California Board of PSYCHOLOGY

1625 North Market Blvd., Suite N-215, Sacramento, CA 95834
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www.psychology.ca.gov

NOTICE OF LEGISLATIVE AND REGULATORY AFFAIRS COMMITTEE MEETING

Friday, June 14, 2024
10:00 a.m. – 2:00 p.m. or until completion of business

https://dca-meetings.webex.com/dca-meetings/j.php?MTID=m57dd9252a9a725e6f2f8c2c62d43575a

If joining using the link above
Webinar number: 2484 526 4023
Webinar password: BOP614

If joining by phone
+1-415-655-0001 US Toll
Access code: 2484 526 4023
Passcode: 267614

The Legislative and Regulatory Affairs Committee will hold the Committee Meeting via WebEx, as noted above, and in-person at:

Department of Consumer Affairs
1625 N. Market Blvd., El Dorado Room
Sacramento, CA 95834

To avoid potential technical difficulties, please consider submitting written comments by June 7, 2024, to bopmail@dca.ca.gov for consideration.

Committee Members
Marisela Cervantes, EdD, MPA, Chair (remote)
Sheryll Casuga, PsyD (remote)
Stephen Phillips, JD, PsyD (remote)

Board Staff
Antonette Sorrick, Executive Officer
Jonathan Burke, Assistant Executive Officer
Cynthia Whitney, Central Services Manager
Sandra Monterrubio, Enforcement Program Manager
Stephanie Cheung, Licensing Manager
Troy Polk, Legislative and Regulatory Analyst
Anthony Pane – Board Counsel
Sam Singh – Regulatory Counsel

Friday, June 14, 2024

AGENDA

10:00 a.m. – 2:00 p.m. or Until Completion of Business

1. Call to Order/Roll Call/Establishment of a Quorum

2. Chairperson's Welcome and Opening Remarks

3. Public Comment for Items Not on the Agenda. Note: The Committee May Not Discuss or Take Action on Any Matter Raised During this Public Comment Section, Except to Decide Whether to Place the Matter on the Agenda of a Future Meeting [Government Code sections 11125 and 11125.7(a)].

4. Discussion and Possible Approval of the Committee Meeting Minutes: April 12, 2024 (C. Whitney)

5. Legislation from the 2024 Legislative Session: Review and Possible Action (M. Cervantes)

    a) Legislative Proposals

        SB 1526 – Consumer Affairs - Psychological Associates: Business and Professions Code Section 2913: Change of Supervisor Fee: Business and Professions Code Section 2987: Health and Safety Code 124260

    b) Review of Bills for Review and Consideration for Action Position Recommendation to the Board
        1. AB 236 (Holden) Health care coverage: provider directories
        2. SB 294 (Wiener) Health care coverage: independent medical review
        3. SB 999 (Wiener) Health coverage: mental health and substance use disorders
        4. SB 1120 (Becker) Health care coverage: utilization review
        5. SB 1451 (Ashby) Professions and vocations

    c) Bills with Active Positions Taken by the Board
        1. AB 1991 (Bonta) Licensee and Registrant Records
        2. AB 2051 (Bonta) Psychology interjurisdictional compact
        3. AB 2270 (Maienschein) Healing arts: continuing education: menopausal mental and physical health
        4. AB 2581 (Maienschein) Healing arts: continuing education: maternal mental health

5. AB 2703 (Aguiar-Curry) Federally qualified health centers and rural health clinics: psychological associates
6. SB 1012 (Wiener) The Regulated Psychedelic-assisted Therapy Act and the Regulated Psychedelic Substances Control Act
7. SB 1067 (Smallwood-Cuevas) Healing Arts: expedited licensure process: medically underserved area or population

d) Watch Bills
   1. AB 2282 (McKinnor) Family reunification services
   2. AB 2862 (Gipson) Licenses: African American applicants

6. Legislative Items for Future Meeting. The Committee May Discuss Other Items of Legislation in Sufficient Detail to Determine Whether Such Items Should be on a Future Committee or Board Meeting Agenda and/or Whether to Hold a Special Meeting of the Committee or Board to Discuss Such Items Pursuant to Government Code Section 11125.4

7. Regulatory Update, Review, and Consideration of Additional Changes (M. Cervantes)

   a) 16 CCR sections 1391.13, and 1391.14 – Inactive Psychological Associates Registration and Reactivating a Psychological Associate Registration
   b) 16 CCR section 1395.2 – Disciplinary Guidelines and Uniform Standards Related to Substance-Abusing Licensees
   c) 16 CCR sections 1380.3, 1381, 1381.1, 1381.2, 1381.4, 1381.5, 1382, 1382.3, 1382.4, 1382.5, 1386, 1387, 1387.1, 1387.2, 1387.3, 1387.4, 1387.5, 1387.6, 1387.10, 1388, 1388.6, 1389, 1389.1, 1391, 1391.1, 1391.3, 1391.4, 1391.5, 1391.6, 1391.8, 1391.11, and 1391.12 – Pathways to Licensure
   d) 16 CCR sections 1380.6, 1393, 1396, 1396.1, 1396.2, 1396.3, 1396.4, 1396.5, 1397, 1397.1, 1397.2, 1397.35, 1397.37, 1397.39, 1397.50, 1397.51, 1397.52, 1397.53, 1397.54, and 1397.55 - Enforcement Provisions
   e) 16 CCR sections 1397.35, 1397.37, 1397.39, and 1937.40 - Corporations
   f) 16 CCR sections 1381, 1387, 1387.10, 1388, 1388.6, 1389, and 1389.1 EPPP-2
   g) 16 CCR sections 1367-1378.5 – Research Psychoanalyst Registration

8. Recommendations for Agenda Items for Future Board Meetings. Note: The Committee May Not Discuss or Take Action on Any Matter Raised During This Public Comment Section, Except to Decide Whether to Place the Matter on the Agenda of a Future Meeting [Government Code Sections 11125 and 11125.7(a)].

ADJOURNMENT
Action may be taken on any item on the agenda. Items may be taken out of order or held over to a subsequent meeting, for convenience, to accommodate speakers, or to maintain a quorum. Meetings of the Board of Psychology are open to the public except when specifically noticed otherwise, in accordance with the Open Meeting Act.

