD, subject to an appropriation by the Legislature, to award grants from the Fund to the THC's operating accredited primary care residency programs, and would require OSHPD to determine the amount of grants awarded per resident by taking into account the direct and indirect costs of GME. This bill would specify that implementation is subject to an appropriation in the Budget Act.

According to the author, THCs are a proven model for addressing the primary care provider shortage that six of nine California regions face and notes that 40% of THC graduates enter into primary care practice in nonprofit community health centers in underserved communities. The author believes that this bill will help ensure California has a sufficient supply of health workforce professionals to serve the needs of this diverse state.

This bill will increase funding for residency programs in California, which will help promote the Board's mission of increasing access to care for consumers. As such, the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: California Health+ Advocates (co-sponsor); CPCA (co-sponsor); AFSCME; Aids Project Los Angeles; Alameda Health Consortium; AltaMed Services Corporation; Ampla Health; Arroyo Vista Family Health Center; Association of California Healthcare Districts; Borrego Health; California Academy of Family Physicians; California Family Health Council; California Nurses Association; California School Employees Association; Clinica Sierra Vista; Clinicas De Salud Del Pueblo, Inc.; Coalition of Orange County Community Health Centers; Community Clinic Association of Los Angeles County; Community Clinic Consortium; County Health Executives Association of California; Community Health Partnership; Family Health Centers of San Diego; Golden Valley Health Centers; Health Alliance of Northern California; Health and Life Organization.; Kheir Center; La Maestra Community Health Centers; Marin Community Clinics; Medical Board of California; Mountain Valleys Health Centers; North Coast Clinics Network; North County Health Services; North East Medical Services; Northeast Valley Health Corporation; Omni Family Health; Open Door Community Health Centers; Operation Samahan; Ravenswood Family Health Center; Redwood Community Health Coalition, SanYsidro Health Center; Shasta Community Health Center; St. John's Well Child and

Family Center; Tiburcio Vasquez Health Center, Inc.; Valley Community Healthcare; West County Health Centers; Western Sierra Medical Clinic; and Westside Family Health Center

OPPOSITION: California Right to Life Committee, Inc.

AMENDED IN ASSEMBLY MAY 27, 2016

AMENDED IN ASSEMBLY APRIL 14, 2016

AMENDED IN ASSEMBLY MARCH 28, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2216

Introduced by Assembly Member Bonta

February 18, 2016

An act to add Article 1.5 (commencing with Section 128245) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to health workforce development.

LEGISLATIVE COUNSEL'S DIGEST

AB 2216, as amended, Bonta. Primary care residency programs: grant program.

Existing federal and state laws contain programs that authorize loan forgiveness to physicians, dentists, and individuals enrolled in a postsecondary institution studying medicine or dentistry who agree to practice in medically or dentally underserved areas. Under existing law, the Teaching Health Center Graduate Medical Education (THCGME) program was created by the federal Patient Protection and Affordable Care Act for the purpose of awarding grants to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

This bill would establish the Teaching Health Center Primary Care Graduate Medical Education Fund for purposes of funding primary care residency programs, as specified, subject to appropriation by the Legislature. The bill would establish criteria for the awarding of grants under these provisions to teaching health centers, as defined. The bill

would require the Office of Statewide Health Planning and Development and the Director of Statewide Health Planning and Development to administer these provisions, as specified. The bill would require the office to adopt emergency regulations to implement these provisions. *The bill would provide that its provisions are subject to an appropriation in the Budget Act for these purposes.*

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 1.5 (commencing with Section 128245) is added to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 1.5. Teaching Health Center Primary Care Graduate Medical Education Act of 2016

128245. For purposes of this article, the following terms have the following meanings:

(a) "Director" means the Director of Statewide Health Planning and Development.

(b) "Fund" means the Teaching Health Center Primary Care Graduate Medical Education Fund.

(c) "Office" means the Office of Statewide Health Planning and Development.

(d) "Sustaining grant" means a grant awarded to ensure the continued operation of an accredited teaching health center, whether that accreditation was first awarded pursuant to the process created by this article or the accreditation was awarded prior to the enactment of this article.

(e) "Teaching health center" has the same meaning as defined in Article 1 (commencing with Section 128200).

128246. There is in the State Treasury the Teaching Health Center Primary Care Graduate Medical Education Fund, which fund is hereby created.

128247. (a) Subject to appropriation by the Legislature, the director shall award planning and development grants from the fund to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

(b) Grants awarded under this section shall be for a term of not more than three years and the maximum award to a teaching health center shall not be more than five hundred thousand dollars ($500,000).

(c) A grant awarded pursuant to this section shall be used to cover the costs of establishing or expanding a primary care residency training program described in subdivision (a), including costs associated with curriculum development, recruitment, training, and retention of residents and faculty, accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA), faculty salaries during the development phase, and technical assistance.

(d) A teaching health center seeking a grant under this section shall submit an application to the office in the format prescribed by the office. The director shall evaluate those applications and award grants based on criteria consistent with a teaching health center's readiness and other factors indicating the likelihood of success at implementing a primary care residency program.

128248. (a) Subject to appropriation by the Legislature, the director shall award sustaining grants from the fund to teaching health centers operating primary care residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA).

(b) The office shall determine the amount of grants awarded per resident by taking into account the direct and indirect costs of graduate medical education. The amount of grants awarded per resident shall be updated, as appropriate, on an annual basis.

128249. The office shall promulgate emergency regulations to implement this article.

128249.5. Implementation of this article shall be subject to an appropriation in the annual Budget Act for these purposes.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2744
Author: Gordon
Bill Date: June 16, 2016, Amended
Subject: Healing Arts: Referrals
Sponsor: The Internet Association
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the payment or receipt of consideration for advertising, where a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients that is prohibited in existing law.

BACKGROUND

Existing law, Business and Professions Code Section 650, prohibits the offer of a commission as compensation for referring a patient. Existing law does allow payment for services other than the referral of a patient. This statute is several decades old, and was put into place before online advertising became available. In the past, if a physician wanted to advertise for his or her services, they could take out an advertisement in the yellow pages, a newspaper, a billboard, or run a commercial on radio or television. In these instances, the advertisement could include a coupon or special offer.

Now, physicians and other healthcare professionals can advertise online and offer purchase vouchers for service in online market places such as Groupon, Living Social, and others. For online voucher advertising companies, the healthcare professional decides whether to advertise and what service to make available for purchase (which is not an essential health benefit), the cost of the service, how many vouchers to offer, and for how long. The healthcare professional pays the online advertising network for making the offer available, generally a percentage of the price of the purchased service. Once a consumer purchases a voucher through this form of online advertising, the consumer contacts the health care professional to set an appointment, just as they would if responding to any other form of advertisement.

Per a 1994 Attorney General Opinion, a referral exists when a third party independent entity who individually has contact with a person in need of health care selects a professional to render the same. Online marketplaces do not select a healthcare professional, but rather make the advertisements and vouchers available on its website.

ANALYSIS

This bill would expressly provide that payment or receipt of consideration for

advertising, where a licensee offers or sells services through a third-party advertiser, does not itself recommend, endorse, or otherwise select a licensee. This bill would require the licensee to refund the full purchase price, as determined by the terms of the advertising service agreement, if the licensee determines the service is not appropriate for the purchaser. This bill would specify that it does not apply to basic health care services or essential health benefits. This bill would require the entity that provides the advertising to demonstrate that the licensee consented in writing to the requirements of this bill. This bill would specify that a third-party advertiser shall make advertisements available to prospective purchasers for all services of licensees in the applicable geographic region.

Board staff has already looked at the issue of Internet advertising for physicians with companies like Groupon and Living Social, and does not believe that these arrangement are in violation of existing referral law. This bill would make it clear that this type of advertising is not in violation of existing law and would add protections for consumers to be refunded if the service is not appropriate. For these reasons, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: The Internet Association (Sponsor)
Groupon

OPPOSITION: California Medical Association
California Society of Plastic Surgeons

AMENDED IN SENATE JUNE 16, 2016

AMENDED IN SENATE JUNE 6, 2016

AMENDED IN ASSEMBLY APRIL 11, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2744

Introduced by Assembly Member Gordon
(Coauthor: Senator Hill)

February 19, 2016

An act to amend Section 650 of the Business and Professions Code, relating to the healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2744, as amended, Gordon. Healing arts: referrals.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, it is unlawful for licensed healing arts practitioners, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person. Existing law makes a violation of this provision a public offense punishable upon a first conviction by imprisonment, as specified, or a fine not exceeding $50,000, or by imprisonment and that fine.

This bill would provide that the payment or receipt of consideration for advertising, wherein a licensed healing arts practitioner offers or sells services through a third-party advertiser does not constitute a referral of patients when the third-party advertiser does not itself

recommend, endorse, or otherwise select a licensee. The bill would require the purchaser of the service to receive a refund of the full purchase price if the licensee determines, after consultation with the purchaser, that the service is not appropriate for the ~~purchaser.~~ *purchaser, as specified.* The bill would specify that these provisions do not apply to basic health care services or essential health benefits, as defined. The bill would also provide that the entity that provides advertising is required to be able to demonstrate that the licensee consented in writing to these provisions. The bill would require a third-party advertiser to make available ~~for purchase services advertised by all licensees~~ *to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser* in the applicable geographic region.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 650 of the Business and Professions Code is amended to read:

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services,

donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and subsequently amended versions.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) The payment or receipt of consideration for advertising, wherein a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or

otherwise select a licensee. ~~To the extent~~ *If* the licensee determines, after consultation with the purchaser of the service, that the service is not appropriate for the purchaser, the purchaser shall receive a refund of the full purchase ~~price.~~ *price as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee.* This subdivision shall not apply to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, or essential health benefits, as defined in Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code. The entity that provides the advertising shall be able to demonstrate that the licensee consented in writing to the requirements of this subdivision. A third-party advertiser shall make available ~~for purchase services advertised by all licensees~~ *to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser* in the applicable geographic region.

(h) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding fifty thousand dollars ($50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by that imprisonment and a fine of fifty thousand dollars ($50,000).

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2745
Author: Holden
Bill Date: April 25, 2016, Amended
Subject: Healing Arts: Licensing and Certification
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make clarifying changes to existing law to assist the Board in its licensing and enforcement functions.

ANALYSIS

This bill would clarify the Board's authority for the allied health licensees licensed by the Board. It would allow the Board to revoke or deny a license for registered sex offenders, allow the Board to take disciplinary action for excessive use of drugs or alcohol, allow allied health licensees to petition the Board for license reinstatement, and would allow the Board to use probation as a disciplinary option for allied health licensees.

Existing law only allows new physician and surgeon applicants and disabled status licensees to apply for a limited practice license (LPL). This bill would allow all physician and surgeon licensees to apply for a LPL at any time. This bill would ensure that physicians who have a disabled status license and want to change to a LPL meet the same requirements in existing law for a LPL.

This bill would clarify that the Board can deny a post graduate training authorization letter for the same reasons it can deny a physician applicant's license in existing law.

This bill would clarify existing law related to investigations of a deceased patient. Existing law allows the Board to obtain a copy of the medical records of a deceased patient without the approval of the next of kin if the Board is unsuccessful in locating or contacting the patients' next of kin after reasonable efforts. Existing law requires the Board to contact the physician that owns the records, however, in many cases the records do not reside with the physician. This bill would allow the Board to send a written request for medical records to the facility where the care occurred or where the records are located. This will ensure that the Board's investigation is not hindered.

This bill would clean up existing law to ensure that the Board's authority to perform its regulatory oversight of licensees is clearly defined and aligned with current law. This is a Board-sponsored bill.

FISCAL: None

SUPPORT: Medical Board of California (Sponsor)
AFSCME

OPPOSITION: None on file

AMENDED IN ASSEMBLY APRIL 25, 2016

AMENDED IN ASSEMBLY APRIL 12, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2745

Introduced by Assembly Member Holden

February 19, 2016

An act to amend Sections 2088, 2221, 2225, 2441, 2519, 2520, 2529, 3576, and 3577 of, and to add Sections 2522, 2523, 2529.1, 2529.6, 3576.1, 3576.2, and 3576.3 to, the Business and Professions Code, relating to healing arts, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2745, as amended, Holden. Healing arts: licensing and certification.

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law authorizes an applicant for a physician's and surgeon's license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license ~~renewal~~ fee and signs an agreement agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. Existing law makes any person who knowingly provides false information in this agreement subject to any sanctions available to the board. Existing law authorizes the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license. Violation

of the act is a crime. Existing law establishes the Contingent Fund of the Medical Board of California, a continuously appropriated fund.

This bill would specify that a licensee who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability is authorized to receive the limited license if the above-described conditions are ~~met.~~ *met, including payment of the appropriate fee.* By adding fees for deposit into the Contingent Fund of the Medical Board of California, this bill would make an appropriation.

This bill would also authorize the board to deny a postgraduate training authorization to an applicant who is guilty of unprofessional conduct or of any cause for revocation or suspension of a license.

(2) Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician.

This bill would require the board to agree to this limit, would authorize the board to require an independent clinical evaluation, and would subject a person who knowingly provides false information in the agreement to sanctions. By expanding the scope of a crime, this bill would impose a state-mandated local program.

(3) Existing law authorizes the board, in any investigation that involves the death of a patient, to inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely to determine the extent to which the death was the result of the physician and surgeon's violation of the Medical Practice Act, if the board provides a written request to the physician and surgeon that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts.

This bill would authorize the board to provide the written request to the facility where the medical records are located or the care to the deceased patient was provided.

(4) Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Board of Licensing of the Medical Board of California. Under the act, the board

is authorized to suspend or revoke the license of a midwife for specified conduct, including unprofessional conduct consisting of, among other things, incompetence or gross negligence in carrying out the usual functions of a licensed midwife. A violation of the act is a crime.

This bill would authorize the board to place a license on probation and establish a fee for monitoring a licensee on probation. The bill would also authorize a person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a license for a person required to register as a sex offender, except as specified.

(5) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified.

The bill would include within the definition of unprofessional conduct, among other things, the use of any controlled substance, or the use of any dangerous drugs, as specified, or of alcoholic beverages, as specified. The bill would also require the revocation of a registration for a person required to register as a sex offender, except as specified.

(6) Existing law prohibits a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless he or she is registered as a certified polysomnographic technologist, is supervised and directed by a licensed physician and surgeon, and meets certain other requirements. Existing law requires polysomnographic technologists to apply to and register with the Medical Board of California and to pay specified fees to be fixed by the board at no more than $100 each, and to renew their registration biennially for a fee of no more than $150. Existing law requires the deposit of those fees in the Contingent Fund of the Medical Board of California. Existing law authorizes a registration to be suspended, revoked, or otherwise subject to discipline for specified conduct.

This bill would also authorize a registration to be placed on probation if a registrant engages in that conduct and would establish a fee for monitoring a registrant on probation. By increasing fees for deposit into the Contingent Fund, this bill would make an appropriation. The bill

would authorize a person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a registration for a person required to register as a sex offender, except as specified. The bill would authorize the suspension or revocation of a registration for unprofessional conduct, as defined.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 2088 of the Business and Professions Code is amended to read:

2088. (a) An applicant for a physician's and surgeon's license or a physician's and surgeon's licensee who is otherwise eligible for that license but is unable to practice some aspects of medicine safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the appropriate initial or renewal license fee.

(2) Signs an agreement on a form prescribed by the board in which the applicant or licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the applicant or licensee described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a limited license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to subdivision (a) shall be subject to any sanctions available to the board.

SEC. 2. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may deny a physician's and surgeon's certificate or postgraduate training authorization letter to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license. The board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the licensee's activities shall be supervised by another physician and surgeon.

(2) Total or partial restrictions on drug prescribing privileges for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

(5) Enrollment and successful completion of a clinical training program.

(6) Abstention from the use of alcohol or drugs.

(7) Restrictions against engaging in certain types of medical practice.

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

(c) The board shall deny a physician's and surgeon's certificate to an applicant who is required to register pursuant to Section 290 of the Penal Code. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(d) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of his or her application, except that the board may, in its discretion and for good cause demonstrated,

permit reapplication after not less than one year has elapsed from the effective date of the denial.

SEC. 3. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c) (1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board

may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy

is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 4. Section 2441 of the Business and Professions Code is amended to read:

2441. (a) Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of medicine unless and until the licensee pays the current renewal fee and does either of the following:

(1) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his or her ability to practice medicine safely.

(2) Signs an agreement on a form prescribed by the board, signed under penalty of perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the licensee described in paragraph (2) of subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a ~~disability~~ *disabled status* license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to paragraph (2) of subdivision (a) shall be subject to any sanctions available to the board.

SEC. 5. Section 2519 of the Business and Professions Code is amended to read:

2519. The board may suspend, revoke, or place on probation the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising that is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that this use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

(j) Failing to do any of the following when required pursuant to Section 2507:

(1) Consult with a physician and surgeon.

(2) Refer a client to a physician and surgeon.

(3) Transfer a client to a hospital.

SEC. 6. Section 2520 of the Business and Professions Code is amended to read:

2520. (a) (1) The fee to be paid upon the filing of a license application shall be fixed by the board at not less than seventy-five dollars ($75) nor more than three hundred dollars ($300).

(2) The fee for renewal of the midwife license shall be fixed by the board at not less than fifty dollars ($50) nor more than two hundred dollars ($200).

(3) The delinquency fee for renewal of the midwife license shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25) nor more than fifty dollars ($50).

(4) The fee for the examination shall be the cost of administering the examination to the applicant, as determined by the organization that has entered into a contract with the board for the purposes set forth in subdivision (a) of Section 2512.5. Notwithstanding subdivision (c), that fee may be collected and retained by that organization.

(b) The fee for monitoring a licensee on probation shall be the cost of monitoring, as fixed by the board.

(c) The fees prescribed by this article shall be deposited in the Licensed Midwifery Fund, which is hereby established, and shall be available, upon appropriation, to the board for the purposes of this article.

SEC. 7. Section 2522 is added to the Business and Professions Code, to read:

2522. (a) A person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the license or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from midwives licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner’s activities during the time the license was in good standing, and the petitioner’s

rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a license or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 8. Section 2523 is added to the Business and Professions Code, to read:

2523. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the license of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a license pursuant to this section shall be conducted in accordance with chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 9. Section 2529 of the Business and Professions Code is amended to read:

2529. (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the

Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrists," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, 2234, 2235, and 2529.1

SEC. 10. Section 2529.1 is added to the Business and Professions Code, to read:

2529.1. (a) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside

the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 11. Section 2529.6 is added to the Business and Professions Code, to read:

2529.6. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with ~~chapter~~ *Chapter* 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 12. Section 3576 of the Business and Professions Code is amended to read:

3576. (a) A registration under this chapter may be denied, suspended, revoked, placed on probation, or otherwise subjected to discipline for any of the following by the holder:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant.

(2) An act of dishonesty or fraud.

(3) Committing any act or being convicted of a crime constituting grounds for denial of licensure or registration under Section 480.

(4) Violating or attempting to violate this chapter or any regulation adopted under this chapter.

(b) Proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all powers granted therein.

SEC. 13. Section 3576.1 is added to the Business and Professions Code, to read:

3576.1. (a) A person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the registration or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a registration surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a registration surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from polysomnographic technologists registered in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner’s activities during the time the registration was in good standing, and the petitioner’s rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a registration or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 14. Section 3576.2 is added to the Business and Professions Code, to read:

3576.2. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with ~~chapter~~ *Chapter* 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 15. Section 3576.3 is added to the Business and Professions Code, to read:

3576.3. (a) The board may suspend or revoke the registration of a polysomnographic technologist, polysomnographic technician, or polysomnographic trainee for unprofessional conduct as described in this section.

(b) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public,

or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(c) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 16. Section 3577 of the Business and Professions Code is amended to read:

3577. (a) Each person who applies for registration under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(b) Each person to whom registration is granted under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(c) The registration shall expire after two years. The registration may be renewed biennially at a fee which shall be paid into the Contingent Fund of the Medical Board of California to be fixed by the board at a sum not in excess of one hundred fifty dollars ($150).

(d) The fee for monitoring a ~~licensee~~ *registrant* on probation shall be the cost of monitoring, as fixed by the board.

(e) The money in the Contingent Fund of the Medical Board of California that is collected pursuant to this section shall be used for the administration of this chapter.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 22
Author: Roth, Cannella and Galgiani
Bill Date: February 29, 2016, Amended
Subject: Residency Training: Funding
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill was substantially amended since the last Board Meeting. This bill would make findings and declarations regarding the availability of primary care residency positions in California and the shortage of primary care physicians in California. This bill would appropriate $300,000,000 from the General Fund to the Office of Statewide Health Planning and Development (OSHPD) to fund physician residency positions in California.

BACKGROUND

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

The Song-Brown Health Care Workforce Training Act was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas, and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC). CHWPC is a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications and recommends contract awards to the Director of OSHPD. The CHWPC meets four times annually and OSHPD provides administrative support to the CHWPC and the accredited training programs.

ANALYSIS

This bill would make the following findings and declarations:

- More than $40 million of funding for the training of California's primary care physicians is expiring in 2016.
- Each year in California, only 368 slots are available to the thousands of medical students seeking to train in family medicine. If the funding is not replaced, 158 of those slots will be lost, creating a deficit of primary care physicians in California's underserved communities.
- Only 36 percent of California's active patient care physicians practice primary care. Twenty-three of California's 58 counties fall below the minimum required primary care physician to population ratio.
- As of 2010, California needed an estimated additional 8,243 primary care physicians by 2030 to prevent projected shortages in the state, which is about 412 new primary care physicians per year.
- More than 32 percent of California's practicing primary care physicians are 60 years of age or older.
- States with higher ratios of primary care physicians to population have better health outcomes, including decreased mortality from cancer, heart disease, and stroke.
- The Song-Brown Program provides an existing state infrastructure to support an increase in the number of primary care providers serving California's underserved populations. By investing in Song-Brown, California will realize an immediate return on investment as each primary care resident provides an average of 600 additional patient visits per physician per year during training alone.
- California's long-term workforce will also grow significantly as the vast majority of physicians who train in a region stay there to practice. California leads all fifty states in the percentage of residency program graduates who stay in the state in which they are trained.

This bill would continuously appropriate $300 million from the General Fund (over a three-year period) to OSHPD for the purpose of funding new and existing graduate medical education physician residency positions, and supporting training faculty, pursuant to the Song-Brown Health Care Workforce Training Act.