In the event that a quorum of the Committee is unavailable, the chair may, at their discretion, continue to discuss items from the agenda and to vote to make recommendations to the full Committee at a future meeting [Government Code section 11125(c)].

The meeting is accessible to the physically disabled. To request disability-related accommodations, use the contact information below. Please submit your request at least five (5) business days before the meeting to help ensure availability of the accommodation.

You may access this agenda and the meeting materials at www.psychology.ca.gov. The meeting may be canceled without notice. To confirm a specific meeting, please contact the Board.

Contact Person: Antonette Sorrick
1625 N. Market Boulevard, Suite N-215
Sacramento, CA 95834
(916) 574-7720
bopmail@dca.ca.gov

The goal of this committee is to advocate and promote legislation that advances the ethical and competent practice of psychology to protect consumers of psychological services. The committee reviews and tracks legislation that affects the Board, consumers, and the profession of psychology, and recommends positions on legislation for consideration by the Board.

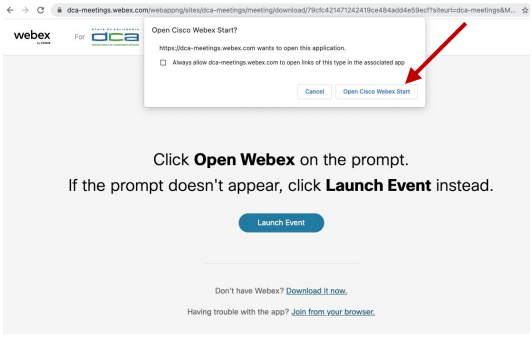
Webex Public Access Guide

Getting Connected

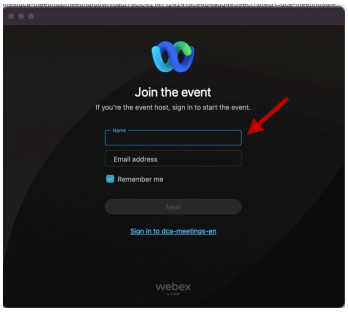
If joining using the meeting link

1. Click on the meeting link. This can be found in the meeting notice you received.

2. If you have not previously used Webex on your device, your web browser may ask if you want to open Webex. Click "Open Cisco Webex Start" or "Open Webex", whichever option is presented. DO NOT click "Join from your browser", as you will not be able to participate during the meeting.



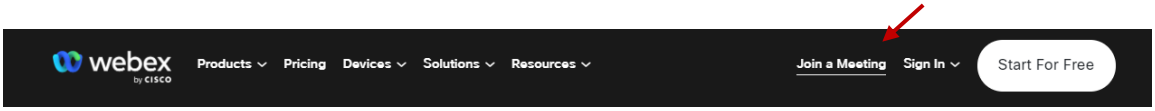
3. Enter your name and email address.
Click "Join as a guest" .
Accept any request for permission to use your microphone and/or camera.



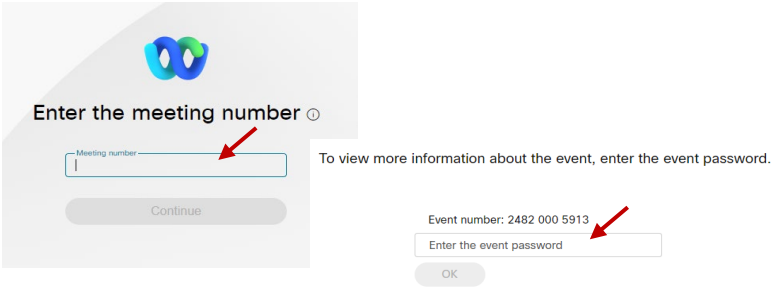
OR

If joining from Webex.com

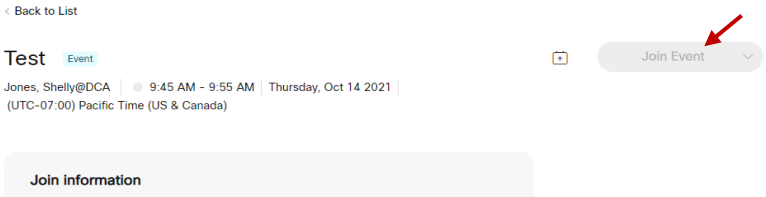
1. Click on "Join a Meeting" at the top of the Webex window.



2. Enter the meeting/event number and click "Continue" . Enter the event password and click "OK" . This can be found in the meeting notice you received.



3. The meeting information will be displayed. Click "Join Event" .



OR

Connect via telephone*:

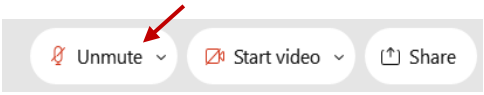
You may also join the meeting by calling in using the phone number, access code, and passcode provided in the meeting notice.

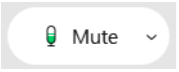
Webex Public Access Guide

Audio

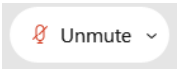
Microphone

Microphone control (mute/unmute button) is located on the command row.





Green microphone = Unmuted: People in the meeting can hear you.

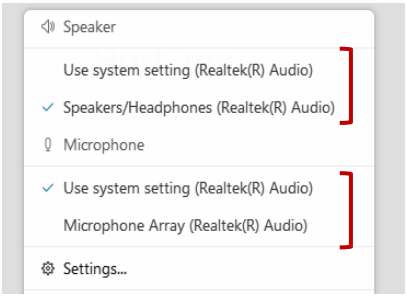


Red microphone = Muted: No one in the meeting can hear you.

Note: Only panelists can mute/unmute their own microphones. Attendees will remain muted unless the moderator enables their microphone at which time the attendee will be provided the ability to unmute their microphone by clicking on "Unmute Me".