This bill would increase funding for residency programs in California, which will help promote the Board's mission of increasing access to care for consumers. This bill would also allow more physicians to receive residency training and potentially end up practicing in California. As such, Board staff is suggesting that the Board continue to support this bill.

FISCAL: None

SUPPORT: **(**Verified 1/26/16) - AARP; Association of California Healthcare Districts; California Academy of Physician Assistants; California Chapter of the American College of Emergency Physicians; California Physical Therapy Association; California Primary Care Association; and Community Clinic Association of Los Angeles County

OPPOSITION: (Verified 1/26/16) - None on file

AMENDED IN ASSEMBLY FEBRUARY 29, 2016

AMENDED IN SENATE JANUARY 25, 2016

AMENDED IN SENATE JUNE 4, 2015

AMENDED IN SENATE JUNE 2, 2015

AMENDED IN SENATE MAY 5, 2015

AMENDED IN SENATE APRIL 21, 2015

SENATE BILL No. 22

Introduced by ~~Senator Roth~~ *Senators Roth, Cannella, and Galgiani*
(Principal coauthors: Assembly Members Alejo, Brown, Calderon, Eduardo Garcia, Gipson, Gonzalez, Gray, Jones-Sawyer, Linder, Olsen, Ridley-Thomas, and Salas)

December 1, 2014

An act ~~to add Article 7 (commencing with Section 128590) to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code,~~ relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 22, as amended, Roth. Residency ~~training.~~ *training: funding.*

The Song-Brown Health Care Workforce Training Act creates a state medical contract program to increase the number of students and residents receiving quality education and training in specified primary care specialties or in nursing, and to maximize the delivery of primary care and family physician services to specific areas of California where there is a recognized unmet priority need for those services. The act requires the Director of Statewide Health Planning and Development to, among other things, contract with accredited medical schools,

teaching health centers, training programs, hospitals, and other health care delivery systems for those purposes, based on recommendations of the California Healthcare Workforce Policy Commission and in conformity with the contract criteria and program standards established by the commission.

This bill would appropriate $300,000,000 from the General Fund to the director for the purpose of funding new and existing graduate medical education physician residency positions, and supporting training faculty, pursuant to the act, for expenditure as specified. The bill would also make related findings and declarations.

~~Existing law, the Song-Brown Health Care Workforce Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in the specialty of family practice and as primary care physician's assistants and primary care nurse practitioners. Existing law establishes, for this purpose, a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, registered nurses, hospitals, and other health care delivery systems.~~

~~Existing law requires the Office of Statewide Health Planning and Development to establish the Health Professions Education Foundation to solicit and receive funds for the purpose of providing financial assistance in the form of scholarships or loans to medical students from underrepresented groups. Under existing law, the foundation also administers other programs for the advancement of health professions, including the Registered Nurse Education Program.~~

~~This bill would establish the Medical Residency Training Advisory Panel, consisting of a total of 13 members to be appointed as specified, within the Health Professions Education Foundation.~~

~~The bill would create the Medical Residency Training Fund in the State Treasury, a continuously appropriated fund, and would require the panel to solicit and accept funds from business, industry, foundations, and other private or public sources for the purpose of establishing and funding new graduate medical residency training programs in specified areas of the state, including medically underserved areas. By creating a continuously appropriated fund, the bill would make an appropriation. The bill would require the foundation to provide technical support and financial management for the panel and to approve and send panel recommendations for new residency programs to the Office of Statewide Health Planning and Development for~~

~~implementation if specified requirements are met, including sufficient funding. The bill would require the office to enter into contracts with public and private sector institutions and other health agencies and organizations in order to fund and establish recommended residency positions. The bill would authorize the Governor to include in the annual budget proposal an amount, as he or she deems reasonable, to be appropriated for this purpose. The bill, if the Legislature appropriates money for this purpose, would require the office to hold the funds and distribute them into the fund, upon request of the panel, in an amount matching the amount deposited into the fund, as specified. The bill would require money that was appropriated, but that has not been distributed to the fund at the end of each fiscal year, to be returned to the General Fund.~~

~~Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.~~

~~This bill would make legislative findings to that effect.~~

Vote: ~~majority~~ ~~2/3~~. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares as follows:

(a) More than $40 million of funding for the training of California's primary care physicians is expiring in 2016.

(b) Each year in California, only 368 slots are available to the thousands of medical students seeking to train in family medicine. If the funding is not replaced, 158 of those slots will be lost, creating a terrible deficit of primary care physicians in California's underserved communities.

(c) Only 36 percent of California's active patient care physicians practice primary care. Twenty-three of California's 58 counties fall below the minimum required primary care physician to population ratio.

(d) As of 2010, California needed an estimated additional 8,243 primary care physicians by 2030 to prevent projected shortages in the state, which is about 412 new primary care physicians per year.

(e) More than 32 percent of California's practicing primary care physicians are 60 years of age or older – only four other states have a larger percentage of soon-to-retire physicians.

(f) States with higher ratios of primary care physicians to population have better health outcomes, including decreased mortality from cancer, heart disease, and stroke.

(g) The Song-Brown program provides an existing state infrastructure to support an increase in the number of primary care providers serving California's underserved populations. By investing in Song-Brown, California will realize an immediate return on investment as each primary care resident provides an average of 600 additional patient visits per physician per year during training alone.

(h) California's long-term workforce will also grow significantly as the vast majority of physicians who train in a region stay there to practice. California leads all fifty states in the percentage of residency program graduates who stay in the state in which they are trained.

SEC. 2. Notwithstanding Section 13340 of the Government Code, there is hereby continuously appropriated from the General Fund the sum of three hundred million dollars ($300,000,000) to the Director of Statewide Health Planning and Development, for the purpose of funding new and existing graduate medical education physician residency positions, and supporting training faculty, pursuant to the Song-Brown Health Care Workforce Training Act (Article 1 (commencing with Section 128200) of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code). The moneys shall be expended as follows:

(a) The sum of one hundred million dollars ($100,000,000) shall be expended in the 2016–17 fiscal year.

(b) The sum of one hundred million dollars ($100,000,000) shall be expended in the 2017–18 fiscal year.

(c) The sum of one hundred million dollars ($100,000,000) shall be expended in the 2018–19 fiscal year.

~~SECTION 1. Article 7 (commencing with Section 128590) is added to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, to read:~~

~~Article 7. California Medical Residency Training Program~~

~~128590. As used in this article:~~

~~(a) "Director" means the Director of Statewide Health Planning and Development.~~

~~(b) "Foundation" means the Health Professions Education Foundation.~~

~~(c) "Fund" means the Medical Residency Training Fund.~~

~~(d) "Office" means the Office of Statewide Health Planning and Development.~~

~~(e) "Panel" means the Medical Residency Training Advisory Panel, established pursuant to Section 128591.~~

~~(f) "Primary care" means the medical practice areas of family medicine, general surgery, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and related specialties and subspecialties as the office deems appropriate.~~

~~(g) "Residency position" means a graduate medical education residency position in the field of primary care.~~

~~128591. (a) (1) There is established within the foundation the Medical Residency Training Advisory Panel.~~

~~(2) The panel shall consist of 13 members. Seven members shall be appointed by the Governor, one member shall be appointed by the Speaker of the Assembly, one member shall be appointed by the Senate Committee on Rules, two members of the Medical Board of California shall be appointed by the Medical Board of California, and two members of the Osteopathic Medical Board of California shall be appointed by the Osteopathic Medical Board of California.~~

~~(3) The members of the panel appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules shall consist of representatives of designated and nondesignated public hospitals, private hospitals, community clinics, public and private health insurance providers, the pharmaceutical industry, associations of health care practitioners, and other appropriate members of health or related professions.~~

~~(4) All persons considered for appointment shall have an interest in increasing the number of medical residencies in the state, an interest in increasing access to health care in underserved areas of California, and the ability and desire to solicit funds for the purposes of this article, as determined by the appointing power.~~

~~(b) The Governor shall appoint the president of the panel from among those members appointed by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, the Medical Board of California, and the Osteopathic Medical Board of California.~~

~~(c) (1) Of the members of the panel first appointed by the Governor, three members shall be appointed to serve a one-year term, three members shall be appointed to serve a two-year term, and one member shall be appointed to serve a three-year term.~~

~~(2) Each member of the panel first appointed by the Speaker of the Assembly and the Senate Committee on Rules shall be appointed to serve a three-year term.~~

~~(3) Each member of the panel appointed by the Medical Board of California and the Osteopathic Medical Board of California shall be appointed to serve a four-year term.~~

~~(4) Upon the expiration of the initial appointments to the panel by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, the Medical Board of California, and the Osteopathic Medical Board of California, each member shall be appointed to serve a four-year term.~~

~~(d) (1) Members of the panel appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the panel.~~

~~(2) The members appointed by the Medical Board of California and the Osteopathic Medical Board of California shall serve without compensation, but shall be reimbursed by the Medical Board of California and the Osteopathic Medical Board of California, respectively, for any actual and necessary expenses incurred in connection with their duties as members of the panel.~~

~~(e) Notwithstanding any law relating to incompatible activities, no member of the panel shall be considered to be engaged in activities inconsistent and incompatible with his or her duties solely as a result of membership on the Medical Board of California or the Osteopathic Medical Board of California.~~

~~(f) The panel shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of~~

~~Division 2 of Title 2 of the Corporations Code), this article shall prevail.~~

~~128592. The panel shall do all of the following:~~

~~(a) Solicit and accept funds from business, industry, foundations, and other private or public sources for the purpose of establishing and funding new residency positions in areas of the state described in subdivision (c).~~

~~(b) Encourage public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations to identify and provide locations for the establishment of new residency positions in areas of the state described in subdivision (c). The panel shall solicit proposals for medical residency programs, as described in subdivision (c), and shall provide to the foundation a copy of all proposals it receives.~~

~~(c) Upon the sufficient solicitation of funds and at the panel's discretion, recommend to the foundation the establishment of new residency positions. A recommendation shall include all pertinent information required to enter into the necessary contracts to establish the residency positions. The panel shall only approve and recommend to the foundation proposals that would establish residency positions that will serve in any of the following medical service areas:~~

~~(1) A service area that is designated as a primary care shortage area by the office.~~

~~(2) A service area that is designated as a health professional shortage area for primary care, by either population or geographic designation, by the Health Resources and Services Administration of the United States Department of Health and Human Services.~~

~~(3) A service area that is designated as a medically underserved area or medically underserved population by the Health Resources and Services Administration of the United States Department of Health and Human Services.~~

~~(d) Upon foundation approval of a recommendation, deposit into the fund necessary moneys required to establish and fund the residency position.~~

~~(e) Recommend to the director that a portion of the funds solicited from the private sector be used for the administrative requirements of the panel and the foundation.~~

~~(f) Prepare and submit an annual report to the Legislature documenting the amount of money solicited, the amount of money deposited by the panel into the fund, the recommendations for the location and fields of practice of residency positions, total expenditures for the year, and prospective fundraising goals.~~

~~128593. The foundation shall do all of the following:~~

~~(a) Provide technical and staff support to the panel in meeting all of its responsibilities.~~

~~(b) Upon receipt of a recommendation made by the panel pursuant to subdivision (c) of Section 128592, approve the recommendation if the recommendation fulfills the requirements of subdivision (c) of Section 128592 and the recommendation fulfills the goals of this article. Upon sufficient funds being available, an approval shall be sent to the office for implementation pursuant to Section 128594.~~

~~128594. The office shall do all of the following:~~

~~(a) Establish a uniform process by which the panel may solicit proposals from public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations that train primary care residents. The office shall require that the proposals contain all necessary and pertinent information, including, but not limited to, all of the following:~~

~~(1) The location of the proposed residency position.~~

~~(2) The medical practice area of the proposed residency position.~~

~~(3) Information that demonstrates the area's need for the proposed residency position and for additional primary care practitioners.~~

~~(4) The amount of funding required to establish and operate the residency position.~~

~~(b) Enter into contracts with public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations in order to fund and establish residency positions at, or in association with, these institutions.~~

~~(c) Ensure that the residency position has been, or will be, approved by the Accreditation Council for Graduate Medical Education.~~

~~(d) Provide all of the following information to the panel and the foundation as requested:~~

~~(1) The areas of the state that are deficient in primary care services.~~

~~(2) The areas of the state that have the highest number of Medi-Cal enrollees and persons eligible to enroll in Medi-Cal, by proportion of population.~~

~~(3) Other information relevant to assist the panel and the foundation in making recommendations on possible locations for new residency positions.~~

~~(e) Monitor the residencies established pursuant to this article.~~

~~(f) (1) Prepare and submit an annual report to the panel, the foundation, and the Legislature documenting the amount of money contributed to the fund by the panel, the amount of money expended from the fund, the purposes of those expenditures, the number and location of residency positions established and funded, and recommendations for the location of future residency positions.~~

~~(2) The report pursuant to paragraph (1) shall be made to the Legislature pursuant to Section 9795 of the Government Code.~~

~~128595. (a) The Medical Residency Training Fund is hereby created within the State Treasury.~~

~~(b) The primary purpose of the fund is to allocate funding for new residency positions throughout the state. Money in the fund shall also be used to pay for the cost of administering the goals of the panel and the foundation as established by this article, and for any other purpose authorized by this article.~~

~~(c) The level of expenditure by the office for the administrative support of the panel and the foundation is subject to review and approval annually through the state budget process.~~

~~(d) In addition to funds raised by the panel, the office and the foundation may solicit and accept public and private donations to be deposited into the fund. All money in the fund is continuously appropriated to the office for the purposes of this article. The office shall manage this fund prudently in accordance with applicable laws.~~

~~128596. Any regulations the office adopts to implement this article shall be adopted as emergency regulations in accordance with Section 11346.1 of the Government Code, except that the regulations shall be exempt from the requirements of subdivisions (e), (f), and (g) of that section. The regulations shall be deemed to be emergency regulations for the purposes of Section 11346.1 of the Government Code.~~

~~128597. Notwithstanding any other law, the office may exempt from public disclosure any document in the possession of the office that pertains to a donation made pursuant to this article if the donor has requested anonymity.~~

~~128598. (a) The Governor may include in the annual budget proposal an amount, as he or she deems reasonable, to be appropriated to the office to be used as provided in this article.~~

~~(b) If the Legislature appropriates money for purposes of this article, the money shall be appropriated to the office, which shall hold the money for distribution to the fund.~~

~~(c) Funds appropriated to the office shall be paid into the fund, upon request of the panel, in an amount matching the amount deposited into the fund by the panel or by the foundation and office pursuant to subdivision (d) of Section 128595 for the purposes of this article. Any money that was appropriated to the office and that has not been distributed to the fund at the end of each fiscal year shall be returned to the General Fund.~~

~~SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Article 7 (commencing with Section 128590) to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:~~

~~The need to protect individual privacy of donations made by a donor to fund new medical residency positions in underserved areas of the state outweighs the interest in the public disclosure of that information.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 482
Author:	Lara
Bill Date:	June 21, 2016, Amended
Subject:	Controlled Substances: CURES Database
Sponsor:	Consumer Attorneys of California and California Narcotics Officers
Current Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all prescribers issuing Schedules II, III or IV drugs to access and consult the CURES database before prescribing a Schedule II, III or IV controlled substance under specified conditions.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that licensees who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General's Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

According to the author's office, other states that have required prescribers to check their drug monitoring systems have seen significantly improved public health outcomes. In 2012, Tennessee required prescribers to check the state's PDMP before prescribing painkillers and within one year, they saw a 36% drop in patients who were

seeing multiple prescribers to obtain the same drugs. In Virginia, the number of doctor-shoppers fell by 73% after use of the database became mandatory. In Oklahoma, which requires mandatory checks for methadone, overdoses fell about 21% in one year. New York also requires prescribers to check their state drug monitoring systems and has seen dramatic decreases in drug overdoses and deaths.

ANALYSIS

This bill would require a prescriber to access and consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment. This bill would require a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed. This bill would define "first time" to mean the initial occurrence in which a health care practitioner intends to prescribe, order, administer, furnish or dispense a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to that patient.

This bill would specify that a prescriber, pharmacist, or any person acting on their behalf, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, or inaccurate information submitted to, or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

This bill would specify that the requirement to consult the CURES database does not apply to a health care practitioner in any of the following circumstances:

- If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered or dispensed to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities:
    - A licensed clinic
    - An outpatient setting
    - A health facility
    - A county medical facility
- When a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance in the emergency department of a general acute care hospital if the quantity of the controlled substance does not exceed a seven-day supply .
- If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient as part of the patient's treatment for a surgical procedure, if the quantity of the controlled substance does not exceed a non-refillable five-day supply and is in a licensed clinic, an outpatient setting, a health facility, a county medical facility or a place of practice.
- If a health care practitioner prescribes, orders, administers, furnishes or dispenses a controlled substance to a patient currently receiving hospice care.
- If all of the following circumstances are satisfied:

    - It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.
    - Another health care practitioner or designee authorized to access CURES is not reasonably available.
    - The quantity of controlled substance does not exceed a non-refillable five-day supply.

- If the CURES database is not operational, as determined by DOJ, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the failure that is reasonably within his or her control.
- If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of the health care practitioner.
- If the CURES database cannot be accessed because of exceptional circumstances, as demonstrated by a health care practitioner.

This bill would specify if CURES is not consulted by the health care practitioner because one of the above exemptions applies, the practitioner shall document the reason he or she did not consult CURES in the patient's medical record.

This bill would specify that if a health care practitioner knowingly fails to consult the CURES database, he or she shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

This bill would specify that it does not create a private cause of action against a health care practitioner and does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

This bill would specify that is not operative until six months after DOJ certifies that the CURES database is ready for statewide use. DOJ would be required to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification.

This bill would specify that the provisions of the bill are severable and if any provision is held invalid, that invalidity shall not affect other provisions of this bill.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping." Requiring all prescribers to consult the CURES system will allow prescribers to make informed decisions about their patient's care. This bill would also ensure that the CURES system will have the capacity to handle this workload before the bill becomes operative.

However, this bill was amended and now includes one very broad exemption, which weakens the requirements in this bill. In addition, this bill would make it very hard for the Board to take any administrative action for physicians who do not comply with the requirements of this bill. For these reasons, Board staff is suggesting that the

Board change its position to support if amended, with the amendments being to remove the broad exemption and to make changes to the provisions related to when the Board can take action and what type of action can be taken for physicians that do not comply.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: Consumer Attorneys of California and California Narcotics Officers' Association (co-sponsors); American Insurance Association; California Chamber of Commerce; California Teamsters Public Affairs Council; Center for Public Interest Law; Consumer Watchdog; National Alliance on Mental Illness; and ShatterProof

OPPOSITION: California Medical Association

POSITION: Recommendation: Support if Amended

AMENDED IN ASSEMBLY JUNE 21, 2016

AMENDED IN ASSEMBLY JUNE 6, 2016

AMENDED IN ASSEMBLY APRIL 7, 2016

AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 16, 2015

SENATE BILL No. 482

Introduced by Senator Lara

February 26, 2015

An act to amend Section 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 482, as amended, Lara. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a controlled substance to consult the CURES database to review a patient's controlled substance history no earlier than 24 hours before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the

first time and at least ~~annually~~ *once every 4 months* thereafter if the substance remains part of the treatment of the patient. The bill would exempt a veterinarian from this requirement. The bill would also exempt a health care practitioner from this requirement under specified circumstances, including, among others, if prescribing, ordering, administering, furnishing, or dispensing a controlled substance to a patient receiving hospice care, to a patient admitted to a specified facility, or to a patient as part of a treatment for a surgical procedure in a specified facility if the quantity of the controlled substance does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use. The bill would exempt a health care practitioner from this requirement if it is not reasonably possible for him or her to access the information in the CURES database in a timely manner, another health care practitioner or designee authorized to access the CURES database is not reasonably available, and the quantity of controlled substance prescribed, ordered, administered, furnished, or dispensed does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

The bill would provide that a health care practitioner who knowingly fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. The bill would make the above-mentioned provisions operative 6 months after the Department of Justice certifies that the CURES database is ready for statewide use.

The bill would also exempt a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, or inaccurate information submitted, to or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or

Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, or inaccurate information submitted to, or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

SEC. 2. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) (1) (A) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense a controlled substance shall consult the CURES database to review a patient's

controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least ~~annually~~ *once every four months* thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before he or she prescribes, orders, administers, furnishes, or dispenses a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered or dispensed to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) When a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance in the emergency department of a general acute care hospital if the quantity of the controlled substance does not exceed a ~~10-day~~ *seven-day* supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient as part of the patient's treatment for a surgical procedure, if the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, furnished, or dispensed does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If the CURES database cannot be accessed because of exceptional circumstances, as demonstrated by a health care practitioner.

(d) (1) A health care practitioner who knowingly fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 538
Author: Hueso
Bill Date: June 29, 2016, Amended
Subject: Naturopathic Doctors
Sponsor: California Naturopathic Doctor Association
Position: Oppose

DESCRIPTION OF CURRENT LEGISLATION:

This bill would expand the scope of practice for a naturopathic doctor (ND) and would allow an ND to prescribe certain drugs without physician supervision.

BACKGROUND:

NDs can currently prescribe natural and synthetic hormones, epinephrine, vitamins, minerals, and amino acids, independent of physician supervision. California NDs complete 72 pharmacology course hours as part of their schooling and are required to complete a minimum of 20 hours of pharmacotherapeutic training every two years as part of their 60 hour continuing education requirement. NDs attend four year, graduate-level accredited naturopathic medical schools and take a national, standardized licensing examination. NDs perform at least 1500 hours of clinical rotations at mostly clinics and private doctors' offices during their education program. There are over 500 ND licenses that have been issued to date in California.

Current law allows an ND to furnish or order legend drugs and Schedule III-V drugs in accordance with standardized procedures or protocols developed by the ND and his or her supervising physician. Current law authorizes an ND to provide repair and care incidental to superficial lacerations and abrasions, except suturing, and permits an ND to remove foreign bodies located in the superficial tissues. A physician may supervise up to four NDs at a time.

ANALYSIS:

This bill has been amended and significantly narrowed. This bill would expand the scope of an ND, as follows:

- Authorize an ND to order diagnostic imaging studies consistent with the practice of naturopathic medicine (instead of only those determined appropriate by the Naturopathic Medicine Committee (NMC)).
- Clarify that an ND may order, provide, or furnish devices consistent with the naturopathic training, as determined by NMC.
- Authorize an ND to prescribe, administer, or order Schedule V and unclassified drugs labeled "for prescription only", except chemotherapeutics, without physician

supervision.
- Require an ND to be subject to peer review reporting provisions.

This bill expands the scope of practice of an ND and would allow an ND to prescribe specified drugs without physician supervision. Although NDs may be well qualified to practice naturopathic medicine that utilizes natural medicine and treatments in a natural approach, NDs do not receive the education and training in naturopathic education programs to safely prescribe without physician supervision. Physician supervision helps to ensure that the patient care provided by an ND includes physician involvement and oversight.

The Board's primary mission is consumer protection. The Board took an oppose position on this bill previously because it believed that expanding the scope of practice for an ND could compromise patient care and consumer protection. Although this bill has been narrowed, it still allows NDs to prescribe Schedule V and legend drugs without physician supervision.

FISCAL: None

SUPPORT: California Naturopathic Doctor Association (Sponsor); AARP; Akasha Center for Integrative Medicine; American Association of Naturopathic Physicians; Arizona Naturopathic Medical Association; Bastyr University; California Chiropractic Association; California Naturopathic Clinic; California Naturopathic Medicine Committee; Center for Health Santa Cruz; Endocrinology Association of Naturopathic Physicians; Integrative Medicine for the Underserved; National College of Natural Medicine; Naturopathic Academy of Primary Care Physicians; Paracelsus Natural Family Health Center; Pediatric Association of Naturopathic Physicians; Santa Cruz Naturopathic Medical Center; Southwest College of Naturopathic Medicine and Health Statistics; Stengler Center for Integrative Medicine; The Oncology Association of Naturopathic Physicians; Washington Association of Naturopathic Physicians; Women's View Medical Group, Inc.; and 1,155 individuals

OPPOSITION: California Academy of Family Physicians; California Chapter of the American College of Cardiology; California Chapter of the American College of Emergency Physicians; California Orthopaedic Association; California Society of Anesthesiologists; California Society of Dermatology and Dermatologic Surgery; California Society of Plastic Surgeons; Medical Board of California; and Osteopathic Physicians and Surgeons of California

AMENDED IN ASSEMBLY JUNE 29, 2016

AMENDED IN ASSEMBLY AUGUST 17, 2015

AMENDED IN ASSEMBLY JULY 7, 2015

AMENDED IN SENATE APRIL 16, 2015

AMENDED IN SENATE APRIL 6, 2015

SENATE BILL No. 538

Introduced by Senator ~~Block~~ *Hueso*
~~(Coauthor: Senator Hueso)~~
(Principal coauthor: Senator Block)
(Coauthor: Senator Stone)
(Coauthor: Assembly Member Nazarian)

February 26, 2015

An act to amend Sections 3640 and 3640.5 of the Business and Professions Code, relating to naturopathic doctors.

LEGISLATIVE COUNSEL'S DIGEST

SB 538, as amended, ~~Block~~ *Hueso*. Naturopathic doctors.

(1) Existing law, the Naturopathic Doctors Act, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee in the Osteopathic Medical Board of California. Existing law authorizes a naturopathic doctor to perform certain tasks, including physical and laboratory examinations for diagnostic purposes and to order diagnostic imaging studies, consistent with naturopathic training as determined by the committee. Under the act, a naturopathic doctor is authorized to dispense, administer, order, prescribe, furnish, or perform certain things, including health education and health counseling.

This bill would, instead, authorize a naturopathic doctor to perform certain tasks, consistent with the practice of naturopathic medicine, and would additionally authorize a naturopathic doctor to dispense, administer, order, prescribe, provide, or furnish devices and durable medical equipment consistent with the naturopathic training as determined by the committee.

(2) Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitation generally placed on controlled substances classified in Schedule V.

Existing law states that nothing in the Naturopathic Doctors Act or any other law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when, among other requirements, the naturopathic doctor is functioning pursuant to standardized procedure, as defined, or protocol developed and approved, as specified, and the Naturopathic Medicine Committee has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be furnished or ordered. Existing law requires that the furnishing or ordering of drugs by a naturopathic doctor occur under the supervision of a physician and surgeon. Existing law also authorizes a naturopathic doctor to furnish or order controlled substances classified in Schedule III, IV, or V of the California Uniform Controlled Substances Act, but limits this authorization to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. Existing law further requires that drugs classified in Schedule III be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician.

This bill would instead provide that, except as specified, nothing in the provisions governing naturopathic doctors or any other law shall be construed to prohibit a naturopathic doctor from administering, furnishing, ordering, or prescribing drugs and would make a conforming change to the scope of the certification duties of the Naturopathic Medicine Committee. The bill would delete certain provisions described above restricting the authority of naturopathic doctors to furnish or order drugs, including the requirements that the naturopathic doctor function pursuant to a standardized procedure, or furnish or order drugs under the supervision of a physician and surgeon for Schedule V controlled substances and for any drug approved by the federal Food

and Drug Administration and labeled "for prescription only," except chemotherapeutics, that is not classified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 3640 of the Business and Professions Code is amended to read:

3640. (a) A naturopathic doctor may order and perform physical and laboratory examinations for diagnostic purposes, including, but not limited to, phlebotomy, clinical laboratory tests, speculum examinations, orificial examinations, and physiological function tests.

(b) A naturopathic doctor may order diagnostic imaging studies, including X-ray, ultrasound, mammogram, bone densitometry, and others, consistent with the practice of naturopathic medicine, but shall refer the studies to an appropriately licensed health care professional to conduct the study and interpret the results.

(c) A naturopathic doctor may dispense, administer, order, prescribe, provide, furnish, or perform the following:

(1) Food, extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and their extracts, botanical medicines, homeopathic medicines, all dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, consistent with the routes of administration identified in subdivision (d).

(2) Hot or cold hydrotherapy; naturopathic physical medicine inclusive of the manual use of massage, stretching, resistance, or joint play examination but exclusive of small amplitude movement at or beyond the end range of normal joint motion; electromagnetic energy; colon hydrotherapy; and therapeutic exercise.

(3) Devices, including, but not limited to, therapeutic devices, barrier contraception, and durable medical equipment consistent with the naturopathic training as determined by the committee.

(4) Health education and health counseling.

(5) Repair and care incidental to superficial lacerations and abrasions, except suturing.

(6) Removal of foreign bodies located in the superficial tissues.

(d) A naturopathic doctor may utilize routes of administration that include oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular.

(e) The committee may establish regulations regarding ocular or intravenous routes of administration that are consistent with the education and training of a naturopathic doctor.

(f) This section shall not exempt a naturopathic doctor from meeting applicable licensure requirements for the performance of clinical laboratory tests, including the requirements imposed under Chapter 3 (commencing with Section 1200).

SEC. 2. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. (a) Except as set forth in this section, nothing in this chapter or any other ~~provision of~~ law shall be construed to prohibit a naturopathic doctor from administering, furnishing, ordering, or prescribing drugs when functioning pursuant to this section.

(b) Schedule III and Schedule IV controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) shall be administered, furnished, ordered, and prescribed by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon.

(c) The naturopathic doctor shall function pursuant to a standardized procedure, as defined by paragraphs (1) and (2) of subdivision (c) of Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the naturopathic doctor, and, where applicable, the facility administrator or his or her designee.

(d) The standardized procedure or protocol covering the administering, furnishing, ordering, or prescribing of Schedule III and Schedule IV drugs shall specify which naturopathic doctors may administer, furnish, order, or prescribe Schedule III and Schedule IV drugs, which Schedule III through Schedule IV drugs may be administered, furnished, ordered, or prescribed and under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the naturopathic doctor's competence, including peer review, which shall be subject

to the reporting requirement in Section 805, and review of the provisions of the standardized procedure.

(e) The administering, furnishing, ordering, or prescribing of Schedule III and Schedule IV drugs by a naturopathic doctor shall occur under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(1) Collaboration on the development of the standardized procedure.

(2) Approval of the standardized procedure.

(3) Availability by telephonic contact at the time of patient examination by the naturopathic doctor.

(f) When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are administered, furnished, ordered, or prescribed by a naturopathic doctor, the controlled substances shall be administered, furnished, ordered, or prescribed in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the naturopathic doctor's standardized procedure or protocol relating to controlled substances shall be provided, upon request, to a licensed pharmacist who dispenses drugs when there is uncertainty about the naturopathic doctor furnishing the order.

(g) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(h) Notwithstanding subdivision (c), drugs administered, furnished, ordered, or prescribed by a naturopathic doctor without the supervision of a physician and surgeon shall include Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and any drug approved by the federal Food and Drug Administration and labeled "for prescription only" or words of similar import, except chemotherapeutics, that is not classified.

(i) The committee shall certify that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be administered, furnished, ordered, or prescribed under this section. The committee shall establish the requirements for satisfactory completion of this subdivision.

(j) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of

the Health and Safety Code, shall include both of the following for Schedule III through Schedule IV controlled substances.

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(k) For purposes of this section, "drug order" or "order" means an order for medication which is dispensed to or for an ultimate user, issued by a naturopathic doctor as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(*l*) Notwithstanding any other law, all of the following shall apply:

(1) A Schedule III through Schedule IV drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician.

(2) All references to prescription in this code and the Health and Safety Code shall include drug orders issued by naturopathic doctors.

(3) The signature of a naturopathic doctor on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 563
Author: Pan
Bill Date: June 23, 2016, Amended
Subject: Workers' Compensation: Utilization Review
Sponsor: California Medical Association (CMA)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would ensure that physicians involved in authorizing injured worker medical care on behalf of the employer and/or payor are not being inappropriately incentivized to modify, delay, or deny requests for medically necessary services.

BACKGROUND

In California's workers' compensation system, an employer or insurer cannot deny treatment. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to utilization review (UR). UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

In April 2013, the Medical Board of California (Board) reaffirmed that engaging in UR is the practice of medicine and that the Board will not automatically deem UR complaints as non-jurisdictional; the Board will review UR complaints against California-licensed physicians to determine if a quality of care issue is present, and if so, the complaint will undergo the normal complaint review process.

ANALYSIS

This bill would prohibit an employer, or any entity conducting UR on behalf of an employer, from providing any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician. This bill would give the administrative director (AD) the authority to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting UR on behalf of the employer, and the UR physician. This bill would prohibit an insurer or third-party administrator from referring a claim for review to a UR organization in which it has a financial

interest, unless that interest is disclosed to the employer. This bill would provide that any information obtained by the AD relating to these contracts is not subject to disclosure pursuant to the Public Records Act.

According to the sponsor, this bill would increase transparency and accountability within the workers' compensation UR process. There is currently no explicit prohibition in law related to UR to ensure that a physician's judgment for medical necessity is not compromised by financial incentives. This bill will promote the Board's mission of consumer protection and the Board took a support position on this bill.

FISCAL: None to the Board

SUPPORT: California Medical Association (sponsor)
Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 23, 2016

AMENDED IN ASSEMBLY JUNE 15, 2016

AMENDED IN SENATE JANUARY 4, 2016

AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 13, 2015

SENATE BILL No. 563

Introduced by Senator Pan

February 26, 2015

An act to amend Section 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 563, as amended, Pan. Workers' compensation: utilization review.

Existing law requires every employer, for purposes of workers' compensation, to establish a utilization review process to prospectively, retrospectively, or concurrently review requests by physicians for authorization to provide recommended medical treatment to injured employees. Existing law establishes timeframes for an employer to make a determination regarding a physician's request. Existing law requires the utilization review process to be governed by written policies and procedures, and requires that these policies and procedures be filed with the Administrative Director of the Division of Workers' Compensation and disclosed by the employer to employees, physicians, and the public upon request.

This bill would prohibit the employer, or any entity conducting utilization review on behalf of the employer, from offering or providing any financial incentive or consideration to a physician based on the

number of modifications, delays, or denials made by the physician. The bill would authorize the administrative director to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. The bill would make any information disclosed to the administrative director confidential and not subject to public disclosure, except as specified.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative

director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) (1) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(2) (A) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician under this section.

(B) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer with prior written disclosure of both of the following:

(i) The entity conducting the utilization review services.

(ii) The insurer or third-party administrator's financial interest in the entity.

(3) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule,

or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government ~~Code) unless the division can demonstrate that the information was in the public domain at the time it was disclosed or has entered the public domain through no fault of the division.~~ *Code)*. Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the

information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical

care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify

the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The

administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which amends Section 4610 of the Labor Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitations on the people's rights of access set forth in this act are necessary to protect the privacy and integrity of information submitted to the Administrative Director of the Division of Workers' Compensation pursuant to paragraph (3) of subdivision (e) of Section 4610 of the Labor Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1174
Author:	McGuire
Bill Date:	June 22, 2016, Amended
Subject:	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications
Sponsor:	National Center for Youth Law
Current Position:	Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would add to the Medical Board of California's (Board) priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill would require the Board to confidentially collect and analyze data submitted by the Department of Health Care Services (DHCS) and the Department of Social Services (DSS), related to physicians prescribing psychotropic medications to children.

BACKGROUND

In August 2014, the Board received a letter from Senator Lieu, who was at the time the Chair of the Senate Business, Professions and Economic Development Committee. The letter asked the Board to look into the issue of inappropriate prescribing of psychotropic medication to foster children. The Board receives very few complaints regarding foster children being prescribed psychotropic medications, so the Board researched other avenues to identify physicians who may be inappropriately prescribing. The Board met with DHCS and DSS regarding what data was available, what could be provided to the Board, and what data would assist in the identification of inappropriately prescribing physicians. After many meetings, a Data Use Agreement (DUA) was finalized in April 2015 requesting a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more. For each child that fit into this category, the Board requested a list of the medications prescribed, the start and stop date for each medication, the prescriber's name and contact information, the child's birth date, and any other information that DHCS and DSS thought might be relevant to assist in this process.

Upon receipt of the information requested in the DUA in 2015, the Board secured an expert pediatric psychiatrist to review the information and determine any physician who may be potentially prescribing inappropriately. It is important to note that once a physician is identified, the Board's normal complaint process will be followed, including obtaining medical records, conducting a physician interview and having an expert physician review the case. The complaint and investigation process is confidential, and nothing is public until an accusation is filed. Upon review by the Board's expert, it was determined that additional information was needed to identify physicians that may warrant additional investigation. The new information

includes diagnosis associated with the medication, dosage of medication prescribed, schedule of dosage, and weight of the child/adolescent. The Board obtained this information in June and the Board's expert is currently reviewing this information.

ANALYSIS

This bill would add to the Board's priorities acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor. Although the Board already has excessive prescribing of controlled substances in its priorities, many psychotropic medications are not controlled substances, so they would not be covered in the Board's existing priorities.

This bill would require DHCS, in collaboration with DSS, to provide quarterly data to the Board pursuant to a data-sharing agreement that includes, but is not limited to, the child welfare psychotropic medication measures and the Healthcare Effectiveness Data and Information Set measures related to psychotropic medications. The data shall be provided for each prescriber with a pattern of prescribing that includes one or more of the following:

- Prescriptions for any class of psychotropic medication for a child who is five years of age or younger.
- Prescriptions for concurrent administration of two or more antipsychotic medications that exceed 60 days.
- Prescriptions for concurrent administration of three or more psychotropic medications exceeding 60 days.
- Prescriptions for a dosage that exceeds the amount recommended for children.

The following information shall be included for each prescriber that meets the above-mentioned prescribing patterns:

- Prescriber name, specialty, location and contact information.
- The child's gender and year of birth.
- A list of the psychotropic medications prescribed, diagnosis, and the medication start and end date.
- Unit of each medication, quantity of medication, the day's supply, and the prescription fill date.
- The child's weight.

This bill would specify that the data provided to the Board shall include a breakdown by population of the following, including rate and age stratifications for birth to 5 years old, 6 to 11 years old and 12-17 years old:

- Children prescribed psychotropic medications in managed care and fee-for-service settings;
- Children adjudged as dependent children placed in foster care; and
- A minor adjudged a ward of the court who has been removed from the physical custody of the parent and placed into foster care.

This bill would require the Board to review the data provided by DHCS and DSS on a quarterly basis to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist, and if warranted, conduct an investigation. This bill would require the Board to take disciplinary action, as appropriate. Lastly, this bill would require the Board to provide an annual report on the results of the data analysis to the Legislature, DHCS and DSS. This bill would require the Board, DHCS and DSS to consult and revise the data methodology every three years, if determined to be necessary.

This bill would require DHCS to disseminate guidelines on an annual basis via email to any prescriber who meets the data requirement threshold for prescribing psychotropic medications to children and adolescents pursuant to this bill.

According to the author, over the past fifteen years the rate of foster youth prescribed psychotropic medication has increased 1,400 percent. Nearly 1 in 4 California foster teens are prescribed psychotropic drugs, and of those nearly 60 percent were prescribed an anti-psychotic, the drug class most susceptible to debilitating side effects. There have been several Senate hearings on this issue, and according to the hearing background information, concerns over the use of psychotropic medications among children has been well documented in research journals and the mainstream media for more than a decade.

Anecdotally, the Board does not receive complaints regarding overprescribing of psychotropic medications to foster children. The data that will be required to be submitted to the Board pursuant to this bill will ensure that the Board can review prescribing data on an on-going basis to help identify physicians who may be inappropriately prescribing. The data the Board has received under the DUA is only a snapshot in time, for a 6 month time period in 2014. Any information that can help the Board identify inappropriate prescribing can be utilized as a tool for the Board to use in its complaint and investigation process. However, once a possible inappropriate prescriber is identified, the board will still have to go through its normal complaint and investigation process.

This bill will further the Board's mission of consumer protection for a very vulnerable population. The Board currently has a support if amended position on this bill. Amendments were taken that ensure that the Board will continue to receive the same data requested under the DUA, including the associated physician information and de-identified patient information; these amendments were requested by the Board. Amendments were also taken to ensure the Board will receive the additional data recently requested by the Board's expert pediatric psychiatrist, which were also requested by the Board. The Board did request an amendment to include a sunset date for receiving the data. The author and sponsor instead included language to allow the Board to revise the data methodology every three years, if needed. This will allow the Board to revise the data being collected, but does not include an actual sunset date. The Board will need to decide if this language is sufficient to address the Board's concern. If it is, the Board's position should change to support.

FISCAL: This bill will result in minor and absorbable fiscal impact to have an expert pediatric psychiatrist review the data and report the results to the Legislature, DHCS and DSS on an on-going basis. This is currently being done now, but not on an on-going basis.

SUPPORT: National Center for Youth Law (Sponsor); Advokids; Bay Area Youth Center; Children Now; Children's Partnership; Consumer Watchdog; John Burton Foundation; Medical Board of California (if amended); and Pacific Juvenile Defender Center

OPPOSITION: California Academy of Child and Adolescent Psychiatry

AMENDED IN ASSEMBLY JUNE 22, 2016

AMENDED IN ASSEMBLY JUNE 15, 2016

AMENDED IN SENATE MARCH 28, 2016

SENATE BILL No. 1174

Introduced by Senator McGuire
(Coauthors: Senators Beall, Hancock, Liu, and Mitchell)

February 18, 2016

An act to amend Section 2220.05 of, and to add Section 2245 to, the Business and Professions Code, and to add Section 14028 to the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1174, as amended, McGuire. Medi-Cal: children: prescribing patterns: psychotropic medications.

Existing law, the Medical Practice Act, among other things provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board's responsibilities include enforcement of the disciplinary and criminal provisions of the act.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. The Medi-Cal program is, in part, governed and funded by federal Medicaid ~~Program~~ *program* provisions. Existing law establishes a statewide system of child welfare services, administered by the State Department of Social Services, with the intent that all children are entitled to be safe and free from abuse and neglect.

This bill would require the ~~Medical Board of California~~ *board* to conduct on a quarterly basis an analysis of data regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services *for specified children and minors placed in foster care* using data provided by the State Department of Health Care Services and the State Department of Social Services, as prescribed. The bill would require that the data concerning psychotropic medications and related services be shared pursuant to a data-sharing agreement and would require that, every 3 years, the ~~Medical Board of California,~~ *board,* the State Department of Health Care Services, and the State Department of Social Services consult and revise the methodology, if determined to be necessary. Commencing July 1, 2017, the bill would require the ~~Medical Board of California~~ *board* to report annually to the Legislature, the State Department of Health Care Services, and the State Department of Social Services the results of the analysis of the data. The bill would require the ~~Medical Board of California~~ *board* to review the data in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and conduct an investigation, if warranted, and would require the board to take disciplinary action, as specified. The bill would require the ~~Medical Board of California to disseminate guidelines for the prescribing of psychotropic medications to children and adolescents on an annual basis to any prescriber who has been flagged for review.~~ *State Department of Health Care Services to disseminate guidelines on an annual basis via email to any prescriber who meets one or more of specified prescribing patterns, such as prescribing any class of psychotropic medication for a child who is 5 years of age or younger, or prescribing a dosage that exceeds the amount recommended for children.* The bill would require the board to handle on a priority basis investigations of repeated acts of excessive prescribing, furnishing, or administering psychotropic medications to a minor, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(7) Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 2. Section 2245 is added to the Business and Professions Code, to read:

2245. (a) The Medical Board of California on a quarterly basis shall review the data provided pursuant to Section 14028 of the Welfare and Institutions Code by the State Department of Health Care Services and the State Department of Social Services in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, shall conduct an investigation.

(b) The ~~Medical Board of California shall disseminate guidelines for the prescribing of psychotropic medications to children and adolescents on an annual basis to any prescriber who has been flagged for review.~~ *State Department of Health Care Services shall disseminate guidelines on an annual basis via email to any prescriber who meets the data requirement threshold for prescribing psychotropic medications to children and adolescents established in subdivision (c) of Section 14028 of the Welfare and Institutions Code.*

(c) If, after an investigation, the Medical Board of California concludes that there was a violation of law, the board shall take disciplinary action, as appropriate, as authorized by Section 2227.

(d) If, after an investigation, the Medical Board of California concludes that there was excessive prescribing of psychotropic medications inconsistent with the standard of care, the board shall take action, as appropriate, as authorized by Section 2227.