If you cannot hear or be heard

1. Click on the bottom facing arrow located on the Mute/Unmute button.

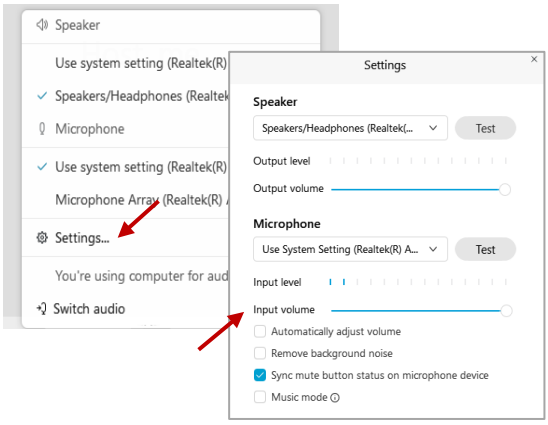


2. From the pop-up window, select a different:
   - Microphone option if participants can't hear you.
   - Speaker option if you can't hear participants.

If your microphone volume is too low or too high

1. Locate the command row – click on the bottom facing arrow located on the Mute/Unmute button.

2. From the pop-up window:
   - Click on "Settings…":
   - Drag the "Input Volume" located under microphone settings to adjust your volume.



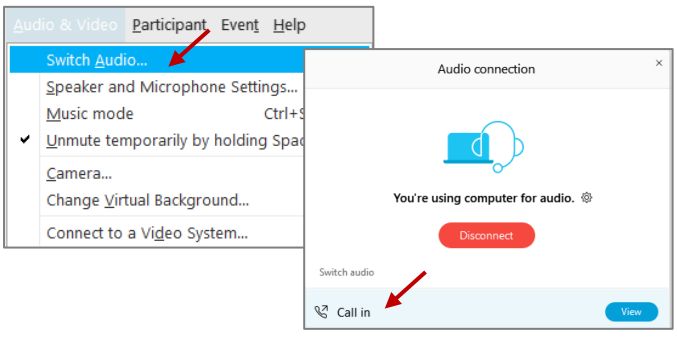
Audio Connectivity Issues

If you are connected by computer or tablet and you have audio issues or no microphone/speakers, you can link your phone through Webex. Your phone will then become your audio source during the meeting.

1. Click on "Audio & Video" from the menu bar.

2. Select "Switch Audio" from the drop-down menu.

3. Select the "Call In" option and following the directions.



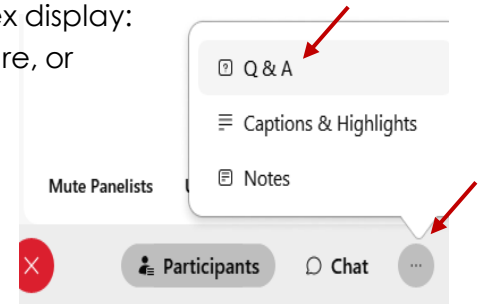
Webex Public Access Guide

Public Comment

The question-and-answer feature (Q&A) is utilized for questions or comments. Upon direction of the meeting facilitator, the moderator will open the Q&A panel for meeting participants to submit questions or comments. *NOTE: This feature is not accessible to those joining the meeting via telephone.*

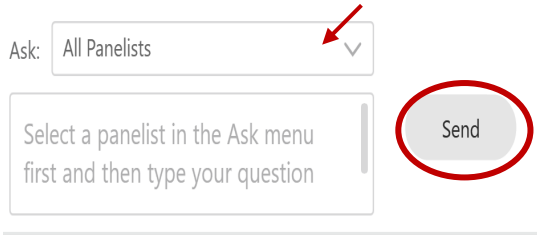
1 Access the Q&A panel at the bottom right of the Webex display:

- Click on the icon that looks like a "?" inside of a square, or
- Click on the 3 dots and select "Q&A".



2 In the text box:

- Select "All Panelists" in the dropdown menu,
- Type your question/comment into the text box, and
- Click "Send".



OR

If connected via telephone:

- Utilize the raise hand feature by pressing *6 to raise your hand.
- Repeat this process to lower your hand.

3 The moderator will call you by name and indicate a request has been sent to unmute your microphone. Upon hearing this prompt:

- Click the **Unmute me** button on the pop-up box that appears.

OR

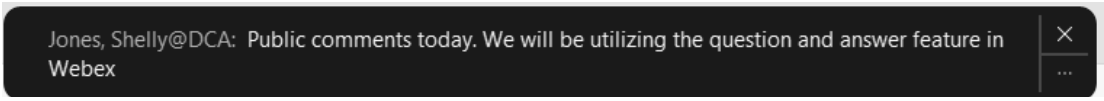
If connected via telephone:

- Press *3 to unmute your microphone.

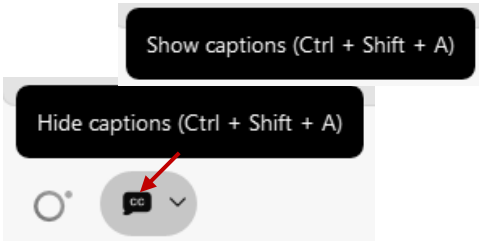
Webex Public Access Guide

Closed Captioning

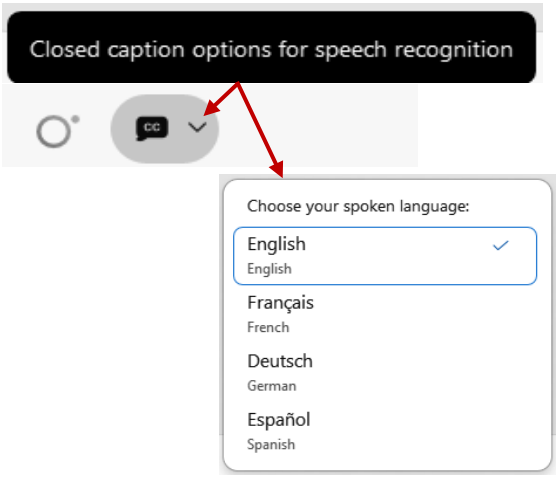
Webex provides real-time closed captioning displayed in a dialog box on your screen. The captioning box can be moved by clicking on the box and dragging it to another location on your screen.