(e) (1) Notwithstanding Section 10231.5 of the Government Code, commencing July 1, 2017, the Medical Board of California shall report annually to the Legislature, the State Department of Health Care Services, and the State Department of Social Services

the results of the analysis of data described in Section 14028 of the Welfare and Institutions Code.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 3. Section 14028 is added to the Welfare and Institutions Code, to read:

14028. (a) The Medical Board of California shall conduct on a quarterly basis an analysis of Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services *for individuals described in subparagraphs (B) and (C) of paragraph (1) of subdivision (b)* using data provided quarterly by the department in collaboration with the State Department of Social Services that shall include, but is not limited to, the child welfare psychotropic medication measures and the Healthcare Effectiveness Data and Information Set measures related to psychotropic medications. The data concerning psychotropic medications and related services shall be shared pursuant to a data-sharing agreement that meets the requirements of all applicable state and federal laws and regulations. Every three years, the Medical Board of California, the State Department of Health Care Services, and the State Department of Social Services shall consult and revise the methodology, if determined to be necessary.

(b) (1) The data provided to the Medical Board of California pursuant to subdivision (a) shall include a breakdown by population of all of the following:

(A) Children prescribed psychotropic medications in managed care and fee-for-service settings.

(B) Children adjudged as dependent children under Section 300 and placed in foster care.

(C) A minor adjudged a ward of the court under Section 601 or 602 who has been removed from the physical custody of the parent and placed into foster care.

~~(D) Children with developmental disabilities, as described in Section 4512.~~

(2) The data provided to the medical board as described in paragraph (1) shall include total rate and age stratifications that include the following:

(A) Birth to five years of age, inclusive.

(B) Six to 11 years of age, inclusive.

(C) Twelve to 17 years of age, inclusive.

(c) (1) The data provided to the Medical Board of California pursuant to subdivision (a) shall include the information listed in paragraph (2) for each prescriber with a pattern of prescribing that includes one or more of the following:

(A) Prescriptions for any class of psychotropic medication for a child who is five years of age or younger.

(B) Prescriptions for concurrent administration of two or more antipsychotic medications that exceed 60 days.

(C) Prescriptions for concurrent administration of three or more psychotropic medications exceeding 60 days.

(D) Prescriptions for a dosage that exceeds the amount recommended for children.

(2) The following information shall be included for each prescriber described in paragraph (1):

(A) Prescriber name, specialty, location, and contact information.

(B) The child's gender and year of birth.

(C) A list of the psychotropic medications prescribed, diagnosis, and the medication start and end date.

(D) Unit of each medication, quantity of each medication, the day's supply, and the prescription fill date.

(E) The child's weight.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1177
Author: Galgiani
Bill Date: June 23, 2016, Amended
Subject: Physician and Surgeon Health and Wellness Program
Sponsor: California Medical Association (CMA)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the establishment of a Physician and Surgeon Health and Wellness Program (PHWP) within the Medical Board of California (Board). The PHWP would provide early identification of, and appropriate interventions to support a licensee in the rehabilitation from, substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety. This bill would authorize the Board to contract with a private third-party independent administering entity to administer the program.

BACKGROUND

The Board's Diversion Program was a monitoring program for substance abusing physicians (and some physicians with mental impairment) that ensured physicians were complying with the requirements of their agreement with the Diversion Program. The terms included abstaining from drugs and/or alcohol, biological fluid testing, attending group therapy, etc. Senate Bill 761 (Ridley-Thomas), which was the vehicle to extend the dates of the Board's Diversion Program from January 1, 2009 through January 1, 2011, did not pass out of the Legislature. During the hearings for this bill, the discussion and debate surrounding the Board's Diversion Program centered on the multiple audits indicating concerns with the Diversion Program and its protection of the consumers of California. The Board's Diversion Program was very different than any other board's Diversion Programs within the Department of Consumer Affairs (DCA). The Board's Diversion Program was run by the Board itself, not by an outside vendor, was staffed by civil service employees hired by the Board, and was subject to the budget/legislative process for any changes in the number of staff needed to run the Diversion Program. Based upon the concerns over the safety of patients, the Legislature did not approve the continuation of this Diversion Program and it became inoperative on July 1, 2008.

The Board and its staff developed a transition plan for the individuals that were in the Diversion Program on July 1, 2008. The plan not only transitioned the individuals in the Program to other monitoring programs, but also identified how the Board would perform its mission of consumer protection with individuals who were found to have a substance abuse

problem without the existence of a Diversion Program for physicians. Under the Diversion Program, physicians who were found to only have a substance abuse problem or mental impairment were allowed to enter the Diversion Program without any record of disciplinary action. If the physician successfully completed the Board's Diversion Program the public never became aware of the issue. The Board determined that the best way to ensure physicians with a substance abuse problem were not endangering the public would be to continue the biological fluid testing requirements. The Board contracted with a vendor to provide these services. Today, without the Diversion Program, when an individual is identified to have an abuse problem, the Board pursues disciplinary action and, if action is taken, the physician is normally placed on probation with terms and conditions including submitting to biological fluid testing. It is up to the physicians to seek a program that will assist them in maintaining abstinence.

With the elimination of the Board's Diversion Program, the Board also knew there would be a need for information regarding physician wellness and resources to assist physicians seeking wellness. Therefore, the Board established a Wellness Committee whose main function was to provide articles for the Board's Newsletter regarding physician wellness, locate resources for physicians who are struggling with impairment issues, and entertain presentations on physician wellness. The information gathered by the Wellness Committee was then provided to physicians via the Board's website or Newsletter. This Committee has since been consolidated with the Education Committee.

At the Board's October 2015 Board Meeting, after meetings with consumer groups, provider groups, and physician health programs, the Board adopted elements that a physician health program should include, in order to be supported by the Board. These elements are attached.

ANALYSIS

This bill would authorize establishment of a PHWP within the Board. The PHWP would provide early identification of, and appropriate interventions to support a physician in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety and maintain the integrity of the medical profession. The PHWP shall aid a physician with substance abuse issues impacting his or her ability to practice medicine.

If the Board establishes a program, it shall do all the following:

- Provide for the education of all licensed physician and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.
- Offer assistance to a physician in identifying substance abuse problems.
- Evaluate the extent of substance abuse problems and refer the physician to the appropriate treatment by executing a written agreement with the physician participant.

- Provide for the confidential participation by a physician with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. If an investigation occurs after the physician has enrolled in the PHWP, the Board may inquire whether the physician is enrolled in the PHWP.
- Comply with the Uniform Standards for Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Business and Professions Code Section 315.

If the Board establishes a PHWP, it would be required to contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the PHWP shall be administered by the Board. The administering entity would be required to have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals. The administering entity would be required to identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and would be required to establish a process for evaluating the effectiveness of such programs. The administering entity would be required to provide counseling and support for the physician participant and for the family of any physician referred for treatment. The administering entity would have to make their services available to all licensed California physicians, including those who self-refer to the PHWP. The administering entity would be required to have a system for immediately reporting a physician from the program to the Board, including but not limited to, a physician who withdraws or is terminated. The system would need to ensure absolute confidentiality in the communication to the Board. The administering entity could not provide this information to any other individual or entity unless authorized by the physician participant. The contract entered into with the Board would need to require the administering entity to do the following:

- Provide regular communication to the Board, including annual reports to the Board with program statistics, including, but not limited to, the number of participants, the number of participants referred by the Board as a condition of probation, the number of participants who successfully completed their agreement period, and the number of participants terminated from the program. The reports would not be allowed to disclose any personally identifiable information.
- Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements and its implementing rules and regulations. Any audit conducted must maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and must not disclose any information identifying a program participant.

If the Board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the Board, the Board would be able to terminate the contract.

This bill would require a physician, as a condition of participation in the PHWP, to enter into an individual agreement with the PHWP and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the written agreement. The agreement shall include the following:

- A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program.
- Compliance with terms and conditions of treatment and monitoring.
- Criteria for program completion.
- Criteria for termination of a physician participant from the program.
- Acknowledgement that withdrawal or termination of a physician participant from the program shall be reported to the Board.
- Acknowledgement that expenses related to treatment, monitoring, laboratory tests, and other specified activities shall be paid by the physician participant.

This bill would specify that any agreement entered into would not be considered a disciplinary action or order by the Board and shall not be disclosed to the Board if both of the following apply:

- The physician did not enroll in the PHWP as a condition of probation or as a result of an action by the Board.
- The physician is in compliance with the conditions and procedures in the agreement.

This bill would require any oral or written information reported to the Board to be confidential and shall not constitute a waiver of any existing evidentiary privileges under any provision or rule of law. This bill would specify that confidentiality would not apply if the Board has referred a physician participant as a condition of probation. This bill would specify that it does not prohibit, require, or otherwise affect the discovery or admissibility of evidence in an action by the Board against a physician based on acts or omissions within the course and scope of his or her practice. This bill would specify that participation in the program shall not be a defense to any disciplinary action that may be taken by the Board. The requirements in this bill would not preclude the Board from taking disciplinary action against a physician who is terminated unsuccessfully from the program but the disciplinary action may not include any confidential information unless authorized (the information is only confidential if the participant is not on probation and is complying with his or her individual agreement with the PHWP).

This bill would establish the Physician and Surgeon Health and Wellness Program Account in the contingent fund of the Board. Any fees collected by the Board from participants shall be deposited into this account and upon appropriation by the Legislature, shall be available for support of the program. This bill would require the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP shall pay. The fee is required to be set at a level sufficient to cover all costs of participating in the

PHWP, including any administrative costs incurred by the Board to administer the PHWP. This bill would allow the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP. These moneys could not be used to cover costs for individual physicians to participate in the program.

According to the sponsor, this bill will bring California in line with the majority of other states who recognize that wellness and treatment programs serve to enhance public health and provide resources for those in need of help.

The PHWP proposed by this bill is not a diversion program, it will not divert physicians from discipline; this is of utmost importance for consumer protection. The Board will not be running this program, it will be run by a private third-party independent administering entity that will be selected pursuant to the request for proposals process. This bill would require the PHWP to comply with the Uniform Standards and would require any physician participants who terminate or withdraw from the PHWP to be reported to the Board. These are both very important elements for consumer protection. This bill would also allow for communication to the Board for those physicians ordered to the PHWP as a condition of probation, which is also important for consumer protection. Board staff believes that the PHWP proposed by this bill aligns with the Board-approved elements and the Board has taken a support position on this bill. Pursuant to a legal review of points raised by the opposition, a clarifying amendment may be needed in Business and Professions Code Section 2340.6 (c) to make it clear that confidentiality shall not apply if a physician is not in compliance with the conditions and procedures in the agreement. This technical amendment will ensure that the bill is in compliance with the Uniform Standards. Board staff can work with the author's office and committee staff to ensure this technical amendment is made.

FISCAL: This bill would require the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP must pay. The fee is required to be set at a level sufficient to cover all costs of participating in the PHWP. Any fees collected by the Board from participants shall be deposited into the newly established Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Board and, upon appropriation by the Legislature, shall be available for support of the program. This bill would allow the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP.

The Board would need one staff position at the Associate Governmental Program Analyst level to set up the PHWP and then coordinate with the third-party vendor to implement the PHWP.

SUPPORT: CMA (Sponsor); California American College of Emergency

Physicians; California Academy of Family Physicians; California Health Advocates; California Hospital Association; California Society of Addiction Medicine; Drug Policy Alliance; Medical Board of California; Union of American Physicians and Dentists; and Western Occupational and Environmental Medical Association

OPPOSITION: Center for Public Interest Law
Consumer Attorneys of California
Consumers' Union Safe Patient Project
One Individual

AMENDED IN ASSEMBLY JUNE 23, 2016

AMENDED IN SENATE JUNE 1, 2016

AMENDED IN SENATE MAY 4, 2016

AMENDED IN SENATE APRIL 20, 2016

AMENDED IN SENATE APRIL 4, 2016

SENATE BILL No. 1177

Introduced by Senator Galgiani

February 18, 2016

An act to add Article 14 (commencing with Section 2340) to Chapter 5 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1177, as amended, Galgiani. Physician and Surgeon Health and Wellness Program.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards and a designee of the State Department of Health Care Services. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees, whether or not a healing arts board has a formal diversion program.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California within the department. Existing law requires all moneys paid to and received by the Medical Board of California to be paid into the

State Treasury and credited to the Contingent Fund of the Medical Board of California, which, except for fine and penalty money, is a continuously appropriated fund.

This bill would authorize the board to establish a Physician and Surgeon Health and Wellness Program for the early identification of, and appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse, as specified. If the board establishes a program, the bill would require the board to contract for the program's administration with a private ~~third-party~~ *3rd-party* independent administering entity meeting certain requirements. The bill would require program participants to enter into an individual agreement with the program that includes, among other things, a requirement to pay expenses related to treatment, monitoring, and laboratory tests, as provided.

This bill would create the Physician and Surgeon Health and Wellness Program Account within the Contingent Fund of the Medical Board of California. The bill would require the board to adopt regulations to determine the appropriate fee for a physician and surgeon to participate in the program, as specified. The bill would require these fees to be deposited in the Physician and Surgeon Health and Wellness Program Account and to be available, upon appropriation by the Legislature, for the support of the program. Subject to appropriation by the Legislature, the bill would authorize the board to use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program, except the bill would prohibit these moneys from being used to cover any costs for individual physician and surgeon participation in the program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Physician and Surgeon Health and Wellness Program

2340. (a) The board may establish a Physician and Surgeon Health and Wellness Program for the early identification of, and

appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse to ensure that the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. The program, if established, shall aid a physician and surgeon with substance abuse issues impacting his or her ability to practice medicine.

(b) For the purposes of this article, "program" shall mean the Physician and Surgeon Health and Wellness Program.

(c) If the board establishes a program, the program shall meet the requirements of this article.

2340.2. If the board establishes a program, the program shall do all of the following:

(a) Provide for the education of all licensed physicians and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.

(b) Offer assistance to a physician and surgeon in identifying substance abuse problems.

(c) Evaluate the extent of substance abuse problems and refer the physician and surgeon to the appropriate treatment by executing a written agreement with a physician and surgeon participant.

(d) Provide for the confidential participation by a physician and surgeon with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. *If an investigation of a physician and surgeon occurs after the physician and surgeon has enrolled in the program, the board may inquire of the program whether the physician and surgeon is enrolled in the program.*

(e) Comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Section 315.

2340.4. (a) If the board establishes a program, the board shall contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the program shall be administered by the board pursuant to Article 4 (commencing with Section 10335) of Chapter 2 of Part 2 of Division 2 of the Public Contract Code. However, Section 10425 of the Public Contract Code shall not apply to this subdivision.

(b) The administering entity shall have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals.

(c) The administering entity shall identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and shall establish a process for evaluating the effectiveness of such programs.

(d) The administering entity shall provide counseling and support for the physician and surgeon and for the family of any physician and surgeon referred for treatment.

(e) The administering entity shall make their services available to all licensed California physicians and surgeons, including those who self-refer to the program.

(f) The administering entity shall have a system for immediately reporting a physician and ~~surgeon~~ *surgeon, including, but not limited to, a physician and surgeon* who withdraws or is terminated from the ~~program~~ *program,* to the board. This system shall ensure absolute confidentiality in the communication to the board. The administering entity shall not provide this information to any other individual or entity unless authorized by the participating physician and surgeon.

(g) The contract entered into pursuant to this section shall also require the administering entity to do the following:

(1) Provide regular communication to the board, including annual reports to the board with program statistics, including, but not limited to, the number of participants currently in the program, the number of participants referred by the board as a condition of probation, the number of participants who have successfully completed their agreement period, and the number of participants terminated from the program. In making reports, the administering entity shall not disclose any personally identifiable information relating to any participant.

(2) Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements of this article and its implementing rules and regulations. Any audit conducted pursuant to this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information identifying a program participant.

(h) In the event that the board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the board, the board may terminate the contract.

2340.6. (a) A physician and surgeon shall, as a condition of participation in the program, enter into an individual agreement with the program and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement. The agreement shall include all of the following:

(1) A jointly ~~agreed upon~~ *agreed-upon* plan and mandatory conditions and procedures to monitor compliance with the program.

(2) Compliance with terms and conditions of treatment and monitoring.

(3) Criteria for program completion.

(4) Criteria for termination of a physician and surgeon participant from the program.

(5) Acknowledgment that withdrawal or termination of a physician and surgeon participant from the program shall be reported to the board.

(6) Acknowledgment that expenses related to treatment, monitoring, laboratory tests, and other activities specified by the program shall be paid by the physician and surgeon participant.

(b) Any agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board and shall not be disclosed to the board if both of the following apply:

(1) The physician and surgeon did not enroll in the program as a condition of probation or as a result of an action by the board.

(2) The physician and surgeon is in compliance with the conditions and procedures in the agreement.

(c) Any oral or written information reported to the board shall remain confidential and shall not constitute a waiver of any existing evidentiary privileges under any other provision or rule of law. However, confidentiality regarding the physician and surgeon's participation in the program and related records shall not apply if the board has referred a participant as a condition of probation.

(d) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action by the board against a physician and surgeon based on acts or omissions within the course and scope of his or her practice.

~~(e) Any information received, developed, or maintained regarding a physician and surgeon in the program shall not be used for any other purposes.~~

~~(f)~~

(e) Participation in the program shall not be a defense to any disciplinary action that may be taken by the board. This section does not preclude the board from commencing disciplinary action against a physician and surgeon who is terminated unsuccessfully from the program. However, that disciplinary action may not include as evidence any confidential information unless authorized by this section.

2340.8. (a) The Physician and Surgeon Health and Wellness Program Account is hereby established within the Contingent Fund of the Medical Board of California. Any fees collected by the board pursuant to subdivision (b) shall be deposited in the Physician and Surgeon Health and Wellness Program Account and shall be available, upon appropriation by the Legislature, for the support of the program.

(b) The board shall adopt regulations to determine the appropriate fee that a physician and surgeon participating in the program shall provide to the board. The fee amount adopted by the board shall be set at a level sufficient to cover all costs for participating in the program, including any administrative costs incurred by the board to administer the program.

(c) Subject to appropriation by the Legislature, the board may use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program under this article, except these moneys shall not be used to cover any costs for individual physician and surgeon participation in the program.

~~2340.10. The Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall apply to regulations adopted pursuant to this article.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1189
Author:	Pan and Jackson
Bill Date:	June 22, 2016, Amended
Subject:	Autopsies: Licensed Physicians and Surgeons
Sponsor:	Union of American Physicians and Dentists (UAPD)
Position	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that a forensic autopsy be conducted by a licensed physician and surgeon and would require that the results of a forensic autopsy can only be determined by a licensed physician and surgeon.

BACKGROUND

California law does not define the term "autopsy", but a 1970 opinion of the California Attorney General states that an autopsy is a "form of postmortem examination in which a dead body is examined and at least partially dissected for the purpose of ascertaining the cause of death, the nature and extent of lesions of disease, or any other abnormalities present."

The Ventura County District Attorney's (DA) Office published a report in February 2016 entitled "A Report on the Ventura County Medical Examiner Investigation." In this report, the Ventura County DA reviews the investigation it conducted on Ventura County's former Medical Examiner, and discusses the obstacles faced by the DA's office in pursuing criminal action. In the report, it brings up several grey areas of law related to autopsies and who can perform them. The report states that there is no California law that defines an autopsy and there is no statute that clearly defines that performance of an autopsy is the practice of medicine. The report also states there is a need for legislation to clarify whether the performance of an autopsy is included in the practice of medicine.

Fifty of California's 58 counties have sheriff-coroner offices, which means that the two offices are consolidated and the sheriff also serves as the coroner. There are sections in the Government Code that authorize the coroner to perform autopsies. There is also a section in the Health and Safety Code that allows an autopsy to be performed by a coroner or other officer authorized by law to perform autopsies. The definition of the practice of medicine in the Medical Practice Act does not specifically address that conducting an autopsy on a dead body constitutes the practice of medicine. The Ventura County DA's office makes recommendations in the conclusion of its report that the Legislature should consider amending existing law to clarify whether an autopsy is the practice of medicine and to define the term autopsy.

ANALYSIS

This bill would expressly state that forensic autopsies can only be conducted by a licensed physician and surgeon. This bill would require that the results of an autopsy may only be determined by a licensed physician and surgeon. This bill would define a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause and manner of death is determined. This bill would define a postmortem examination to mean the external examination of the body where no manner or cause of death is determined. This bill would require the manner of death to be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the licensed physician and surgeon in the determination of the manner of death.

This bill would provide, for health and safety purposes, all persons in the autopsy suite to be informed of the risks presented by blood borne pathogens and they should wear personal protective equipment, as specified. This bill would only allow individuals who are directly involved in the investigation of the death of the decedent in the autopsy suite. If an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved with the care and custody of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of an autopsy. This bill would allow individuals in the autopsy suite for educational and research purposes at the discretion of the coroner, and in consultation with the licensed physician and surgeon conducting the autopsy. This bill would require police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to the death that is incident to law enforcement activity to be made available to the forensic pathologist prior to the completion of the investigation of the death. This bill would make conforming changes to other portions of the Government Code that reference autopsies.

According to the authors, a medically trained physician and surgeon is best equipped to determine the results of an autopsy. Clarifying that a medically trained professional should be the one who conducts the autopsy also clarifies ambiguities in existing law. The sponsors of this bill believe that elected officials lack the medical expertise necessary to perform an autopsy to the same degree as a licensed physician and surgeon and this bill seeks to add further legitimacy and authority to death investigations in coroner cases.

In reading the Ventura County DA report, and in discussions with Senator Jackson's office, Board staff believes there are grey areas in the law related to autopsies being the practice of medicine and who can perform autopsies. It should be made clear in the law that autopsies can only be performed by licensed physicians and surgeons. This clarification will assist the Board in its enforcement actions and further the Board's mission of consumer protection. For these reasons, the Board has taken a support position on this bill and the recent amendments do not affect the Board's position or the reasons for taking that position.

FISCAL: None

SUPPORT: UAPD (Sponsor)
California District Attorneys Association
California Society of Pathologists
College of American Pathologists
Consumer Attorneys of California
Medical Board of California
National Association of Medical Examiners
Ventura County District Attorney's Office

OPPOSITION: California State Coroner's Association
California State Sheriff's Association

AMENDED IN ASSEMBLY JUNE 22, 2016

AMENDED IN SENATE APRIL 26, 2016

AMENDED IN SENATE APRIL 13, 2016

AMENDED IN SENATE MARCH 28, 2016

SENATE BILL No. 1189

Introduced by Senators Pan and Jackson

February 18, 2016

An act to amend Sections 27491.4, 27491.41, 27491.43, 27491.46, 27491.47, and 27520 of, and to add Section 27522 to, the Government Code, relating to autopsies.

LEGISLATIVE COUNSEL'S DIGEST

SB 1189, as amended, Pan. Postmortem examinations or autopsies: forensic pathologists.