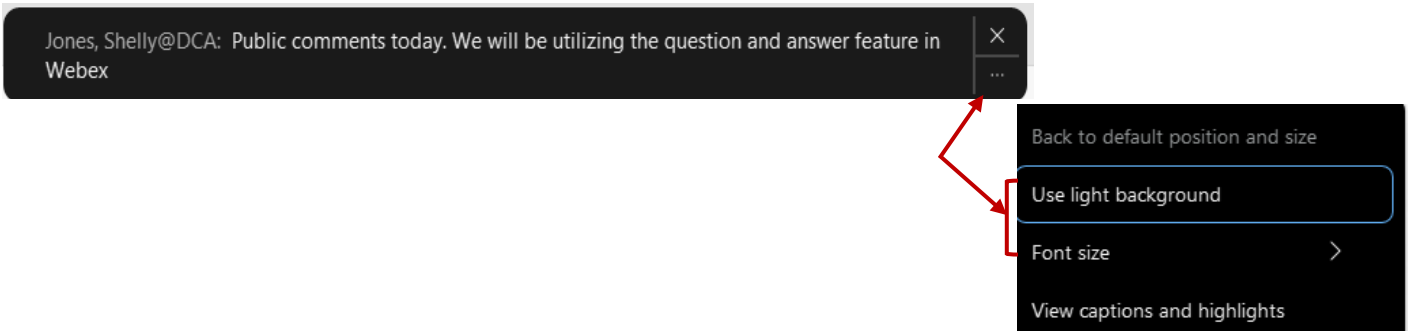
The closed captioning can be hidden from view by clicking on the closed captioning icon. You can repeat this action to unhide the dialog box.



You can select the language to be displayed by clicking the drop-down arrow next to the closed captioning icon.



You can view the closed captioning dialog box with a light or dark background or change the font size by clicking the 3 dots on the right side of the dialog box.



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MEMORANDUM

DATE	May 20, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Cynthia Whitney Central Services Manager
SUBJECT	Agenda Item # 4 – Discussion and Possible Approval of the Committee Meeting Minutes: April 12, 2024

Background:

Attached are the draft minutes of the April 12, 2024, Committee Meeting.

Action Requested:

Review and approve the minutes of the April 12, 2024, Committee Meeting.

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Legislative And Regulatory Affairs Committee Meeting

Committee Members
Marisela Cervantes, EdD, MPA, Chairperson
Sheryll Casuga, PsyD
Stephen Phillips, JD, PsyD

Board Staff
Antonette Sorrick, Executive Officer
Jonathan Burke, Assistant Executive Officer
Cynthia Whitney, Central Services Manager
Stephanie Cheung, Licensing Manager
Sandra Monterrubio, Enforcement Program Manager
Sarah Proteau, Central Services Office Technician
Evan Gage, Special Projects Analyst
Anthony Pane, Board Counsel
Sam Singh, Regulatory Counsel

Friday, April 12, 2024

Agenda Item #1: Call to Order/Roll Call/Establishment of a Quorum

Dr. Cervantes called the meeting to order at 1:00 p.m. A quorum was present and due notice had been sent to all interested parties.

Agenda Item #2: Chairperson's Welcome and Opening Remarks

Dr. Cervantes offered opening remarks.

Agenda Item #3: Public Comment for Items Not on the Agenda. Note: The Board May Not Discuss or Take Action on Any Matter Raised During this Public Comment Section, Except to Decide Whether to Place the Matter on the Agenda of a Future Meeting [Government Code sections 11125 and 11125.7(a)].

Dr. Cervantes called for public comment.

Public comment addressed concerns over PSYPACT's financial impact to California-resident licensees. Further comment was offered regarding legislation about suicide prevention in schools.

Agenda Item #4: Discussion and Possible Approval of Legislative and Regulatory Affairs Committee Meeting Minutes: June 16, 2023

It was (M)Phillips(S)Casuga(C) to adopt the June 16, 2023, Legislative and Regulatory Affairs Committee meeting minutes.

Dr. Cervantes called for public comment.

No public comment was offered.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

Agenda Item #5: Legislation from the 2024 Legislative Session: Review and Possible Action

Mr. Polk provided the update on this item.

a) Legislative Proposals

1) Psychological Associates: Business and Professions Code Section 2913: Change of Supervisor Fee: Business and Professions Code Section 2987: Health and Safety Code 124260

Board Staff submitted a proposal to the Senate Committee on Business, Professions and Economic Development (BP&ED) for technical, non-substantive changes to be included in the Committee's omnibus bill.

The proposal included amendments to Business and Professions Codes (BPC) 2913, 2987, and Health and Safety Code (HSC) 124260.

Amendment to Business and Profession Code (BPC) 2987 regarded the $25 fee associated with a request to change supervisors for psychological testing technicians, as the $25 was inadvertently removed from BPC 2987, when Senate Bill (SB) 816 was passed last year, and the proposal would add the fee back into BPC 2987.

Amendment to BPC 2913 addressed current language related to the requirements of a foreign master's degree, and the advancement to candidacy, as the current language created confusion to not only applicants seeking registration as a psychological associate but also to Licensing Staff; the proposed amendments would clarify the requirements.

On March 1, 2024, the proposed language for BPC 2913 was amended, and the amendment and proposal were approved by the Board. The amended language was submitted to the Senate BP&ED consults to be included in the proposal.

The last amendment was to Health and Safety Code (HSC) 124260 to update the language as the code referenced outdated registration categories for "registered psychologist" and "psychological assistant".

On March 18, 2024, Senate Bill 1526 was introduced by the Senate Business, Professions and Economic Development Committee. The Language included the proposed amendment to HSC 124260. The other proposal had not been included. Board Staff had been in contact with the Committee consultant regarding the other two proposals. The consultant advised that the other proposals were still being reviewed for consideration for SB 1526.

Through discussions with the Committee Consultant, it was discovered that other BPC and HSC codes also included the outdated registration categories. Board staff advised that the proposed changes would need to apply to those sections as well, and that Board staff would continue to monitor SB 1526 and the other proposed amendments.

Staff advised the Committee to recommend that the full Board ask the Senate Committee to consider the additional changes to be included in SB 1526.

Dr. Cervantes called for public comment.

No public comment was offered.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

b) Review of Bills with Active Positions Recommendations to the Board

1) AB 2270 (Maienschein) Healing arts: continuing education: menopausal mental and physical health

On February 8, 2024, AB 2270 was introduced by Assembly Member Maienschein.