Existing law requires a county coroner to inquire into and determine the circumstances, manner, and cause of certain deaths. Existing law either requires or authorizes a county coroner, under certain circumstances, to perform, or cause to be performed, an autopsy on a decedent. Existing law imposes certain requirements on a postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified body or human remains.

Existing law authorizes the board of supervisors of a county to consolidate the duties of certain county offices in one or more of specified combinations, including, but not limited to, sheriff and coroner, district attorney and coroner, and public administrator and coroner. Existing law authorizes the board of supervisors of a county to abolish the office of coroner and provide instead for the office of medical examiner, as specified, and requires the medical examiner to be a

licensed physician and surgeon duly qualified as a specialist in pathology.

This bill would require that a forensic autopsy, as defined, be conducted by a licensed physician and surgeon. The bill would require that the results of a forensic autopsy ~~and the cause and manner of death~~ be determined by a licensed physician and surgeon. *The bill would require the manner of death to be determined by the coroner or medical examiner of a county. The bill would require, if a licensed physician and surgeon conducts a forensic autopsy, the coroner to consult with the licensed physician and surgeon in the determination of the manner of death.*

The bill would require, for health and safety purposes, that all persons in the autopsy suite ~~have current bloodborne pathogen training~~ *be informed of the risks presented by bloodborne pathogens* and *be informed that they should wear* personal protective equipment, as specified. The bill would ~~provide that police and other law enforcement personnel who have completed the specified training may~~ *require that only individuals who are directly involved in the investigation of the death of the decedent* be allowed into the autopsy suite ~~at the discretion of the forensic pathologist,~~ but *would permit individuals to be in the autopsy suite for educational and research purposes at the discretion of the coroner, in consultation with any licensed physician and surgeon conducting an autopsy. The bill* would prohibit law enforcement personnel directly involved ~~with the care and custody~~ *in the death* of an individual who died due to involvement of law enforcement activity from being involved with any portion of the postmortem examination or being inside the autopsy suite during the performance of the autopsy. The bill would define a postmortem examination for this purpose to be the external examination of the body where no manner or cause of death is determined.

The bill would require specified materials that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity to be made available to the forensic pathologist prior to the completion of the investigation of the death.

The bill would specify that these provisions shall not be construed to limit the practice of an autopsy for educational or research purposes.

By imposing additional duties upon local officials and law enforcement agencies, this bill would create a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

The bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 27491.4 of the Government Code is amended to read:

27491.4. (a) For purposes of inquiry the coroner shall, within 24 hours or as soon as feasible thereafter, where the suspected cause of death is sudden infant death syndrome and, in all other cases, the coroner may, in his or her discretion, take possession of the body, which shall include the authority to exhume the body, order it removed to a convenient place, and make or cause to be made a postmortem examination, or cause to be made an autopsy thereon, and make or cause to be made an analysis of the stomach, stomach contents, blood, organs, fluids, or tissues of the body. The detailed medical findings resulting from an inspection of the body or autopsy by an examining licensed physician and surgeon shall be either reduced to writing or permanently preserved on recording discs or other similar recording media, shall include all positive and negative findings pertinent to establishing the cause of death in accordance with medicolegal practice and this, along with the written opinions and conclusions of the examining licensed physician and surgeon, shall be included in the coroner's record of the death. The coroner shall have the right to retain only those tissues of the body removed at the time of the autopsy as may, in his or her opinion, be necessary or advisable to the inquiry into the case, or for the verification of his or her findings. ~~No person~~ *Only individuals who are directly involved in the investigation of the death of the decedent* may be present during the performance of ~~an autopsy without the express consent of the licensed physician and surgeon who is conducting~~ the autopsy.

(b) In any case in which the coroner knows, or has reason to believe, that the deceased has made valid provision for the disposition of his or her body or a part or parts thereof for medical or scientific purposes in accordance with Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code, the coroner shall neither perform nor authorize any other person to perform an autopsy on the body unless the coroner has contacted or attempted to contact the physician last in attendance to the deceased. If the physician cannot be contacted, the coroner shall then notify or attempt to notify one of the following of the need for an autopsy to determine the cause of death: (1) the surviving spouse; (2) a surviving child or parent; (3) a surviving brother or sister; (4) any other kin or person who has acquired the right to control the disposition of the remains. Following a period of 24 hours after attempting to contact the physician last in attendance and notifying or attempting to notify one of the responsible parties listed above, the coroner may authorize the performance of an autopsy, as otherwise authorized or required by law.

(c) Nothing in this section shall be deemed to prohibit the discretion of the coroner to cause to be conducted an autopsy upon any victim of sudden, unexpected, or unexplained death or any death known or suspected of resulting from an accident, suicide, or apparent criminal means, or other death, as described in Section 27491.

SEC. 2. Section 27491.41 of the Government Code is amended to read:

27491.41. (a) For purposes of this section, "sudden infant death syndrome" means the sudden death of any infant that is unexpected by the history of the infant and where a thorough postmortem examination fails to demonstrate an adequate cause of death.

(b) The Legislature finds and declares that sudden infant death syndrome (SIDS) is the leading cause of death for children under age one, striking one out of every 500 children. The Legislature finds and declares that sudden infant death syndrome is a serious problem within the State of California, and that public interest is served by research and study of sudden infant death syndrome, and its potential causes and indications.

(c) (1) To facilitate these purposes, the coroner shall, within 24 hours, or as soon thereafter as feasible, cause an autopsy to be performed in any case where an infant has died suddenly and unexpectedly.

(2) However, if the attending licensed physician and surgeon desires to certify that the cause of death is sudden infant death syndrome, an autopsy may be performed at the discretion of the coroner. If the coroner causes an autopsy to be performed pursuant to this section, he or she shall also certify the cause of death.

(d) The autopsy shall be conducted pursuant to a standardized protocol developed by the State Department of Health *Care* Services. The protocol is exempt from the procedural requirements pertaining to the adoption of administrative rules and regulations pursuant to Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code. The protocol shall be developed and approved by July 1, 1990.

(e) The protocol shall be followed by all ~~licensed physicians and surgeons~~ *coroners* throughout the state when conducting the autopsies required by this section. The coroner shall state on the certificate of death that sudden infant death syndrome was the cause of death when the ~~licensed physician and surgeon's~~ *coroner's* findings are consistent with the definition of sudden infant death syndrome specified in the standardized autopsy protocol. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, and criteria for any specific tissue sampling, and any other requirements. The protocol may also require that specific tissue samples must be provided to a central tissue repository designated by the State Department of Health *Care* Services.

(f) The State Department of Health *Care* Services shall establish procedures and protocols for access by researchers to any tissues, or other materials or data authorized by this section. Research may be conducted by any individual with a valid scientific interest and prior approval from the State Committee for the Protection of Human Subjects. The tissue samples, the materials, and all data shall be subject to the confidentiality requirements of Section 103850 of the Health and Safety Code.

(g) The coroner may take tissue samples for research purposes from infants who have died suddenly and unexpectedly without

consent of the responsible adult if the tissue removal is not likely to result in any visible disfigurement.

(h) A coroner or licensed physician and surgeon shall not be liable for damages in a civil action for any act or omission done in compliance with this section.

(i) No consent of any person is required prior to undertaking the autopsy required by this section.

SEC. 3. Section 27491.43 of the Government Code is amended to read:

27491.43. (a) (1) Notwithstanding any other law, except as otherwise provided in this ~~section~~ *section*, in any case in which the ~~licensed physician and surgeon,~~ *coroner,* before *the* beginning *of* an autopsy, dissection, or removal of corneal tissue, pituitary glands, or any other organ, tissue, or fluid, has received a certificate of religious belief, executed by the decedent as provided in subdivision (b), that the procedure would be contrary to his or her religious belief, the coroner shall ~~not perform~~ *neither perform, nor order the performance of,* that procedure on the body of the decedent.

(2) If, before beginning the procedure, the coroner ~~or licensed physician and surgeon~~ is informed by a relative or a friend of the decedent that the decedent had executed a certificate of religious belief, the ~~licensed physician and surgeon~~ *coroner* shall not ~~perform the procedure,~~ *order an autopsy to be performed,* except as otherwise provided in this section, for 48 hours. If the certificate is produced within 48 hours, the case shall be governed by this section. If the certificate is not produced within that time, the case shall be governed by the other provisions of this article.

(b) Any person, 18 years of age or older, may execute a certificate of religious belief which shall state in clear and unambiguous language that any postmortem anatomical dissection or that specified procedures would violate the religious convictions of the person. The certificate shall be signed and dated by the person in the presence of at least two witnesses. Each witness shall also sign the certificate and shall print on the certificate his or her name and residence address.

(c) Notwithstanding the existence of a certificate, the coroner may at any time cause an autopsy to be performed or any other procedure if he or she has a reasonable suspicion that the death

was caused by the criminal act of another or by a contagious disease constituting a public health hazard.

(d) (1) If a certificate is produced, and if subdivision (c) does not apply, the coroner may petition the superior court, without fee, for an order authorizing an autopsy or other procedure or for an order setting aside the certificate as invalid. Notice of the proceeding shall be given to the person who produced the certificate. The proceeding shall have preference over all other cases.

(2) The court shall set aside the certificate if it finds that the certificate was not properly executed or that it does not clearly state the decedent's religious objection to the proposed procedure.

(3) The court may order an autopsy or other procedure despite a valid certificate if it finds that the cause of death is not evident, and that the interest of the public in determining the cause of death outweighs its interest in permitting the decedent and like persons fully to exercise their religious convictions.

(4) Any procedure performed pursuant to paragraph (3) shall be the least intrusive procedure consistent with the order of the court.

(5) If the petition is denied, and no stay is granted, the body of the deceased shall immediately be released to the person authorized to control its disposition.

(e) In any case in which the circumstances, manner, or cause of death is not determined because of the provisions of this section, the coroner may state on the certificate of death that an autopsy was not conducted because of the provisions of this section.

(f) A coroner shall not be liable for damages in a civil action for any act or omission taken in compliance with the provisions of this section.

SEC. 4. Section 27491.46 of the Government Code is amended to read:

27491.46. (a) The coroner shall have the right to retain pituitary glands solely for transmission to a university, for use in research or the advancement of medical science, in those cases in which the coroner has required an autopsy to be performed pursuant to this chapter, and during a 48-hour period following such autopsy the body has not been claimed and the coroner has not been informed of any relatives of the decedent.

(b) In the course of any autopsy, the coroner may cause to be removed the pituitary gland from the body for transmittal to any public agency for use in manufacturing a hormone necessary for the physical growth of persons who are, or may become, hypopituitary dwarfs, if the coroner has no knowledge of objection to the removal and release of the pituitary gland having been made by the decedent or any other person specified in Section 7151.5 of the Health and Safety Code. Neither the coroner nor the medical examiner authorizing the removal of the pituitary gland, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of the pituitary gland pursuant to this section, shall incur civil liability for the removal of the pituitary gland in an action brought by any person who did not object prior to the removal of the pituitary gland, nor be subject to criminal prosecution for removal of the pituitary gland pursuant to the authority of this section.

Nothing in this subdivision shall supersede the terms of any gift made pursuant to Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code.

SEC. 5. Section 27491.47 of the Government Code is amended to read:

27491.47. (a) Notwithstanding any other law, the coroner may, in the course of an autopsy, authorize the removal and release of corneal eye tissue from a body within the coroner's custody, if all of the following conditions are met:

(1) The autopsy has otherwise been authorized.

(2) The coroner has no knowledge of objection to the removal and release of corneal tissue having been made by the decedent or any other person specified in Section 7151 of the Health and Safety Code and has obtained any one of the following:

(A) A dated and signed written consent by the donor or any other person specified in Section 7151 of the Health and Safety Code on a form that clearly indicates the general intended use of the tissue and contains the signature of at least one witness.

(B) Proof of the existence of a recorded telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code in the form of an audio recording of the conversation or a transcript of the recorded conversation, which indicates the general intended use of the tissue.

(C) A document recording a verbal telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code, witnessed and signed by no fewer than two members of the requesting entity, hospital, eye bank, or procurement organization, memorializing the consenting person's knowledge of and consent to the general intended use of the gift.

The form of consent obtained under subparagraph (A), (B), or (C) shall be kept on file by the requesting entity and the official agency for a minimum of three years.

(3) The removal of the tissue will not unnecessarily mutilate the body, be accomplished by enucleation, nor interfere with the autopsy.

(4) The tissue will be removed by a licensed physician and surgeon or a trained transplant technician.

(5) The tissue will be released to a public or nonprofit facility for transplant, therapeutic, or scientific purposes.

(b) Neither the coroner nor medical examiner authorizing the removal of the corneal tissue, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of corneal tissue pursuant to this section, shall incur civil liability for the removal in an action brought by any person who did not object prior to the removal of the corneal tissue, nor be subject to criminal prosecution for the removal of the corneal tissue pursuant to this section.

(c) This section shall not be construed to interfere with the ability of a person to make an anatomical gift pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

SEC. 6. Section 27520 of the Government Code is amended to read:

27520. (a) The coroner shall cause to be performed an autopsy on a decedent, for which an autopsy has not already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner shall cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(b) The coroner may cause to be performed an autopsy on a decedent, for which an autopsy has already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner may cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(c) The cost of an autopsy requested pursuant to either subdivision (a) or (b) shall be borne by the person requesting that it be performed.

SEC. 7. Section 27522 is added to the Government Code, to read:

27522. (a) A forensic autopsy shall only be conducted by a licensed physician and surgeon. The results of a forensic autopsy shall only be determined by a licensed physician and surgeon.

(b) A forensic autopsy shall be defined as an examination of a body of a decedent to generate medical evidence for which the cause ~~and manner~~ of death is determined.

(c) For purposes of this section, a postmortem examination shall be defined as the external examination of the body where no manner or cause of death is determined.

(d) For purposes of this section, the manner of death shall be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the licensed physician and surgeon in the determination of the manner of death.

~~(d)~~

(e) For health and safety purposes, all persons in the autopsy suite shall ~~have current bloodborne pathogen training~~ *be informed of the risks presented by bloodborne pathogens* and *that they should wear* personal protective equipment in accordance with the requirements described in Section 5193 of Title 8 of the California Code of Regulations or its successor.

~~(e)~~

(f) (1) ~~Police and other law enforcement personnel who have completed training as described in subdivision (d) may~~ *Only individuals who are directly involved in the investigation of the death of the decedent shall* be allowed into the autopsy ~~suite at the discretion of the forensic pathologist.~~ *suite.*

(2) ~~Notwithstanding paragraph (1), if~~ *If* an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved ~~with the care and custody~~ *in the death* of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of the autopsy.

(3) Notwithstanding paragraph (1), individuals may be permitted in the autopsy suite for educational and research purposes at the discretion of the coroner and in consultation with any licensed physician and surgeon conducting an autopsy.

~~(f)~~

(g) Any police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity shall be made available to the forensic pathologist prior to the completion of the investigation of the death.

~~(g)~~

(h) This section shall not be construed to limit the practice of an autopsy for educational or research purposes.

SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1261
Author: Stone
Bill Date: May 3, 2016, Amended
Subject: Physicians and Surgeons: Fee Exemption: Residency
Sponsor: California Primary Care Association (CPCA)
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill was substantially amended and now would only delete the requirement in existing law that a physician and surgeon must reside in California in order to get the license and renewal fees waived for providing volunteer services.

ANALYSIS

Currently, the initial or renewal license fee is waived for a physician and surgeon who resides in California, has a California address of record, and certifies to the Medical Board of California that the initial or renewal license is for the sole purpose of providing voluntary, unpaid service. A voluntary service physician licensee whose initial and/or renewal license fee has been waived pursuant to Business and Professions Code sections 2083 and 2442 must comply with the continuing medical education requirements.

ANALYSIS

This bill would change existing law to allow out-of-state physicians who are licensed in California to have license and renewal fees waived if they certify to the board that the sole purpose of their license is to provide voluntary, unpaid service. This bill may encourage more licensed physicians to provide volunteer services in California. The Board has taken a neutral position on this bill.

FISCAL: Minor and absorbable

SUPPORT: None on file

OPPOSITION: None on file

AMENDED IN SENATE MAY 3, 2016

SENATE BILL No. 1261

Introduced by Senator Stone

February 18, 2016

An act to ~~add Section 902 to~~ *amend Sections 2083 and 2442 of* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1261, as amended, Stone. Physicians and surgeons: ~~licensure exemption.~~ *fee exemption: residency.*

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and establishes specific requirements for licensure and renewal. That act generally requires that an application for a certificate be accompanied by the fee required by the act, but requires the waiver of the fee for a physician and surgeon residing in California who certifies to the board that the license is for the sole purpose of providing voluntary, unpaid service. The act establishes a parallel fee waiver requirement for the renewal of a physician and surgeon's certificate.

This bill would remove from those application and renewal fee waiver provisions the requirement that a physician and surgeon reside in California.

~~Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.~~

~~Existing law provides, until January 1, 2018, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.~~

~~This bill would provide an exemption similar to that sponsored event exemption to be administered by the Medical Board of California, applicable only to a physician, defined as a person licensed or certified in good standing in another jurisdiction of the United States, who offers or provides health care services for which he or she is licensed or certified, and who engages in acts that are subject to licensure or regulation under the Medical Practice Act. That exemption would be for health care services that are provided through free clinics, as defined, rather than through sponsored events. Such a physician would be authorized to volunteer for up to 60 days in a calendar year, which need not be consecutive.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2083 of the Business and Professions Code is amended to read:

2083. (a) Except as provided in subdivision (b), each application for a certificate shall be accompanied by the fee required by this chapter and shall be filed with the Division of Licensing.

(b) The license fee shall be waived for a physician and surgeon ~~residing in California~~ who certifies to the Medical Board of California that the issuance of the license ~~or the renewal of the~~

~~license~~ is for the sole purpose of providing voluntary, unpaid service.

SEC. 2. Section 2442 of the Business and Professions Code is amended to read:

2442. The renewal fee shall be waived for a physician and surgeon ~~residing in California~~ who certifies to the Medical Board of California that license renewal is for the sole purpose of providing voluntary, unpaid service.

~~SECTION 1. Section 902 is added to the Business and Professions Code, to read:~~

~~902. (a) For purposes of this section, the following definitions apply:~~

~~(1) "Board" means the Medical Board of California.~~

~~(2) "Free clinic" has the same meaning as defined in Section 1204 of the Health and Safety Code.~~

~~(3) "Physician" means any person, licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified and who engages in acts that are subject to licensure or regulation under Chapter 5 (commencing with Section 2000).~~

~~(4) "Uninsured or underinsured person" means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the physician under this section.~~

~~(b) A physician who offers or provides health care services at a free clinic is exempt from the requirement for licensure under Chapter 5 (commencing with Section 2000) if all of the following requirements are met:~~

~~(1) Prior to providing those services, he or she does all of the following:~~

~~(A) Obtains authorization from the board to participate in a free clinic after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the free clinic, within 20 calendar days of receiving a~~

~~request for authorization, whether that request is approved or denied.~~

~~(B) Satisfies the following requirements:~~

~~(i) The physician has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.~~

~~(ii) The physician has the appropriate education and experience to participate in a free clinic, as determined by the board.~~

~~(iii) The physician shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.~~

~~(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.~~

~~(2) The services are provided under all of the following circumstances:~~

~~(A) To uninsured or underinsured persons.~~

~~(B) On voluntary basis, for a total of days not to exceed 60 days in a calendar year. The 60 days need not be consecutive.~~

~~(C) In association with a free clinic enrolled in the Medi–Cal program that complies with subdivision (d).~~

~~(D) Without charge to the recipient or to a third party on behalf of the recipient.~~

~~(c) The board may deny a physician authorization to practice without a license if the physician fails to comply with this section or for any act that would be grounds for denial of an application for licensure.~~

~~(d) A free clinic enrolled in the Medi–Cal program seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:~~

~~(1) Register with the board by completing a registration form that shall include all of the following:~~

~~(A) The name of the free clinic.~~

~~(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the free clinic.~~

~~(C) The address, including street, city, ZIP Code, and county, of the free clinic's principal office and each individual listed pursuant to subparagraph (B).~~

~~(D) The telephone number for the principal office of the free clinic and each individual listed pursuant to subparagraph (B).~~

~~(E) Any additional information required by the board.~~

~~(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.~~

~~(e) The free clinic shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.~~

~~(f) Within 15 calendar days of the provision of health care services pursuant to this section, the free clinic shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the physicians who participated in providing that care.~~

~~(g) The free clinic shall maintain a list of physicians associated with the provision of health care services under this section. The free clinic shall maintain a copy of each physician's current license or certification and shall require each physician to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The free clinic shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.~~

~~(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2017, shall not exclude coverage of a physician or a free clinic that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or free clinic complies with this section.~~

~~(i) Subdivision (b) shall not be construed to authorize a physician to render care outside the scope of practice authorized by his or her license or certificate or this division.~~

~~(j) (1) The board may terminate authorization for a physician to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of the board.~~

~~(2) The board shall provide both the free clinic and the physician with a written notice of termination including the basis for that termination. The physician may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the physician wishes to present to the board.~~

~~(3) A physician whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A physician who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of Chapter 5 (commencing with Section 2000), and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.~~

~~(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1471
Author: Hernandez
Bill Date: April 21, 2016, Amended
Subject: Health Professions Development: Loan Repayment
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would transfer specified moneys from the Managed Care Administrative Fines and Penalties Fund (MCAFPF) to the Medically Underserved Account for Physicians (MUAP) in the Health Professions Education Fund (HPEF) for use by the Steven M. Thompson Loan Repayment Program (STLRP).

BACKGROUND

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to the Health Professions Education Foundation (HPEF). Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates, these programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

ANALYSIS

Under current law, revenue from fines and penalties levied on health plans is deposited in the MCAFPF. Existing law requires fines and penalties collected up to $1 million to be deposited in to the MUAP in the HPEF for purposes of the STLRP. Existing law requires any amount over the first $1 million to be transferred to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature by the Major Risk Medical Insurance Program (MRMIP).

This bill would require, beginning January 1, 2017 and annually thereafter, any amount over the first $2 million, including accrued interest, to be transferred to the HPEF for the STLRP program. This bill would allow one-half of these moneys to be prioritized to fund repayment of loans for those physicians who are trained in, and practice, psychiatry, as

specified. This bill would also make other conforming changes and delete references to inoperative programs.