AB 2270 was introduced to give medical providers, including psychologists, the option to complete coursework in menopausal mental and physical health as part of the continuing education or professional development requirements by adding BPC 2914.4.

On February 26, 2024, AB 2270 was referred to the Assembly Committee on Business and Profession.

On April 1, 2024, the bill was amended by the Business and Professions Committee which removed the term “physical health” from the course requirement and added “within the scope of their practice to BPC 2914.4. and read as “a licensee shall have the option of taking coursework on menopausal mental ~~and physical~~ health *within the scope of their practice* to satisfy continuing education requirements”.

However, the bill was amended on April 10, to add BPC 2914.4, so it now reads “*In determining its continuing professional development, the board shall consider including a course in menopausal mental or physical health.”* The new language still does not fully

require the course to be completed in order to meet the requirements, but board staff will continue to monitor AB 2270.

Dr. Phillips asked Mr. Polk whether coursework would still need to satisfy continuing professional development requirements as they relate to continuing education. Mr. Polk confirmed that this was the case. Dr. Phillips commented that there was currently nothing preventing someone from taking coursework on maternal mental health, and questioned whether it was necessary to take any action. Dr. Casuga commented that she agreed with Dr. Phillips, and asked Mr. Polk for a recommended position.

No other boards currently support this bill, although the California Retired Teachers Association is in support.

Board staff would continue to monitor AB 2270.

It was (M)Phillips(S)Casuga(C) to recommend to the full Board to take a position of Support for AB 2270.

Dr. Cervantes called for public comment.

Public comment regarded the necessity for this coursework to be imposed by legislation since this coursework was already available as an option.

Dr. Phillips commented further that taking a Support position signals the Board's awareness of this bill's importance for licensees.

Drs. Cervantes and Casuga concurred.

Dr. Casuga commented that a Support position might encourage licensees to take this coursework when it might not have occurred to them before, and it might encourage providers to generate more such coursework.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

Public comment was allowed at the conclusion of the passing vote.

Public comment referred to recent research on menopausal mental health that should be considered by providers who want to be well-prepared to address these issues.

2) AB 2282 (McKinnor) Family reunification services

On February 8, 2024, AB 2282 was introduced by Assembly Member McKinnor.

AB 2282 provided that reunification services would not need to be rendered to a parent or guardian when a court finds that the parent or guardian of the child had been convicted of a violent felony against a child.

AB 2282 would also limit criminal convictions used to deny reunification services to families. It would amend the law to deny services only to the most serious and violent felons who have endangered children or their family.

By expanding the scope of individuals requiring reunification services, the bill would impose additional duties on county child welfare departments.

The Board took a support position on SB 331 which in 2023 established the Safe Child Act, thereby prohibiting a court from ordering family reunification treatments in a custody or visitation dispute. AB 2282 was not specific to child custody.

Board staff would continue to monitor AB 2282 for any additional amendments.

Dr. Phillips commented that the Board had heard much testimony in the past about family reunification camps, and took an interest in previous legislation, noting that this legislation clarifies the scope of these services and is not necessarily under the auspice of the Board. Dr. Phillips recommended taking a Watch position on AB 2282.

Board Counsel Mr. Pane confirmed that no action needed to be taken to watch the bill.

Dr. Phillips withdrew his motion.

Dr. Casuga agreed that a Watch position was appropriate.

No public comment called for because this was a non-action item.

3) AB 2581 (Maienschein) Healing arts: continuing education: maternal mental health

On February 14, 2024, AB 2581 was introduced by Assembly Member Maienschein.

AB 2581 would give medical providers, including psychologists, the option to take a course in maternal mental health as part of the continuing education or professional development requirements under BPC 2914.4.

On March 4, 2024, AB 2581 was referred to the Assembly Committee on Business and Profession.

Board staff had been in contact with Committee consultants regarding the impact of the bill and possible amendments to the bill language.

The bill was amended on April 10 to match the amended language of AB 2270 to read "*In determining its continuing professional development, the board shall consider including a course in menopausal mental or physical health.*"

Board Staff would continue to monitor AB 2581.

It was (M)Casuga(S)Phillips(C) to recommend that the Board take a Support position on AB 2581.

Dr. Cervantes called for public comment.

No public comment was offered.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

4) AB 2703 (Aguiar-Curry) Federally qualified health centers and rural health clinics: psychological associates

On February 14, 2024, AB 2703 was introduced by Assembly Member Aguiar-Curry.

The bill was co-sponsored by The California Psychological Association (CPA) and the Primary Care Association.

AB 2703 would amend the current law to permit psychological associates to perform services in Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) and allow the centers to be reimbursed for the services.

As the existing law does not specifically allow these FQHC's and RHC's to be reimbursed for services provided by psychological associates, AB 2703 would promote greater access to care.

On March 4, 2024, AB 2703 was referred to the Assembly Committee on Health.

It was (M)Casuga(S)Phillips(C) to recommend that the Board take a Support position on AB 2703.

Dr. Cervantes called for public comment.

Dr. Elizabeth Winkelman from CPA thanked the Committee for taking a Support position.

No further public comment offered.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

5) AB 2862 (Gipson) Licenses: African American applicants

On February 15, 2024, AB 2862 was introduced by Assembly Member Gipson.

AB 2862 would require various business and professions, including healing arts boards, under the Department of Consumer Affairs to prioritize African American applicants seeking licensure, especially applicants who are descended from a person who was enslaved in the United States.

On March 11, 2024, AB 2862 was referred to the Assembly Committee on Business and Professions and the committee on Judiciary.

In meetings with the Department of Consumer Affairs Legislative Unit and other healing arts boards, concerns arose regarding the verification of documents, and to whose discretion it would fall to determine which applicants qualified for the expedited processing; it was unclear whether or not this determination would be made by staff, since the current bill language does not provide further clarification or language addressing the concerns.

Board staff would continue to monitor this bill.

Dr. Phillips commented that there is a growing list of populations that are being considered for expedited licensure. Ms. Cheung commented that there are currently five other categories of applicants, namely asylees, and military personnel and their spouses, who receive expedited licensure.