According to the author, the STLRP was created in response to the physician shortage problem in underserved areas, but funding for this program has been unpredictable and insufficient, with demand exceeding available funding every year. Currently up to 20% of the available funding for the STLRP may be awarded to program applicants from specialties outside of the primary care specialties, including psychiatry, but is annually disbursed among other specialties. This bill would provide much needed funding for the STLRP to assist with loan repayment for physicians who agree to practice in medically underserved areas of the state, as well as prioritize new funds for those who are trained in, and practice, psychiatry. This bill would promote the Board's mission of access to care and the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Marriage and Family Therapists
California Psychiatric Association
County Behavioral Health Directors Association
Medical Board of California

OPPOSITION: None on file

AMENDED IN SENATE APRIL 21, 2016

AMENDED IN SENATE APRIL 14, 2016

SENATE BILL No. 1471

Introduced by Senator Hernandez

February 19, 2016

An act to amend Sections 1341.45, 128551, and 128552 ~~of, and to add Section 128555.5 to,~~ *of* the Health and Safety Code, relating to health professions development.

LEGISLATIVE COUNSEL'S DIGEST

SB 1471, as amended, Hernandez. Health professions development: loan repayment.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, including repayment of educational loans, to a physician and surgeon who practices in a medically underserved area, as ~~defined.~~ *defined, and who is trained in, and practices, in certain practice settings or primary specialities, as defined. Existing law authorizes the selection committee to fill up to 20% of the available positions with program applicants from specialities outside of the primary specialties, including psychiatry.* Existing law establishes the Medically Underserved Account for Physicians, a continuously appropriated account, within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development, to primarily provide funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes various fines and administrative penalties on health care service plans for certain violations of the act, which are deposited into the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians and to be used, upon appropriation by the Legislature, for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund and to be used, upon appropriation by the Legislature, for purposes of the Major Risk Medical Insurance Program.

~~This bill would expand the eligibility for loan repayment funds under the Steven M. Thompson Physician Corps Loan Repayment Program to include those physicians providing psychiatric services. The bill would provide that continuously appropriated funds deposited into the Medically Underserved Account for Physicians shall not be made available under the Steven M. Thompson Physician Corps Loan Repayment Program to fund the repayment of loans for those physicians providing psychiatric services or those physicians whose primary specialty is psychiatry, as specified.~~

The bill would instead require, after the first $1,000,000 is transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians, $1,000,000 to be transferred each year to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for the Major Risk Medical Insurance Program. The bill would require any amount remaining over the amounts transferred to the Medically Underserved Account for Physicians and the Major Risk Medical Insurance Fund to be transferred each year to the Medically Underserved Account for Physicians to be used, upon appropriation by the Legislature, for the Steven M. Thompson Physician Corps Loan Repayment Program, and provide that one-half of these moneys ~~are to be used~~ *may be prioritized* to fund the repayment of loans for those ~~physicians providing psychiatric services or those physicians whose primary specialty is psychiatry~~ *program applicants who are trained in, and practice, psychiatry,* under the Steven M. Thompson Physician Corps Loan Repayment Program.

The bill would also delete a reference to an obsolete program and make other technical, nonsubstantive changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, annually, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Until January 1, 2017, any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund continued pursuant to Section 15893 of the Welfare and Institutions Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(3) On and after January 1, 2017, and annually thereafter, the second one million dollars ($1,000,000) shall be transferred to the Major Risk Medical Insurance Fund continued pursuant to Section 15893 of the Welfare and Institutions Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(4) (A) On and after January 1, 2017 any amount over the first two million dollars ($2,000,000), including accrued interest, in the fund shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, and subject to subparagraph (B), be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(B) ~~One-half~~ *Up to one-half* of the moneys deposited into the Medically Underserved Account for Physicians within the Health Professions Education Fund under this paragraph ~~shall, upon appropriation by the Legislature, be used~~ *may be prioritized* to fund the repayment of ~~loans~~ *loans pursuant to paragraph (2) of subdivision (d) of Section 128553* for those ~~physicians providing psychiatric services or those physicians whose primary specialty is psychiatry~~ *program applicants who are trained in, and practice, psychiatry,* under the Steven M. Thompson Physician Corps Loan Repayment ~~Program, as specified in Article~~ *Program (Article* 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division ~~107.~~ *107).*

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

SEC. 2. Section 128551 of the Health and Safety Code is amended to read:

128551. (a) It is the intent of this article that the Health Professions Education Foundation and the office provide the ongoing program management of the two programs identified in subdivision (b) of Section 128550 as a part of the California Physician Corps Program.

(b) For purposes of subdivision (a), the foundation shall consult with the Medical Board of California, Office of Statewide Health Planning and Development, and shall establish and consult with an advisory committee of not more than seven members, that shall include two members recommended by the California Medical Association and may include other members of the medical

community, including ethnic representatives, medical schools, health advocates representing ethnic communities, primary care clinics, public hospitals, and health systems, statewide agencies administering state and federally funded programs targeting underserved communities, and members of the public with expertise in health care issues.

SEC. 3. Section 128552 of the Health and Safety Code is amended to read:

128552. For purposes of this article, the following definitions shall apply:

(a) "Account" means the Medically Underserved Account for Physicians established within the Health Professions Education Fund pursuant to this article.

(b) "Foundation" means the Health Professions Education Foundation.

(c) "Fund" means the Health Professions Education Fund.

(d) "Medi-Cal threshold languages" means primary languages spoken by limited-English-proficient (LEP) population groups meeting a numeric threshold of 3,000, eligible LEP Medi-Cal beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal beneficiaries residing in two contiguous ZIP Codes.

(e) "Medically underserved area" means an area defined as a health professional shortage area in Part 5 (commencing with Section 5.1) of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

(f) "Medically underserved population" means the Medi-Cal program and uninsured populations.

(g) "Office" means the Office of Statewide Health Planning and Development (OSHPD).

(h) "Physician Volunteer Program" means the Physician Volunteer Registry Program established by the Medical Board of California.

(i) "Practice setting," for the purposes of this article only, means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or

operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(2) A physician owned and operated medical practice setting that provides primary care ~~or psychiatric services~~ located in a medically underserved area and has a minimum of 50 percent of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

(j) "Primary specialty" means family practice, internal medicine, pediatrics, ~~psychiatry,~~ or obstetrics/gynecology.

(k) "Program" means the Steven M. Thompson Physician Corps Loan Repayment Program.

(*l*) "Selection committee" means a minimum three-member committee of the board, that includes a member that was appointed by the Medical Board of California.

~~SEC. 4. Section 128555.5 is added to the Health and Safety Code, to read:~~

~~128555.5. Notwithstanding subdivision (e) of Section 128555, funds deposited into the Medically Underserved Account for Physicians shall not be made available to fund the repayment of loans under the Steven M. Thompson Physician Corps Loan Repayment Program for those physicians providing psychiatric services or those physicians whose primary specialty is psychiatry, except as provided in subparagraph (B) of paragraph (4) of subdivision (c) of Section 1341.45.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1478
Author: Senate Business, Professions and Economic Development Committee
Bill Date: March 10, 2016, Introduced
Subject: Healing Arts
Sponsor: Author and affected healing arts boards
Position: Support provisions related to the Medical Board of California

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis only includes the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). This bill would delete outdated sections of the BPC that are related to the Board.

ANALYSIS

- This bill would delete BPC Section 2029 that requires the Board to keep copies of complaints for 10 years. The Board already has its own record retention schedule and BPC Section 2227.5 only requires the Board to keep complaints for seven years or until the statute of limitations has expired, whichever is shorter. BPC Section 2230.5 sets forth the statute of limitations for filing an accusation, which is three years form the date the Board finds out about the event or seven years from the date of the event, whichever occurs first. Both of these section of law make BPC 2029 inapplicable.

- This bill would delete the Task Force created in BPC Section 852, as it no longer exists.

- This bill would also delete Sections 2380-2392 of the BPC, which create the Bureau of Medical Statistics in the Board. The Bureau of Medical Statistics does not exist, so this change is code clean up only.

These changes will remove outdated and inapplicable sections from the BPC and the Board is pleased to sponsor/support these provisions in SB 1478.

FISCAL: None

SUPPORT: Medical Board of California

OPPOSITION: None on File

SENATE BILL No. 1478

Introduced by Committee on Business, Professions and Economic Development (Senators Hill (Chair), Bates, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza, and Wieckowski)

March 10, 2016

An act to amend Sections 1632, 1634.1, 2467, 4980.36, 4980.37, 4980.43, 4980.78, 4980.79, 4992.05, 4996.18, 4996.23, 4999.12, 4999.40, 4999.47, 4999.52, 4999.60, 4999.61, and 4999.120 of, to add Sections 4980.09 and 4999.12.5 to, to repeal Sections 852, 2029, 4980.40.5, and 4999.54 of, and to repeal Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, as introduced, Committee on Business, Professions and Economic Development. Healing arts.

Existing law provides for the licensure and regulation of healing arts professions and vocations by boards within the Department of Consumer Affairs.

(1) Existing law establishes the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the task force to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency, identify the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices and assess the need for voluntary certification standards and examinations for cultural and linguistic competency.

This bill would delete those provisions.

(2) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. Existing law requires

each applicant to, among other things, successfully complete the Part I and Part II written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

This bill would instead require the applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(3) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.

Existing law requires the board to keep a copy of a complaint it receives regarding the poor quality of care rendered by a licensee for 10 years from the date the board receives the complaint, as provided.

This bill would delete that requirement.

Existing law creates the Bureau of Medical Statistics within the board. Under existing law, the purpose of the bureau is to provide the board with statistical information necessary to carry out their functions of licensing, medical education, medical quality, and enforcement.

This bill would abolish that bureau.

(4) Under existing law, the California Board of Podiatric Medicine is responsible for the certification and regulation of the practice of podiatric medicine. Existing law requires the board to annually elect one of its members to act as president and vice president.

This bill would instead require the board to elect from its members a president, a vice president, and a secretary.

(5) The Board of Behavioral Sciences is responsible for administering, among others, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

(A) Existing law, the Licensed Marriage and Family Therapist Act, provides for the regulation of the practice of marriage and family therapy by the Board of Behavioral Sciences. A violation of the act is a crime. Existing law requires the licensure of marriage and family therapists and the registration of marriage and family therapist interns. Under existing law, an “intern” is defined as an unlicensed person who has earned his or her master’s or doctoral degree qualifying him or her for licensure and is registered with the board. Existing law prohibits the abbreviation “MFTI” from being used in an advertisement unless the title “marriage and family therapist registered intern” appears in the advertisement.

Existing law, the Licensed Professional Clinical Counselor Act, provides for the regulation of the practice of professional clinical

counseling by the Board of Behavioral Sciences. Existing law requires the licensure of professional clinical counselors and the registration of professional clinical counselor interns. Under existing law, an "intern" is defined as an unlicensed person who meets specified requirements for registration and is registered with the board.

This bill, commencing January 1, 2018, would provide that certain specified titles using the term "intern" or any reference to the term "intern" in those acts shall be deemed to be a reference to an "associate," as specified. Because this bill would change the definition of a crime, it would impose a state-mandated local program.

(B) The Licensed Marriage and Family Therapist Act generally requires specified applicants for licensure and registration to meet certain educational degree requirements, including having obtained that degree from a school, college, or university that, among other things, is accredited by a regional accrediting agency recognized by the United States Department of Education.

This bill would authorize that accreditation to be by a regional or national institutional accrediting agency recognized by the United States Department of Education.

Under the Licensed Marriage and Family Therapist Act, a specified doctoral or master's degree approved by the Bureau for Private Postsecondary and Vocational Education as of June 30, 2007, is considered by the Board of Behavioral Sciences to meet the specified licensure and registration requirements if the degree is conferred on or before July 1, 2010. As an alternative, existing law requires the Board of Behavioral Sciences to accept those doctoral or master's degrees as equivalent degrees if those degrees are conferred by educational institutions accredited by specified associations.

This bill would delete those provisions.

(C) Under the Licensed Marriage and Family Therapist Act, an applicant for licensure is required to complete experience related to the practice of marriage and family therapy under the supervision of a supervisor. Existing law requires applicants, trainees who are unlicensed persons enrolled in an educational program to qualify for licensure, and interns who are unlicensed persons who have completed an educational program and is registered with the board to be at all times under the supervision of a supervisor. Existing law requires interns and trainees to only gain supervised experience as an employee or volunteer and prohibits experience from being gained as an independent contractor. Similarly, the Licensed Professional Clinical Counselor Act requires

clinical counselor trainees, interns, and applicants to perform services only as an employee or as a volunteer. The Licensed Professional Clinical Counselor Act prohibits gaining mental health experience by interns or trainees as an independent contractor.

The Clinical Social Worker Practice Act requires applicants to complete supervised experience related to the practice of clinical social work.

This bill would prohibit these persons from being employed as independent contractors and from gaining experience for work performed as an independent contractor reported on a specified tax form.

(D) The Licensed Professional Clinical Counselor Act defines the term "accredited" for the purposes of the act to mean a school, college, or university accredited by the Western Association of Schools and Colleges, or its equivalent regional accrediting association. The act requires each educational institution preparing applicants to qualify for licensure to notify each of its students in writing that its degree program is designed to meet specified examination eligibility or registration requirements and to certify to the Board of Behavioral Sciences that it has provided that notice.

This bill would re-define "accredited" to mean a school, college, or university accredited by a regional or national institutional accrediting agency that is recognized by the United States Department of Education. The bill would additionally require an applicant for registration or licensure to submit to the Board of Behavioral Sciences a certification from the applicant's educational institution specifying that the curriculum and coursework complies with those examination eligibility or registration requirements.

(6) This bill would additionally delete various obsolete provisions, make conforming changes, and make other nonsubstantive changes.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 852 of the Business and Professions Code is repealed.

~~852. (a) The Task Force on Culturally and Linguistically Competent Physicians and Dentists is hereby created and shall consist of the following members:~~

~~(1) The State Director of Health Services and the Director of Consumer Affairs, who shall serve as cochairs of the task force.~~

~~(2) The Executive Director of the Medical Board of California.~~

~~(3) The Executive Director of the Dental Board of California.~~

~~(4) One member appointed by the Senate Committee on Rules.~~

~~(5) One member appointed by the Speaker of the Assembly.~~

~~(b) Additional task force members shall be appointed by the Director of Consumer Affairs, in consultation with the State Director of Health Services, as follows:~~

~~(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.~~

~~(2) California licensed physicians and dentists that provide health services to members of language and ethnic minority groups.~~

~~(3) Representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups.~~

~~(4) Representatives of entities that offer continuing education for physicians and dentists.~~

~~(5) Representatives of California's medical and dental schools.~~

~~(6) Individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.~~

~~(c) The duties of the task force shall include the following:~~

~~(1) Developing recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency.~~

~~(2) Identifying the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices.~~

~~(3) Assessing the need for voluntary certification standards and examinations for cultural and linguistic competency.~~

~~(d) The task force shall hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups to determine their needs and preferences for having culturally competent medical providers. These hearings and~~

~~meetings shall be convened in communities that have large populations of language and ethnic minority groups.~~

~~(e) The task force shall report its findings to the Legislature and appropriate licensing boards within two years after creation of the task force.~~

~~(f) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.~~

~~(g) Nothing in this section shall be construed to require mandatory continuing education of physicians and dentists.~~

SEC. 2. Section 1632 of the Business and Professions Code is amended to read:

1632. (a) The board shall require each applicant to successfully complete the ~~Part I and Part II written examinations~~ *written examination* of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(b) The board shall require each applicant to successfully complete an examination in California law and ethics developed and administered by the board. The board shall provide a separate application for this examination. The board shall ensure that the law and ethics examination reflects current law and regulations, and ensure that the examinations are randomized. Applicants shall submit this application and required fee to the board in order to take this examination. In addition to the aforementioned application, the only other requirement for taking this examination shall be certification from the dean of the qualifying dental school attended by the applicant that the applicant has graduated, or will graduate, or is expected to graduate. Applicants who submit completed applications and certification from the dean at least 15 days prior to a scheduled examination shall be scheduled to take the examination. Successful results of the examination shall, as established by board regulation, remain valid for two years from the date that the applicant is notified of having passed the examination.

(c) Except as otherwise provided in Section 1632.5, the board shall require each applicant to have taken and received a passing score on one of the following:

(1) A portfolio examination of the applicant's competence to enter the practice of dentistry. This examination shall be conducted while the applicant is enrolled in a dental school program at a

board-approved school located in California. This examination shall utilize uniform standards of clinical experiences and competencies, as approved by the board pursuant to Section 1632.1. The applicant shall pass a final assessment of the submitted portfolio at the end of his or her dental school program. Before any portfolio assessment may be submitted to the board, the applicant shall remit the required fee to the board to be deposited into the State Dentistry Fund, and a letter of good standing signed by the dean of his or her dental school or his or her delegate stating that the applicant has graduated or will graduate with no pending ethical issues.

(A) The portfolio examination shall not be conducted until the board adopts regulations to carry out this paragraph. The board shall post notice on its Internet Web site when these regulations have been adopted.

(B) The board shall also provide written notice to the Legislature and the Legislative Counsel when these regulations have been adopted.

(2) A clinical and written examination administered by the Western Regional Examining Board, which board shall determine the passing score for that examination.

(d) Notwithstanding subdivision (b) of Section 1628, the board is authorized to do either of the following:

(1) Approve an application for examination from, and to examine an applicant who is enrolled in, but has not yet graduated from, a reputable dental school approved by the board.

(2) Accept the results of an examination described in paragraph (2) of subdivision (c) submitted by an applicant who was enrolled in, but had not graduated from, a reputable dental school approved by the board at the time the examination was administered.

In either case, the board shall require the dean of that school or his or her delegate to furnish satisfactory proof that the applicant will graduate within one year of the date the examination was administered or as provided in paragraph (1) of subdivision (c).

SEC. 3. Section 1634.1 of the Business and Professions Code is amended to read:

1634.1. Notwithstanding Section 1634, the board may grant a license to practice dentistry to an applicant who submits all of the following to the board:

(a) A completed application form and all fees required by the board.

(b) Satisfactory evidence of having graduated from a dental school approved by the board or by the Commission on Dental Accreditation of the American Dental Association.

(c) Satisfactory evidence of having completed a clinically based advanced education program in general dentistry or an advanced education program in general practice residency that is, at minimum, one year in duration and is accredited by either the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the board. The advanced education program shall include a certification of clinical residency program completion approved by the board, to be completed upon the resident's successful completion of the program in order to evaluate his or her competence to practice dentistry in the state.

(d) Satisfactory evidence of having successfully completed the written ~~examinations~~ *examination* of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(e) Satisfactory evidence of having successfully completed an examination in California law and ethics.

(f) Proof that the applicant has not failed the examination for licensure to practice dentistry under this chapter within five years prior to the date of his or her application for a license under this chapter.

SEC. 4. Section 2029 of the Business and Professions Code is repealed.

~~2029. The board shall keep a copy of a complaint it receives regarding the poor quality of care rendered by a licensee for 10 years from the date the board receives the complaint. For retrieval purposes, these complaints shall be filed by the licensee's name and license number.~~

SEC. 5. Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of the Business and Professions Code is repealed.

SEC. 6. Section 2467 of the Business and Professions Code is amended to read:

2467. (a) The board may convene from time to time as it deems necessary.

(b) Four members of the board constitute a quorum for the transaction of business at any meeting.

(c) It shall require the affirmative vote of a majority of those members present at a meeting, those members constituting at least a quorum, to pass any motion, resolution, or measure.

(d) The board shall ~~annually~~ elect ~~one of~~ *from* its members ~~to act as president and a member to act as~~ *a president, a* vice ~~president~~ *president, and a secretary* who shall hold their respective positions at the pleasure of the board. The president may call meetings of the board and any duly appointed committee at a specified time and place.

SEC. 7. Section 4980.09 is added to the Business and Professions Code, to read:

4980.09. (a) The title "marriage and family therapist intern" or "marriage and family therapist registered intern" is hereby renamed "associate marriage and family therapist" or "registered associate marriage and family therapist," respectively. Any reference in statute or regulation to a "marriage and family therapist intern" or "marriage and family therapist registered intern" shall be deemed a reference to an "associate marriage and family therapist" or "registered associate marriage and family therapist."

(b) Nothing in this section shall be construed to expand or constrict the scope of practice of a person licensed or registered pursuant to this chapter.

(c) This section shall become operative January 1, 2018.

SEC. 8. Section 4980.36 of the Business and Professions Code is amended to read:

4980.36. (a) This section shall apply to the following:

(1) Applicants for licensure or registration who begin graduate study before August 1, 2012, and do not complete that study on or before December 31, 2018.

(2) Applicants for licensure or registration who begin graduate study before August 1, 2012, and who graduate from a degree program that meets the requirements of this section.

(3) Applicants for licensure or registration who begin graduate study on or after August 1, 2012.

(b) To qualify for a license or registration, applicants shall possess a doctoral or master's degree meeting the requirements of this section in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical

psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education, or accredited by either the Commission on Accreditation for Marriage and Family Therapy Education, or a regional *or national institutional* accrediting agency that is recognized by the United States Department of Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.

(c) A doctoral or master's degree program that qualifies for licensure or registration shall do the following:

(1) Integrate all of the following throughout its curriculum:

(A) Marriage and family therapy principles.

(B) The principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, among others.

(C) An understanding of various cultures and the social and psychological implications of socioeconomic position, and an understanding of how poverty and social stress impact an individual's mental health and recovery.

(2) Allow for innovation and individuality in the education of marriage and family therapists.

(3) Encourage students to develop the personal qualities that are intimately related to effective practice, including, but not limited to, integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(4) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(5) Provide students with the opportunity to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(d) The degree described in subdivision (b) shall contain no less than 60 semester or 90 quarter units of instruction that includes, but is not limited to, the following requirements:

(1) Both of the following:

(A) No less than 12 semester or 18 quarter units of coursework in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, including elder adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.

(B) Practicum that involves direct client contact, as follows:

(i) A minimum of six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience.

(ii) A minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(iii) A student must be enrolled in a practicum course while counseling clients, except as specified in subdivision (c) of Section 4980.42.

(iv) The practicum shall provide training in all of the following areas:

(I) Applied use of theory and psychotherapeutic techniques.

(II) Assessment, diagnosis, and prognosis.

(III) Treatment of individuals and premarital, couple, family, and child relationships, including trauma and abuse, dysfunctions, healthy functioning, health promotion, illness prevention, and working with families.