Ms. Cheung commented that the expedited processing of a particular category of application does not create workflow issues for staff, because the application is merely prioritized, and does not create additional work thereby.

Dr. Casuga asked Mr. Polk whether this bill is still in early stages. Mr. Polk confirmed that this is the case, and many of the fiscal and other considerations would take shape later through the amendment process. Dr. Casuga commented that it was too early to take an active position and recommended that staff continue to watch this bill.

Drs. Cervantes and Phillips concurred.

6) SB 1012 (Wiener) The Regulated Psychedelic Substances Control Act

On February 5, 2024, SB 1012 was introduced by Senator Wiener.

On February 14, 2024, SB 1012 was referred to the Senate Committees on Business, Professions and Economic Development and Public Safety.

SB 1012 would enact the Regulated Psychedelic-Assisted Therapy Act, which would establish the Board of Regulated Psychedelic Facilitators within the Department of

Consumer Affairs to license and regulate psychedelic-assisted therapy facilitators. The new Board would be required to establish education, training, and other qualifications and requirements for obtaining a license as a regulated psychedelic-assisted therapy facilitator and would require the Board to be appointed by April 1, 2025, and begin accepting license applications by April 1, 2026.

Regulated Psychedelic Facilitator qualification would be open to anyone 21 years of age or older, who had completed curriculum in regulated psychedelic facilitation and related subjects, accumulating the hours of coursework as established by the Board, such as would incorporate appropriate school assessment of student knowledge and skills, prior experience accepted by the Board as an equivalent to, or equivalent to a portion of, the required curricula or practicum requirement, including existing licensure in a health or mental health profession, and any practicum experience that is required by the Board, and the individual had passed a regulated psychedelic facilitator competency assessment examination that meets generally recognized principles and standards and that is created and administered by the Board or an entity designated by the Board.

Dr. Casuga asked how this new type of licensed practice might affect the practice of psychologists. Mr. Polk commented that the current language leaves room for a licensed psychologist to obtain dual licensure as a Regulated Psychedelic Facilitator if they completed the curriculum and passed the assessment. There is still the question of whether this new qualification should be administered by an entirely new board or brought under the authority of an existing board.

Mr. Polk commented that he would continue to monitor the language now and after it is taken up by committees.

Dr. Phillips voiced concern that a new class of provider was being created by this bill, and this provider need not necessarily be a medical or mental health professional.

Ms. Sorrick commented that in past discussions where a bill under discussion might have multidisciplinary impacts affecting different populations of stakeholders, sometimes it was appropriate to hold a stakeholder meeting where the impacted Boards could have a place at the table.

It was (M)Phillips(S)Casuga(C) to recommend to the full Board to take an Oppose position to SB 1012.

Dr. Casuga commented that the Board should be given the opportunity to articulate its concerns, and that there should be a stakeholder meeting to discuss overlap between impacted disciplines.

Dr. Cervantes called for public comment.

Public comment touched on the perception that any confusion arising from a lack of clarity to this bill affected consumers perhaps more than it affected mental health

professionals. Further comment advised that the Board should absolutely have a seat at the table when this bill is being discussed, or else the Board will not have a say in the final result.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

7) SB 1067 (Smallwood-Cuevas) Healing arts: expedited licensure process: medically underserved area or population.

On February 12, 2024, SB 1067 was introduced by Senator Smallwood-Cuevas.

SB 1067 would require each healing arts board under the Department of Consumer Affairs to develop a process to expedite the licensure process by giving priority to applicants who are seeking licensure if they demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population.

On February 21, 2024, SB 1067 was referred to the Senate Committee on Business, Professions and Economic Development.

In meeting with the Department of Consumer Affairs Legislative Unit, the Medical Board advised that their Board currently expedites applicants who meet the criteria, since the definitions are federally defined, and HCAI provides a database based on Zip Code to determine whether the applicants would be providing services in those specific areas.

Health and Safety Code (HSC) 128552 defines “Medically underserved area” as an area with health professional shortage or an area of the state where unmet priority needs for physicians exist. HSC 128552 also defines “medically underserved population” as individuals in the Medi-Cal program and uninsured populations.

Dr. Phillips commented that the term “medically underserved” was problematic because it fell outside of the Board’s purview. He commented that if the language were amended to provide specificity over which individuals would be covered by this definition, and what documentation would be required.

Dr. Casuga expressed concern over how board staff might be impacted. She commented that she would like more details about how the bill might be implemented.

It was (M)Phillips(S)Casuga(C) to recommend that the Board take a Support if Amended position on SB 1067 if it clarified a) what constituted an underserved area and population and b) what documentation would be necessary from the licensee as to their intention to serve that area.

Dr. Cervantes called for public comment.

No public comment was offered.

Votes: 3 ayes (Casuga, Cervantes, Phillips), 0 noes

Motion passed.

c) Bills with Active Positions Taken by the Board

Mr. Polk presented this item.

1) AB 2051 (Bonta) Psychology interjurisdictional compact

Assembly Bill 2051 was introduced by Assemblymember Bonta.

AB 2051 would incorporate California under the Psychology Interjurisdictional Compact (PSYPACT), to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines.

On March 1, 2024, the Board adopted an Oppose position.

On March 15, 2024, an Oppose Letter was submitted to the members of the Assembly Business and Professions Committee, as well as the author's office.

AB 2051 was scheduled to heard in the Assembly Business and Professions Committee on April 16, 2024. Staff provided in-person testimony in opposition.

Dr. Cervantes called for staff and Committee comment.

Dr. Casuga asked who from board staff would be attending the April 16 meeting. Assistant Executive Officer Jonathan Burke will be attending the meeting.

No further staff or Committee comments were offered.

Agenda Item #6: Legislative Items for Future Meeting. The Committee May Discuss Other Items of Legislation in Sufficient Detail to Determine Whether Such Items Should be on a Future Committee or Board Meeting Agenda and/or Whether to Hold a Special Meeting of the Committee or Board to Discuss Such Items Pursuant to Government Code Section 11125.4

Dr. Cervantes called for Committee and staff comments.

Mr. Polk commented that in the legislative roundtable that staff had with the legislative affairs unit in DCA, staff was made aware of AB 1991.

AB 1991 was introduced by Assembly Member Bonta.

AB 1991 would require boards that regulate healing arts licensees or registrants to collect workforce data from their licensees or registrants and would require the demographic/workforce survey to be completed at the time of electronic license or registration renewal and would no longer be optional or give the option to "decline to answer". Applicants who fail to complete the survey would be subject to discipline and would not be able to renew their license or registration until the demographic data was provided.

An update would be provided to the full Board at the May 2024 Board meeting.

Dr. Cervantes called for public comment.

No public comment offered.

Agenda Item #7: Regulatory Update, Review, and Consideration of Additional Changes

Mr. Polk provided the update on this item.

a) 16 CCR sections 1391.13 and 1391.14 – Inactive Psychological Associates Registration and Reactivating a Psychological Associate Registration

On March 21, 2024, the regulatory package was approved by Agency and sent to the Office of Administrative Law for approval of publishing. The regulatory package was approved for publishing by OAL. The 45-public comment period started on April 5th and would be completed on May 21, 2024.

This regulatory package would do the following:

Allows a psychological associate to request that the Board place their active registration in an inactive status. In addition, the proposed regulations would allow the Board to place the registration in an inactive status when the registrant has no primary supervisor. While the registration is in an inactive status, time would not be counted towards the cumulative total of six years registration limitation. The Board is also proposing the adoption of the process for reactivating an inactive psychological associate registration.

Dr. Cervantes called for Committee comment.

No comment offered.

b) 16 CCR section 1395.2 - Disciplinary Guidelines and Uniform Standards Related to Substance-Abusing Licensees

Production Phase. Review of the proposed regulatory language at the May 19, 2023 Board Meeting was postponed to the August 18, 2023 Board Meeting. At the August 18, 2023, Board Meeting the Board voted to adopt the proposed regulatory language. Staff

was preparing the initial submission documents for DCA and Agency review before filing with OAL for notice publication.

This regulatory package would do the following:

Update the Board's disciplinary guidelines including conforming changes required by the passage of AB 2138, the Board's new regulations regarding criminal convictions and substantial relationship criteria, and the Department's Uniform Standards for Substance Abusing Licensees.

c) 16 CCR sections 1380.3, 1381, 1381.1, 1381.2, 1381.4, 1381.5, 1382, 1382.3, 1382.4, 1382.5, 1386, 1387, 1387.1, 1387.2, 1387.3, 1387.4, 1387.5, 1387.6, 1387.10, 1388, 1388.6, 1389, 1389.1, 1391, 1391.1, 1391.3, 1391.4, 1391.5, 1391.6, 1391.8, 1391.11, and 1391.12 – Pathways to Licensure

Status: Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

This regulatory package would do the following:

Streamlines the licensing process and removes unnecessary barriers for applicants and the supervisors who support their training.

d) 16 CCR sections 1380.6, 1393, 1396, 1396.1, 1396.2, 1396.3, 1396.4, 1396.5, 1397, 1397.1, 1397.2, 1397.35, 1397.37, 1397.39, 1397.50, 1397.51, 1397.52, 1397.53, 1397.54, and 1397.55 - Enforcement Provisions

Status: Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

This regulatory package would update the Board's enforcement provisions.

e) 16 CCR sections 1397.35, 1397.37, 1397.39, and 1937.40 - Corporations

Status: Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

This regulatory package would update the Board's requirements for professional corporations provisions.

f) 16 CCR sections 1381, 1387, 1387.10, 1388, 1388.6, 1389, and 1389.1 EPPP-2

Status: Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel. On May 19, 2023, the Board approved the statutory and regulatory changes that would implement the EPPP part 2 Skills Exam, effective January 1, 2026.

This regulatory package updates the statutory and regulatory sections needed to implement the EPPP-2.

Agenda Item #8: Recommendations for Agenda Items for Future Board Meetings. Note: The Committee May Not Discuss or Take Action on Any Matter Raised During This Public Comment Section, Except to Decide Whether to Place the Matter on the Agenda of a Future Meeting [Government Code Sections 11125 and 11125.7(a)].

Dr. Cervantes called for Committee and staff comment.

No Committee or staff comment offered.

Dr. Cervantes called for public comment.

No public comment offered.

ADJOURNMENT

The meeting adjourned at 2:53 p.m.

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(a) - SB 1526 – Consumer Affairs - Psychological Associates: Business and Professions Code Section 2913: Change of Supervisor Fee: Business and Professions Code Section 2987: Health and Safety Code 124260

Background

On January 2, 2024, Board Staff submitted a proposal to the Senate Committee on Business, Professions and Economic Development (BP&ED) for technical, non-substantive changes to be included in the Committee's omnibus bill. The proposal included amendments to Business and Professions Codes (BPC) 2913, 2987, and Health and Safety Code (HSC) 124260.

On January 16, 2024, Board Staff met with the Committee Consultants to discuss the proposal and was advised the proposal would be presented to the Committee Members.

On March 1, 2024, the proposed language for BPC 2913 was amended, and the proposal was approved by the Board. The amended language was submitted to the Senate BP&ED consultants to be included in the proposal.

On March 18, 2024, Senate Bill (SB) 1526 was introduced by the Senate BP&ED Committee. The bill language includes the Board's proposed amendments to HSC 124260.

On April 12, 2024, a Support Position Letter was submitted to the Senate BP&ED Committee.

On April 17, 2024, SB 1526 was amended to include HSC's 1374.72 and 128454, which updated the registration categories.

On April 22, 2024, SB 1526 passed the Senate Committee on BP&ED, and was referred to the Appropriations Committee

On April 30, 2024, a Support Position Letter was submitted to the Appropriations Committee.

On May 7, 2024, the Appropriations Committee ordered SB 1526 to the consent calendar.

On May 9, 2024, SB 1526 passed the Appropriations Committee and was Ordered to the Assembly.