(IV) Professional writing, including documentation of services, treatment plans, and progress notes.

(V) How to connect people with resources that deliver the quality of services and support needed in the community.

(v) Educational institutions are encouraged to design the practicum required by this subparagraph to include marriage and family therapy experience in low income and multicultural mental health settings.

(vi) In addition to the 150 hours required in clause (ii), 75 hours of either of the following, or a combination thereof:

(I) Client centered advocacy, as defined in Section 4980.03.

(II) Face-to-face experience counseling individuals, couples, families, or groups.

(2) Instruction in all of the following:

(A) Diagnosis, assessment, prognosis, and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer reviewed literature.

(B) Developmental issues from infancy to old age, including instruction in all of the following areas:

(i) The effects of developmental issues on individuals, couples, and family relationships.

(ii) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.

(iii) Aging and its biological, social, cognitive, and psychological aspects. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(iv) A variety of cultural understandings of human development.

(v) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.

(vi) The understanding of human behavior within the social context of a representative variety of the cultures found within California.

(vii) The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.

(C) The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following:

(i) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(ii) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

(iii) Cultural factors relevant to abuse of partners and family members.

(iv) Childbirth, child rearing, parenting, and stepparenting.

(v) Marriage, divorce, and blended families.

(vi) Long-term care.

(vii) End of life and grief.

(viii) Poverty and deprivation.

(ix) Financial and social stress.

(x) Effects of trauma.

(xi) The psychological, psychotherapeutic, community, and health implications of the matters and life events described in clauses (i) to (x), inclusive.

(D) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.

(E) Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability, and their incorporation into the psychotherapeutic process.

(F) The effects of socioeconomic status on treatment and available resources.

(G) Resilience, including the personal and community qualities that enable persons to cope with adversity, trauma, tragedy, threats, or other stresses.

(H) Human sexuality, including the study of physiological, psychological, and social cultural variables associated with sexual behavior and gender identity, and the assessment and treatment of psychosexual dysfunction.

(I) Substance use disorders, co-occurring disorders, and addiction, including, but not limited to, instruction in all of the following:

(i) The definition of substance use disorders, co-occurring disorders, and addiction. For purposes of this subparagraph, "co-occurring disorders" means a mental illness and substance abuse diagnosis occurring simultaneously in an individual.

(ii) Medical aspects of substance use disorders and co-occurring disorders.

(iii) The effects of psychoactive drug use.

(iv) Current theories of the etiology of substance abuse and addiction.

(v) The role of persons and systems that support or compound substance abuse and addiction.

(vi) Major approaches to identification, evaluation, and treatment of substance use disorders, co-occurring disorders, and addiction, including, but not limited to, best practices.

(vii) Legal aspects of substance abuse.

(viii) Populations at risk with regard to substance use disorders and co-occurring disorders.

(ix) Community resources offering screening, assessment, treatment, and followup for the affected person and family.

(x) Recognition of substance use disorders, co-occurring disorders, and addiction, and appropriate referral.

(xi) The prevention of substance use disorders and addiction.

(J) California law and professional ethics for marriage and family therapists, including instruction in all of the following areas of study:

(i) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the scope of practice of marriage and family therapy.

(ii) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including, but not limited to, family law.

(iii) The current legal patterns and trends in the mental health professions.

(iv) The psychotherapist-patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(v) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

(vi) Differences in legal and ethical standards for different types of work settings.

(vii) Licensing law and licensing process.

(e) The degree described in subdivision (b) shall, in addition to meeting the requirements of subdivision (d), include instruction in case management, systems of care for the severely mentally ill, public and private services and supports available for the severely mentally ill, community resources for persons with mental illness and for victims of abuse, disaster and trauma response, advocacy for the severely mentally ill, and collaborative treatment. This instruction may be provided either in credit level coursework or through extension programs offered by the degree-granting institution.

(f) The changes made to law by this section are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and are not intended

to expand or restrict the scope of practice for marriage and family therapists.

SEC. 9. Section 4980.37 of the Business and Professions Code is amended to read:

4980.37. (a) This section shall apply to applicants for licensure or registration who begin graduate study before August 1, 2012, and complete that study on or before December 31, 2018. Those applicants may alternatively qualify under paragraph (2) of subdivision (a) of Section 4980.36.

(b) To qualify for a license or registration, applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by a regional *or national institutional* accrediting agency that is recognized by the United States Department of Education or approved by the Bureau for Private Postsecondary Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this section, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. This instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment. The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment.

(2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.

(3) Developmental issues and life events from infancy to old age and their effect on individuals, couples, and family relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and

health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, abuse and neglect of older and dependent adults, and geropsychology.

(4) A variety of approaches to the treatment of children.

The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(c) (1) In addition to the 12 semester or 18 quarter units of coursework specified in subdivision (b), the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic technique, assessments, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(d) As an alternative to meeting the qualifications specified in subdivision (b), the board shall accept as equivalent degrees those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(e) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program that meets the educational qualifications for licensure or registration under this section shall do all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(f) Educational institutions are encouraged to design the practicum required by this section to include marriage and family therapy experience in low income and multicultural mental health settings.

(g) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 10. Section 4980.40.5 of the Business and Professions Code is repealed.

~~4980.40.5. (a) A doctoral or master's degree in marriage, family, and child counseling, marital and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling, or marriage and family therapy, obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education as of June 30, 2007, shall be considered by the board to meet the requirements necessary for licensure as a marriage and family therapist and for registration as a marriage and family therapist intern provided that the degree is conferred on or before July 1, 2010.~~

~~(b) As an alternative to meeting the qualifications specified in subdivision (a) of Section 4980.40, the board shall accept as equivalent degrees those doctoral or master's degrees that otherwise~~

~~meet the requirements of this chapter and are conferred by educational institutions accredited by any of the following associations:~~

~~(1) Northwest Commission on Colleges and Universities.~~

~~(2) Middle States Association of Colleges and Secondary Schools.~~

~~(3) New England Association of Schools and Colleges.~~

~~(4) North Central Association of Colleges and Secondary Schools.~~

~~(5) Southern Association of Colleges and Schools.~~

SEC. 11. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) To qualify for licensure as specified in Section 4980.40, each applicant shall complete experience related to the practice of marriage and family therapy under a supervisor who meets the qualifications set forth in Section 4980.03. The experience shall comply with the following:

(1) A minimum of 3,000 hours of supervised experience completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.

(10) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. ~~Experience shall not be gained by an intern or trainee as an independent contractor.~~ *Associates and trainees shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.*

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(d) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in

paragraph (9) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.

(e) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth

in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(f) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (e), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(g) Except as provided in subdivision (h), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.

(h) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral

degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(i) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(j) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with subdivision (c), may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(k) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(*l*) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are

encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 12. Section 4980.78 of the Business and Professions Code is amended to read:

4980.78. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016, and who do not hold a license as described in Section 4980.72.

(b) For purposes of Section 4980.74, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from a school, college, or university accredited by ~~an~~ *a regional or national institutional* accrediting agency that is recognized by the United States Department of Education and consists of, at a minimum, the following:

(A) (i) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.36, the degree shall contain no less than 60 semester or 90 quarter units of instruction.

(ii) Up to 12 semester or 18 quarter units of instruction may be remediated, if missing from the degree. The remediation may occur while the applicant is registered as an intern.

(B) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.37, the degree shall contain no less than 48 semester units or 72 quarter units of instruction.

(C) Six semester or nine quarter units of practicum, including, but not limited to, a minimum of 150 hours of face-to-face counseling, and an additional 75 hours of either face-to-face counseling or client-centered advocacy, or a combination of face-to-face counseling and client-centered advocacy.

(D) Twelve semester or 18 quarter units in the areas of marriage, family, and child counseling and marital and family systems approaches to treatment, as specified in subparagraph (A) of paragraph (1) of subdivision (d) of Section 4980.36.

(2) The applicant shall complete coursework in California law and ethics as follows:

(A) An applicant who completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81, that did not contain instruction in California law and ethics, shall complete an 18-hour course in California law and professional ethics. The

content of the course shall include, but not be limited to, advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and licensing process. This coursework shall be completed prior to registration as an intern.

(B) An applicant who has not completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81 shall complete this required coursework. The coursework shall contain content specific to California law and ethics. This coursework shall be completed prior to registration as an intern.

(3) The applicant completes the educational requirements specified in Section 4980.81 not already completed in his or her education. The coursework may be from an accredited school, college, or university as specified in paragraph (1), from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate courses shall not satisfy this requirement.

(4) The applicant completes the following coursework not already completed in his or her education from an accredited school, college, or university as specified in paragraph (1) from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate courses shall not satisfy this requirement.

(A) At least three semester units, or 45 hours, of instruction regarding the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, including structured meetings with various consumers and family members of consumers of mental health

services to enhance understanding of their experience of mental illness, treatment, and recovery.

(B) At least one semester unit, or 15 hours, of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.

(5) An applicant may complete any units and course content requirements required under paragraphs (3) and (4) not already completed in his or her education while registered as an intern, unless otherwise specified.

(6) The applicant's degree title need not be identical to that required by subdivision (b) of Section 4980.36.

SEC. 13. Section 4980.79 of the Business and Professions Code is amended to read:

4980.79. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016, and who hold a license as described in Section 4980.72.

(b) For purposes of Section 4980.72, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from a school, college, or university accredited by ~~an~~ *a regional or national institutional* accrediting agency recognized by the United States Department of Education and consists of, at a minimum, the following:

(A) (i) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.36, the degree shall contain no less than 60 semester or 90 quarter units of instruction.

(ii) Up to 12 semester or 18 quarter units of instruction may be remediated, if missing from the degree. The remediation may occur while the applicant is registered as an intern.

(B) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.37, the degree shall contain no less than 48 semester or 72 quarter units of instruction.

(C) Six semester or nine quarter units of practicum, including, but not limited to, a minimum of 150 hours of face-to-face counseling, and an additional 75 hours of either face-to-face counseling or client-centered advocacy, or a combination of face-to-face counseling and client-centered advocacy.

(i) An out-of-state applicant who has been licensed for at least two years in clinical practice, as verified by the board, is exempt from this requirement.

(ii) An out-of-state applicant who has been licensed for less than two years in clinical practice, as verified by the board, who does not meet the practicum requirement, shall remediate it by obtaining 150 hours of face-to-face counseling, and an additional 75 hours of either face-to-face counseling or client-centered advocacy, or a combination of face-to-face counseling and client-centered advocacy. These hours are in addition to the 3,000 hours of experience required by this chapter, and shall be gained while registered as an intern.

(D) Twelve semester or 18 quarter units in the areas of marriage, family, and child counseling and marital and family systems approaches to treatment, as specified in subparagraph (A) of paragraph (1) of subdivision (d) of Section 4980.36.

(2) An applicant shall complete coursework in California law and ethics as follows:

(A) An applicant who completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81 that did not include instruction in California law and ethics, shall complete an 18-hour course in California law and professional ethics. The content of the course shall include, but not be limited to, advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and licensing process. This coursework shall be completed prior to registration as an intern.

(B) An applicant who has not completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81 shall complete this required coursework. The coursework shall include

content specific to California law and ethics. An applicant shall complete this coursework prior to registration as an intern.

(3) The applicant completes the educational requirements specified in Section 4980.81 not already completed in his or her education. The coursework may be from an accredited school, college, or university as specified in paragraph (1), from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate coursework shall not satisfy this requirement.

(4) The applicant completes the following coursework not already completed in his or her education from an accredited school, college, or university as specified in paragraph (1) above, from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate coursework shall not satisfy this requirement.

(A) At least three semester units, or 45 hours, of instruction pertaining to the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, including structured meetings with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(B) At least one semester unit, or 15 hours, of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.

(5) An applicant's degree title need not be identical to that required by subdivision (b) of Section 4980.36.

(6) An applicant may complete any units and course content requirements required under paragraphs (3) and (4) not already completed in his or her education while registered as an intern, unless otherwise specified.

SEC. 14. Section 4992.05 of the Business and Professions Code is amended to read:

4992.05. (a) Effective January 1, 2016, an applicant for licensure as a clinical social worker shall pass the following two examinations as prescribed by the board:

(1) A California law and ethics examination.

(2) A clinical examination.

(b) Upon registration with the board, an associate *clinical* social worker registrant shall, within the first year of registration, take an examination on California law and ethics.

(c) A registrant may take the clinical examination only upon meeting all of the following requirements:

(1) Completion of all education requirements.

(2) Passage of the California law and ethics examination.

(3) Completion of all required supervised work experience.

(d) This section shall become operative on January 1, 2016.

SEC. 15. Section 4996.18 of the Business and Professions Code is amended to read:

4996.18. (a) A person who wishes to be credited with experience toward licensure requirements shall register with the board as an associate clinical social worker prior to obtaining that experience. The application shall be made on a form prescribed by the board.

(b) An applicant for registration shall satisfy the following requirements:

(1) Possess a master's degree from an accredited school or department of social work.

(2) Have committed no crimes or acts constituting grounds for denial of licensure under Section 480.

(3) Commencing January 1, 2014, have completed training or coursework, which may be embedded within more than one course, in California law and professional ethics for clinical social workers, including instruction in all of the following areas of study:

(A) Contemporary professional ethics and statutes, regulations, and court decisions that delineate the scope of practice of clinical social work.

(B) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of clinical social work, including, but not limited to, family law.

(C) The current legal patterns and trends in the mental health professions.

(D) The psychotherapist-patient privilege, confidentiality, dangerous patients, and the treatment of minors with and without parental consent.

(E) A recognition and exploration of the relationship between a practitioner's sense of self and human values, and his or her professional behavior and ethics.

(F) Differences in legal and ethical standards for different types of work settings.

(G) Licensing law and process.

(c) An applicant who possesses a master's degree from a school or department of social work that is a candidate for accreditation by the Commission on Accreditation of the Council on Social Work Education shall be eligible, and shall be required, to register as an associate clinical social worker in order to gain experience toward licensure if the applicant has not committed any crimes or acts that constitute grounds for denial of licensure under Section 480. That applicant shall not, however, be eligible ~~for~~ *to take the clinical* examination until the school or department of social work has received accreditation by the Commission on Accreditation of the Council on Social Work Education.

(d) All applicants and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of clinical social work.

(e) Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has a personal relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

(f) An applicant who possesses a master's degree from an accredited school or department of social work shall be able to apply experience the applicant obtained during the time the accredited school or department was in candidacy status by the Commission on Accreditation of the Council on Social Work Education toward the licensure requirements, if the experience meets the requirements of Section 4996.23. This subdivision shall apply retroactively to persons who possess a master's degree from an accredited school or department of social work and who obtained experience during the time the accredited school or department was in candidacy status by the Commission on Accreditation of the Council on Social Work Education.

(g) An applicant for registration or licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a master's of social work degree that is equivalent to a master's degree issued from a school or department of social work that is accredited by the Commission on Accreditation of the Council on Social Work Education. These applicants shall provide the board with a comprehensive evaluation of the degree and shall provide any other documentation the board deems necessary. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements regardless of evaluation or accreditation.

(h) A registrant shall not provide clinical social work services to the public for a fee, monetary or otherwise, except as an employee.

(i) A registrant shall inform each client or patient prior to performing any professional services that he or she is unlicensed and is under the supervision of a licensed professional.

SEC. 16. Section 4996.23 of the Business and Professions Code is amended to read:

4996.23. (a) To qualify for licensure as specified in Section 4996.2, each applicant shall complete 3,200 hours of post-master's degree supervised experience related to the practice of clinical social work. The experience shall comply with the following:

(1) At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a licensed mental health professional acceptable to the board as defined by a regulation adopted by the board.

(2) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling.

(3) A maximum of 1,200 hours in client centered advocacy, consultation, evaluation, research, direct supervisor contact, and workshops, seminars, training sessions, or conferences directly related to clinical social work that have been approved by the applicant's supervisor.

(4) Of the 2,000 clinical hours required in paragraph (2), no less than 750 hours shall be face-to-face individual or group

psychotherapy provided to clients in the context of clinical social work services.

(5) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was filed.

(6) Experience shall not be credited for more than 40 hours in any week.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) "Supervision" means responsibility for, and control of, the quality of clinical social work services being provided. Consultation or peer discussion shall not be considered to be supervision.

(d) (1) Prior to the commencement of supervision, a supervisor shall comply with all requirements enumerated in Section 1870 of Title 16 of the California Code of Regulations and shall sign under penalty of perjury the "Responsibility Statement for Supervisors of an Associate Clinical Social Worker" form.

(2) Supervised experience shall include at least one hour of direct supervisor contact for a minimum of 104 weeks. For purposes of this subdivision, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours of face-to-face contact in a group conducted within the same week as the hours claimed.

(3) An associate shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(4) Supervision shall include at least one hour of direct supervisor contact during each week for which experience is gained in each work setting. Supervision is not required for experience gained attending workshops, seminars, training sessions, or conferences as described in paragraph (3) of subdivision (a).

(5) The six hours of supervision that may be credited during any single week pursuant to paragraph (3) shall apply only to supervision hours gained on or after January 1, 2010.

(6) Group supervision shall be provided in a group of not more than eight supervisees and shall be provided in segments lasting no less than one continuous hour.

(7) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, and of the 52 weeks of required individual supervision, not less than 13 weeks shall be supervised by a licensed clinical social worker.

(8) Notwithstanding paragraph (2), an associate clinical social worker working for a governmental entity, school, college, or university, or an institution that is both a nonprofit and charitable institution, may obtain the required weekly direct supervisor contact via live two-way videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is preserved.

(e) The supervisor and the associate shall develop a supervisory plan that describes the goals and objectives of supervision. These goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

(f) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

(g) Experience shall not be gained until the applicant has been registered as an associate clinical social worker.

(h) Employment in a private practice as defined in subdivision (i) shall not commence until the applicant has been registered as an associate clinical social worker.

(i) A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed professional clinical counselor, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(j) Associates shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.

~~(j)~~

(k) If volunteering, the associate shall provide the board with a letter from his or her employer verifying his or her voluntary status upon application for licensure.

~~(k)~~

(l) If employed, the associate shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

~~(l)~~

(m) While an associate may be either a paid employee or volunteer, employers are encouraged to provide fair remuneration to associates.

~~(m)~~

(n) An associate shall not do the following:

(1) Receive any remuneration from patients or clients and shall only be paid by his or her employer.

(2) Have any proprietary interest in the employer's business.

(3) Lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

~~(n)~~

(o) An associate, whether employed or volunteering, may obtain supervision from a person not employed by the associate's employer if that person has signed a written agreement with the employer to take supervisory responsibility for the associate's social work services.

~~(o)~~

(p) Notwithstanding any other provision of law, associates and applicants for examination shall receive a minimum of one hour of supervision per week for each setting in which he or she is working.

SEC. 17. Section 4999.12 of the Business and Professions Code is amended to read:

4999.12. For purposes of this chapter, the following terms have the following meanings:

(a) "Board" means the Board of Behavioral Sciences.

(b) "Accredited" means a school, college, or university accredited by ~~the Western Association of Schools and Colleges, or its equivalent regional accrediting association.~~ *a regional or national institutional accrediting agency that is recognized by the United States Department of Education.*

(c) "Approved" means a school, college, or university that possessed unconditional approval by the Bureau for Private Postsecondary Education at the time of the applicant's graduation from the school, college, or university.

(d) "Applicant" means an unlicensed person who has completed a master's or doctoral degree program, as specified in Section 4999.32 or 4999.33, as applicable, and whose application for registration as an intern is pending or who has applied for examination eligibility, or an unlicensed person who has completed the requirements for licensure specified in this chapter and is no longer registered with the board as an intern.

(e) "Licensed professional clinical counselor" or "LPCC" means a person licensed under this chapter to practice professional clinical counseling, as defined in Section 4999.20.

(f) "Intern" means an unlicensed person who meets the requirements of Section 4999.42 and is registered with the board.

(g) "Clinical counselor trainee" means an unlicensed person who is currently enrolled in a master's or doctoral degree program, as specified in Section 4999.32 or 4999.33, as applicable, that is designed to qualify him or her for licensure under this chapter, and who has completed no less than 12 semester units or 18 quarter units of coursework in any qualifying degree program.

(h) "Approved supervisor" means an individual who meets the following requirements:

(1) Has documented two years of clinical experience as a licensed professional clinical counselor, licensed marriage and family therapist, licensed clinical psychologist, licensed clinical social worker, or licensed physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology.

(2) Has received professional training in supervision.

(3) Has not provided therapeutic services to the clinical counselor trainee or intern.

(4) Has a current and valid license that is not under suspension or probation.

(i) "Client centered advocacy" includes, but is not limited to, researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services.

(j) "Advertising" or "advertise" includes, but is not limited to, the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper or magazine or in any directory, or any printed matter whatsoever, with or without any limiting qualification. It also includes business solicitations communicated by radio or television broadcasting. Signs within church buildings or notices in church bulletins mailed to a congregation shall not be construed as advertising within the meaning of this chapter.

(k) "Referral" means evaluating and identifying the needs of a client to determine whether it is advisable to refer the client to other specialists, informing the client of that judgment, and communicating that determination as requested or deemed appropriate to referral sources.

(*l*) "Research" means a systematic effort to collect, analyze, and interpret quantitative and qualitative data that describes how social characteristics, behavior, emotion, cognitions, disabilities, mental disorders, and interpersonal transactions among individuals and organizations interact.

(m) "Supervision" includes the following:

(1) Ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised.

(2) Reviewing client or patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the clinical counselor trainee.

(3) Monitoring and evaluating the ability of the intern or clinical counselor trainee to provide services to the particular clientele at the site or sites where he or she will be practicing.

(4) Ensuring compliance with laws and regulations governing the practice of licensed professional clinical counseling.

(5) That amount of direct observation, or review of audio or videotapes of counseling or therapy, as deemed appropriate by the supervisor.

SEC. 18. Section 4999.12.5 is added to the Business and Professions Code, to read:

4999.12.5. (a) The title "professional clinical counselor intern" or "professional clinical counselor registered intern" is hereby renamed "associate professional clinical counselor" or "registered associate professional clinical counselor," respectively. Any reference in any statute or regulation to a "professional clinical counselor intern" or "professional clinical counselor registered intern" shall be deemed a reference to an "associate professional clinical counselor" or "registered associate professional clinical counselor."

(b) Nothing in this section shall be construed to expand or constrict the scope of practice of a person licensed or registered pursuant to this chapter.

(c) This section shall become operative January 1, 2018.

SEC. 19. Section 4999.40 of the Business and Professions Code is amended to read:

4999.40. (a) Each educational institution preparing applicants to qualify for licensure shall notify each of its students by means of its public documents or otherwise in writing that its degree program is designed to meet the requirements of Section 4999.32 or 4999.33 and shall certify to the board that it has so notified its students.

(b) An applicant for registration or licensure shall submit to the board a certification by the applicant's educational institution that the institution's required curriculum for graduation and any associated coursework completed by the applicant does one of the following:

(1) Meets all of the requirements set forth in Section 4999.32.

(2) Meets all of the requirements set forth in Section 4999.33.

~~(b)~~

(c) An applicant trained at an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a qualifying degree that is equivalent to a degree earned from an institution of higher education that is accredited or approved. These applicants shall provide the board with a comprehensive evaluation of the degree performed by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services and shall provide any other documentation the board deems necessary.

SEC. 20. Section 4999.47 of the Business and Professions Code is amended to read:

4999.47. (a) Clinical counselor trainees, interns, and applicants shall perform services only as an employee or as a volunteer.

The requirements of this chapter regarding gaining hours of clinical mental health experience and supervision are applicable equally to employees and volunteers. ~~Experience shall not be gained by interns or trainees as an independent contractor.~~ *Associates and trainees shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.*

(1) If employed, a clinical counselor intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure as a professional clinical counselor.

(2) If volunteering, a clinical counselor intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure as a professional clinical counselor.

(b) Clinical counselor trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(c) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration.

(d) Clinical counselor trainees, interns, and applicants who provide voluntary services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those clinical counselor trainees, interns, and applicants for services rendered in any lawful work setting other than a private practice shall be considered an employee and not an independent contractor.

(e) The board may audit an intern or applicant who receives reimbursement for expenses and the intern or applicant shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(f) Clinical counselor trainees, interns, and applicants shall only perform services at the place where their employer regularly conducts business and services, which may include other locations,

as long as the services are performed under the direction and control of the employer and supervisor in compliance with the laws and regulations pertaining to supervision. Clinical counselor trainees, interns, and applicants shall have no proprietary interest in the employer's business.

(g) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and clinical counselor trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 21. Section 4999.52 of the Business and Professions Code is amended to read:

4999.52. (a) ~~Except as provided in Section 4999.54, every~~ *Every* applicant for a license as a professional clinical counselor shall be examined by the board. The board shall examine the candidate with regard to his or her knowledge and professional skills and his or her judgment in the utilization of appropriate techniques and methods.

(b) The examinations shall be given at least twice a year at a time and place and under supervision as the board may determine.

(c) The board shall not deny any applicant who has submitted a complete application for examination admission to the licensure examinations required by this section if the applicant meets the educational and experience requirements of this chapter, and has not committed any acts or engaged in any conduct that would constitute grounds to deny licensure.

(d) The board shall not deny any applicant whose application for licensure is complete admission to the examinations specified by paragraph (2) of subdivision (a) of Section 4999.53, nor shall the board postpone or delay this examination for any applicant or delay informing the candidate of the results of this examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

(e) If an applicant for the examination specified by paragraph (2) of subdivision (a) of Section 4999.53, who has passed the California law and ethics examination, is the subject of a complaint or is under board investigation for acts or conduct that, if proven to be true, would constitute grounds for the board to deny licensure, the board shall permit the applicant to take this examination, but may notify the applicant that licensure will not be granted pending completion of the investigation.

(f) Notwithstanding Section 135, the board may deny any applicant who has previously failed either the California law and ethics examination, or the examination specified by paragraph (2) of subdivision (a) of Section 4999.53, permission to retake either examination pending completion of the investigation of any complaints against the applicant.

(g) Nothing in this section shall prohibit the board from denying an applicant admission to any examination, withholding the results, or refusing to issue a license to any applicant when an accusation or statement of issues has been filed against the applicant pursuant to Section 11503 or 11504 of the Government Code, respectively, or the application has been denied in accordance with subdivision (b) of Section 485.

(h) Notwithstanding any other provision of law, the board may destroy all examination materials two years following the date of an examination.

(i) On and after January 1, 2016, the examination specified by paragraph (2) of subdivision (a) of Section 4999.53 shall be passed within seven years of an applicant's initial attempt.

(j) A passing score on the clinical examination shall be accepted by the board for a period of seven years from the date the examination was taken.

(k) No applicant shall be eligible to participate in the examination specified by paragraph (2) of subdivision (a) of Section 4999.53, if he or she fails to obtain a passing score on this examination within seven years from his or her initial attempt. If the applicant fails to obtain a passing score within seven years of initial attempt, he or she shall obtain a passing score on the current version of the California law and ethics examination in order to be eligible to retake this examination.

(*l*) This section shall become operative on January 1, 2016.

SEC. 22. Section 4999.54 of the Business and Professions Code is repealed.

~~4999.54. (a) Notwithstanding Section 4999.50, the board may issue a license to any person who submits an application for a license between January 1, 2011, and December 31, 2011, provided that all documentation is submitted within 12 months of the board's evaluation of the application, and provided he or she meets one of the following sets of criteria:~~

~~(1) He or she meets all of the following requirements:~~

~~(A) Has a master's or doctoral degree from a school, college, or university as specified in Section 4999.32, that is counseling or psychotherapy in content. If the person's degree does not include all the graduate coursework in all nine core content areas as required by paragraph (1) of subdivision (c) of Section 4999.32, a person shall provide documentation that he or she has completed the required coursework prior to licensure pursuant to this chapter. Except as specified in clause (ii), a qualifying degree must include the supervised practicum or field study experience as required in paragraph (3) of subdivision (c) of Section 4999.32.~~

~~(i) A counselor educator whose degree contains at least seven of the nine required core content areas shall be given credit for coursework not contained in the degree if the counselor educator provides documentation that he or she has taught the equivalent of the required core content areas in a graduate program in counseling or a related area.~~

~~(ii) Degrees issued prior to 1996 shall include a minimum of 30 semester units or 45 quarter units and at least six of the nine required core content areas specified in paragraph (1) of subdivision (c) of Section 4999.32 and three semester units or four and one-half quarter units of supervised practicum or field study experience. The total number of units shall be no less than 48 semester units or 72 quarter units.~~

~~(iii) Degrees issued in 1996 and after shall include a minimum of 48 semester units or 72 quarter units and at least seven of the nine core content areas specified in paragraph (1) of subdivision (c) of Section 4999.32.~~

~~(B) Has completed all of the coursework or training specified in subdivision (e) of Section 4999.32.~~

~~(C) Has at least two years, full-time or the equivalent, of postdegree counseling experience, that includes at least 1,700 hours~~

~~of experience in a clinical setting supervised by a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, a licensed physician and surgeon specializing in psychiatry, a professional clinical counselor or a person who is licensed in another state to independently practice professional clinical counseling, as defined in Section 4999.20, or a master's level counselor or therapist who is certified by a national certifying or registering organization, including, but not limited to, the National Board for Certified Counselors or the Commission on Rehabilitation Counselor Certification.~~

~~(D) Has a passing score on the following examinations:~~

~~(i) The National Counselor Examination for Licensure and Certification or the Certified Rehabilitation Counselor Examination.~~

~~(ii) The National Clinical Mental Health Counselor Examination.~~

~~(iii) A California jurisprudence and ethics examination, when developed by the board.~~

~~(2) Is currently licensed as a marriage and family therapist in the State of California, meets the coursework requirements described in subparagraph (A) of paragraph (1), and passes the examination described in subdivision (b).~~

~~(3) Is currently licensed as a clinical social worker in the State of California, meets the coursework requirements described in subparagraph (A) of paragraph (1), and passes the examination described in subdivision (b).~~

~~(b) (1) The board and the Office of Professional Examination Services shall jointly develop an examination on the differences, if any differences exist, between the following:~~

~~(A) The practice of professional clinical counseling and the practice of marriage and family therapy.~~

~~(B) The practice of professional clinical counseling and the practice of clinical social work.~~

~~(2) If the board, in consultation with the Office of Professional Examination Services, determines that an examination is necessary pursuant to this subdivision, an applicant described in paragraphs (2) and (3) of subdivision (a) shall pass the examination as a condition of licensure.~~

~~(c) Nothing in this section shall be construed to expand or constrict the scope of practice of professional clinical counseling, as defined in Section 4999.20.~~

SEC. 23. Section 4999.60 of the Business and Professions Code is amended to read:

4999.60. (a) This section applies to persons who are licensed outside of California and apply for examination eligibility on or after January 1, 2016.

(b) The board may issue a license to a person who, at the time of submitting an application for a license pursuant to this chapter, holds a valid license as a professional clinical counselor, or other counseling license that allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States, if all of the following conditions are satisfied:

(1) The applicant's education is substantially equivalent, as defined in Section 4999.63.

(2) The applicant complies with subdivision ~~(b)~~ *(c)* of Section 4999.40, if applicable.

(3) The applicant's supervised experience is substantially equivalent to that required for a license under this chapter. The board shall consider hours of experience obtained outside of California during the six-year period immediately preceding the date the applicant initially obtained the license described above. If the applicant has less than 3,000 hours of qualifying supervised experience, time actively licensed as a professional clinical counselor shall be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours if the applicant's degree meets the practicum requirement described in subparagraph (C) of paragraph (1) of subdivision (b) of Section 4999.63 without exemptions or remediation.

(4) The applicant passes the examinations required to obtain a license under this chapter. An applicant who obtained his or her license or registration under another jurisdiction may apply for licensure with the board without taking the clinical examination if both of the following conditions are met:

(A) The applicant obtained a passing score on the licensing examination set forth in regulation as accepted by the board.

(B) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and is not revoked, suspended, surrendered, denied, or otherwise restricted or encumbered.

SEC. 24. Section 4999.61 of the Business and Professions Code is amended to read:

4999.61. (a) This section applies to persons who apply for examination eligibility or registration on or after January 1, 2016, and who do not hold a license as described in Section 4999.60.

(b) The board shall accept education gained while residing outside of California for purposes of satisfying licensure or registration requirements if the education is substantially equivalent, as defined in Section 4999.62, and the applicant complies with subdivision ~~(b)~~ *(c)* of Section 4999.40, if applicable.

(c) The board shall accept experience gained outside of California for purposes of satisfying licensure or registration requirements if the experience is substantially equivalent to that required by this chapter.

SEC. 25. Section 4999.120 of the Business and Professions Code is amended to read:

4999.120. The board shall assess fees for the application for and the issuance and renewal of licenses and for the registration of interns to cover administrative and operating expenses of the board related to this chapter. Fees assessed pursuant to this section shall not exceed the following:

(a) The fee for the application for examination eligibility shall be up to two hundred fifty dollars ($250).

(b) The fee for the application for intern registration shall be up to one hundred fifty dollars ($150).

(c) The fee for the application for licensure shall be up to one hundred eighty dollars ($180).

(d) The fee for the board-administered clinical examination, if the board chooses to adopt this examination in regulations, shall be up to two hundred fifty dollars ($250).

(e) The fee for the law and ethics examination shall be up to one hundred fifty dollars ($150).

~~(f) The fee for the examination described in subdivision (b) of Section 4999.54 shall be up to one hundred dollars ($100).~~

~~(g)~~

(f) The fee for the issuance of a license shall be up to two hundred fifty dollars ($250).

~~(h)~~

(g) The fee for annual renewal of an intern registration shall be up to one hundred fifty dollars ($150).

~~(i)~~

(h) The fee for two-year renewal of licenses shall be up to two hundred fifty dollars ($250).

~~(j)~~

(i) The fee for issuance of a retired license shall be forty dollars ($40).

~~(k)~~

(j) The fee for rescoring an examination shall be twenty dollars ($20).

~~(l)~~

(k) The fee for issuance of a replacement license or registration shall be twenty dollars ($20).

~~(m)~~

(l) The fee for issuance of a certificate or letter of good standing shall be twenty-five dollars ($25).

SEC. 26. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MBC TRACKER II BILLS
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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 12	Cooley	State Government: Administrative Regulations: Review	Sen. Approps	08/19/15
AB 26	Jones-Sawyer	Medical Cannabis	Sen. Approps	06/23/16
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Sen. 3rd Reading	03/28/16
AB 72	Bonta	Health Care Coverage: Out-of-Network Coverage	Sen. Approps	06/15/16
AB 83	Gatto	Personal Data	Sen. Inactive File	07/15/15
AB 174	Gray	UC: Medical Education	Sen. Approps	06/01/15
AB 259	Dababneh	Personal Information: Privacy	Sen. Approps	
AB 507	Olsen	DCA: BreEZe System: Annual Report	Sen. B&P	07/09/15
AB 533	Bonta	Health Care Coverage: Out-of-Network Coverage	Assembly	09/04/15
AB 572	Gaines	Diabetes Prevention: Treatment	Sen. Approps	07/02/15
AB 635	Atkins	Medical Interpretation Services	Sen. Inactive File	
AB 649	Patterson	Medical Waste: Law Enforcement Drug Take back Programs	Sen. Approps	06/24/15
AB 741	Williams	Mental Health: Community Care Facilities	Sen. Approps	06/16/16
AB 766	Ridley-Thomas	Public School Health Center Support Program	Sen. Approps	04/27/15
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	Sen. Approps	04/12/16
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	Senate	06/21/16
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	Sen. PE&R	
AB 923	Steinorth	Respiratory Care Practitioners	Sen. 3rd Reading	05/31/16
AB 1001	Maienschein	Child Abuse: Reporting	Sen. 3rd Reading	05/11/16
AB 1033	Garcia, E.	Economic Impact Analysis: Small Business Definition	Asm. Concurrence	05/02/16
AB 1067	Gipson	Foster Children: Rights	Sen. Approps	05/11/16
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	Sen. Approps	07/01/15
AB 1117	Garcia, C.	Medi-Cal: Vaccination Rates	Sen. Approps	06/01/15
AB 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	Sen. Approps	07/16/15
AB 1300	Ridley-Thomas	Mental Health: Involuntary Commitment	Senate	06/21/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	Sen. Approps	06/28/16
AB 1575	Bonta	Medical Cannabis	Sen. Approps	06/22/16
AB 1639	Maienschein	Pupil Health: Sudden Cardiac Arrest Prevention Act	Sen. Approps	06/14/16
AB 1644	Bonta	School-Based Early Mental Health Intervention and Prevention	Sen. Approps	05/27/16
AB 1668	Calderon	Investigational Drugs, Biological Products, and Devices	Sen. Approps	03/07/16
AB 1696	Holden	Medi-Cal: Tobacco Cessation Services	Sen. Approps	06/27/16
AB 1703	Santiago	Inmates: Medical Treatment	Enrollment	
AB 1748	Mayes	Pupils: Pupil Health: Opioid Antagonist	Sen. Approps	06/20/16
AB 1763	Gipson	Health Care Coverage: Colorectal Cancer: Screening and Testing	Sen. Approps	06/27/16
AB 1795	Atkins	Health Care Programs: Cancer	Sen. Approps	05/31/16
AB 1823	Bonilla	California Cancer Clinical Trials Program	Sen. Approps	06/23/16
AB 1827	Kim	Emergency Medical Services: Mobile Field Hospitals	Asm. Health	03/16/16
AB 1831	Low	Health Care Coverage: Prescription Drugs: Refills	Sen. Approps	06/09/16
AB 1836	Maienschein	Mental Health	Sen. Approps	06/15/16
AB 1864	Cooley	Inquests: Sudden Unexplained Death in Childhood	Sen. 3rd Reading	03/17/16
AB 1887	Low	State Government: Discrimination: Travel	Sen. Approps	06/20/16
AB 1954	Burke	Health Care Coverage: Reproductive Health Care Services	Sen. Approps	06/27/16
AB 2004	Bloom	Hearing Aids: Minors	Sen. Approps	05/31/16
AB 2048	Gray	National Health Service Corps State Loan Repayment Program	Sen. Approps	05/27/16
AB 2083	Chu	Interagency Child Death Review	Sen. Approps	06/14/16
AB 2086	Cooley	Workers' Compensation: Neuropsychologists	Sen. Approps	05/16/16
AB 2105	Rodriguez	Workforce Development: Allied Health Professionals	Sen. Approps	06/14/16
AB 2115	Wood	Health Care Coverage: Disclosures	Sen. Approps	05/11/16
AB 2119	Chu	Medical Information: Disclosure: Medical Examiners and Forensic Pathologists	Sen. Approps	06/01/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2179	Gipson	Hepatitis C Testing	Sen. Approps	06/22/16
AB 2193	Salas	California Board of Podiatric Medicine: Physician Assistant Board: Extension	Sen. Approps	04/05/16
AB 2235	Thurmond	Board of Dentistry: Pediatric Anesthesia: Committee	Sen. Approps	06/29/16
AB 2311	Brown	Emergency Services	Sen. Approps	05/27/16
AB 2317	Mullin	California State University: Doctor of Audiology Degrees	Sen. 3rd Reading	06/29/16
AB 2325	Bonilla	Ken Maddy California Cancer Registry	Sen. 3rd Reading	06/21/16
AB 2394	Garcia, E.	Medi-Cal: Non-Medical Transportation	Sen. Approps	06/14/16
AB 2404	Cooley	Public Employees' Retirement System: Optional Settlements	Sen. Approps	06/13/16
AB 2424	Gomez	Community-Based Health Improvement and Innovation Fund	Sen. Approps	06/20/16
AB 2503	Obernolte	Workers' Compensation: Utilization Review	Sen. 3rd Reading	04/19/16
AB 2531	Burke	Reproductive Health and Research	Sen. Approps	
AB 2640	Gipson	Public Health: HIV	Sen. Approps	04/21/16
AB 2688	Gordon	Privacy: Commercial Health Monitoring Programs	Sen. 3rd Reading	04/28/16
AB 2696	Gaines, B.	Diabetes Prevention and Management	Enrollment	04/18/16
AB 2737	Bonta	Nonprovider Health Care Districts	Sen. Approps	06/20/16
AB 2828	Chau	Personal Information: Privacy Breach	Sen. Approps	05/27/16
AB 2843	Chau	Public Records: Employee Contact Information	Sen. Approps	06/28/16
AB 2844	Bloom	Public Contracts: Discrimination	Sen. Approps	06/20/16
AB 2853	Gatto	Public Records	Sen. Approps	06/16/16
AB 2859	Low	Professions and Vocations: Retired Category: Licenses	Sen. Approps	06/15/16
Ab 2883	Ins. Comm.	Workers' Compensation: Utilization Review	Sen. Approps	06/28/16
ACA 3	Gallagher	Public Employees' Retirement	Asm. PER&SS	
ACR 131	Patterson	Professions and Vocations: Licensing Fees: Equity	Sen. Approps	06/23/16
SB 3	Leno	Minimum Wage: Adjustment	Chaptered, #4	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 10	Lara	Health Care Coverage: Immigration Status	Chaptered, #22	05/27/16
SB 24	Hill	California Public Employees' Pension Reform Act	Asm. Approps	01/05/16
SB 139	Galgiani	Controlled Substances	Asm. Approps	06/15/16
SB 253	Monning	Juveniles: Psychotropic Medication	Asm. Inactive File	08/31/15
SB 296	Cannella	Medi-Cal: Specialty Mental Health Services: Documentation	Sen. Inactive File	08/28/15
SB 315	Monning	Health Care Access Demonstration Project Grants	Asm. Inactive File	08/31/15
SB 441	Wolk	California Public Records Act: Exemptions	Asm. Approps	06/22/16
SB 447	Allen	Medi-Cal: Clinics: Enrollment Applications	Asm. Approps	08/24/15
SB 492	Liu	Coordinate Care Initiative: Consumer Ed. & Info. Guide	Senate	06/25/15
SB 547	Liu	Aging and Long-Term Care Services, Supports and Program. Coord.	Asm. Approps	01/26/16
SB 573	Pan	Statewide Open Data Portal	Asm. Approps	07/09/15
SB 614	Leno	Medi-Cal: Mental Health Services	Asm. Inactive File	08/31/15
SB 780	Mendoza	Psychiatric Technicians and Assistants	Asm. Approps	
SB 914	Mendoza	Workers' Compensation: Medical Provider Networks	Enrollment	01/26/16
SB 923	Hernandez	Health Care Coverage: Cost Sharing Changes	Asm. 3rd Reading	05/31/16
SB 938	Jackson	Conservatorships: Psychotropic Drugs	Asm. Approps	06/29/16
SB 950	Nielsen	Excluded Employees: Arbitration	Asm. Approps	06/29/16
SB 999	Pavley	Health Insurance: Contraceptives: Annual Supply	Asm. Approps	06/20/16
SB 1010	Hernandez	Health Care: Prescription Drug Costs	Asm. Approps	05/31/16
SB 1034	Mitchell	Health Care Coverage: Autism	Asm. Approps	06/30/16
SB 1090	Mitchell	Sexually Transmitted Diseases: Outreach and Screening Services	Asm. Approps	06/01/16
SB 1095	Pan	Newborn Screening Program	Asm. Approps	05/31/16
SB 1135	Monning	Health Care Coverage: Notice of Timely Access to Care	Asm. Approps	06/30/16
SB 1139	Lara	Health Professionals: Medical Residency Programs: Undocumented Immigrants	Asm. Approps	06/21/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1155	Morrell	Professions and Vocations: Licenses: Military Service	Asm. Approps	06/23/16
SB 1159	Hernandez	California Health Care Cost and Quality Database	Asm. Approps	06/30/16
SB 1160	Mendoza	Workers' Compensation: Utilization Review	Asm. Approps	06/20/16
SB 1193	Hill	Healing Arts	Asm. Approps	06/21/16
SB 1220	McGuire	Child Welfare Services: Case Plans: Behavioral Health Services	Asm. Approps	04/06/16
SB 1229	Jackson	Home-Generated Pharmaceutical Waste: Secure Drug Take-Back Bins	Asm. 3rd Reading	06/27/16
SB 1348	Cannella	Licensure Applications: Military Experience	Assembly	05/31/16
SB 1466	Mitchell	Early and Periodic Screening, Diagnosis, and Treatment Program	Asm. Approps	05/31/16
SCR 117	Pan	Palliative Care	Assembly	
SR 17	Jackson	Relative to California Health Care Decisions Day	Sen. Adopted	03/16/15
SR 55	Bates	Relative to Drug Facts Week	Sen. Adopted	
SR 71	Berryhill	Relative to Organ Donation	Sen. Adopted	