On May 17, 2024, Board Staff contacted the Senate Committee on BP&ED consultant regarding the proposed amendments to BPC 2913 and 2987.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: Amended SB 1526 Bill Text
Attachment #2: Senate BP&ED Committee proposal
Attachment #3: Amended proposed language BPC 2913
Attachment #4: SB 1526 Support Letter

AMENDED IN SENATE APRIL 17, 2024

SENATE BILL No. 1526

Introduced by Committee on Business, Professions and Economic Development (Senators Ashby (Chair), Alvarado-Gil, Archuleta, Becker, Dodd, Eggman, Glazer, Menjivar, Nguyen, Niello, Roth, Smallwood-Cuevas, and Wilk)

March 18, 2024

An act to amend Sections 144, 205, 208, 1903, 1905.2, 1910.5, 1944, 2538.3, 2538.10, 2538.25, 2538.27, 2539.1, 2736, 2816, 3503, 3526, 3531, 3534.4, 3534.5, 3545, 3620, 3620.1, 3621.5, 3622, 3623, 3624, 3627, 3630, 3633, 3633.1, 3634, 3636, 3640, 3640.2, 3640.3, 3640.5, 3640.8, 3641, 3644, 3650, 3651.5, 3652, 3660, 3661, 3663, 3663.5, 3670, 3672, 3675, 3681, 3685, 4175, 4800, 4800.1, 4809.6, 4810, 4811, *4826.7,* 4836.1, 4842.2, 4846, 4848.1, 4857, 4860, 4875, 4886, 4903, 4904, 4905, 4910, 4920.2, 4920.4, 4920.8, 4980.54, 9884, and 17913 of the Business and Professions Code, to amend Sections 94816, 94850, 94856, 94876, 94883, 94899.5, 94901, 94906, 94913, and 94949.71 of the Education Code, and to amend ~~Section 124260~~ *Sections 1374.72, 124260, and 128454* of the Health and Safety Code, relating to consumer affairs.

LEGISLATIVE COUNSEL'S DIGEST

SB 1526, as amended, Committee on Business, Professions and Economic Development. Consumer affairs.

(1) Existing law establishes the Department of Consumer Affairs in the Business, Consumer Services, and Housing Agency. Existing law establishes various entities within the department for the licensure, regulation, and discipline of various professions and vocations.

Existing law establishes the Professions and Vocations Fund in the State Treasury, which consists of specified special funds and accounts. Other existing law, the Naturopathic Doctors Act, establishes the Naturopathic Doctor's Fund in the State Treasury.

This bill would include the Naturopathic Doctor's Fund in those special funds and accounts in the Professions and Vocations Fund.

(2) Existing law, the Dental Practice Act, provides for the licensure and regulation of dental hygienists by the Dental Hygiene Board of California. Existing law defines "dental hygiene board" to mean the Dental Hygiene Board of California and "dental board" to mean the Dental Board of California.

This bill would correct references to these boards.

(3) Existing law, the Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act, provides for the licensure and regulation by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of, among others, speech-language pathology assistants, hearing aid dispensers, and dispensing audiologists.

Existing law requires a person applying for approval as a speech-language pathology assistant to have graduated from a speech-language pathology assistant associate of arts degree program, or equivalent course of study, approved by the board.

This bill would require graduation from a speech-language pathology assistant associate degree program, or equivalent course of study, approved by the board.

Existing law, as it relates to hearing aid dispensers and dispensing audiologists, refers to a "hearing aid dispenser's license."

This bill would instead refer to a "hearing aid dispenser license."

(4) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing to license and regulate the practice of nursing.

Existing law requires an applicant for licensure as a registered nurse to comply with prescribed requirements, including a requirement to have successfully completed the courses of instruction prescribed by the board for licensure, in a program in this state accredited by the board for training registered nurses, or to have successfully completed courses of instruction in a school of nursing outside of this state that, in the opinion of the board at the time the application is filed, are equivalent to the minimum requirements of the board for licensure established for an accredited program in this state.

This bill would replace references to an "accredited program" with "approved program."

Existing law prohibits an individual from holding themselves out as a public health nurse or using a title that includes the term "public health nurse" unless that individual is in possession of a valid California public health nurse certificate. Existing law establishes minimum and maximum amounts for a fee for an evaluation of qualifications to use the title "public health nurse," a fee for an application for renewal of the certificate to practice as a public health nurse, and a penalty fee for failure to renew a certificate to practice as a public health nurse within the prescribed time.

This bill would delete the minimum amounts for those public health nurse fees.

(5) Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Board.

This bill would make nonsubstantive changes in that act.

(6) Existing law, the Naturopathic Doctors Act, establishes the California Board of Naturopathic Medicine. Existing law changed the name of the former Naturopathic Medicine Committee to the board and former law changed the name of the Bureau of Naturopathic Medicine to the committee. Existing law specifies that any reference in any law or regulation to the bureau or the committee refers to the board.

This bill would update numerous outdated references to the bureau or the committee to instead refer to the board.

Existing law requires the board to adopt regulations in order to carry out the purposes of the Naturopathic Doctors Act and, unless contrary to the Naturopathic Doctors Act, applies regulations adopted by the bureau to the board and its licensees.

This bill, unless contrary to the Naturopathic Doctors Act, would also apply regulations adopted by the committee to the board and its licensees.

(7) Existing law, the Veterinary Medicine Practice Act, establishes the Veterinary Medical Board for the licensure and regulation of veterinarians and the practice of veterinary medicine. Under existing law, revenues of specified fees and fines are deposited in the Veterinary Medical Board Contingent Fund (veterinary fund), an account in the Professions and Vocations Fund subject to appropriation by the Legislature.

This bill would rename the act, the board, and the veterinary fund, respectively, the "California Veterinary Medicine Practice Act," the

"California Veterinary Medical Board," and the "California Veterinary Medical Board Contingent Fund."

(8) Existing law establishes the Board of Behavioral Sciences and requires the board to license and regulate various registrants and licensees under existing law, including licensees and registrants under the Licensed Marriage and Family Therapist Act. A violation of the act is a crime. Existing law prohibits the board from renewing any registration as an associate marriage and family therapist unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than 3 hours of continuing education on the subject of California law and ethics during the preceding year. Existing law requires the continuing education to be obtained from one of prescribed sources, including an accredited school or state-approved school that meets specified requirements.

This bill would instead authorize a school, college, or university that is accredited or approved, as defined, to be a continuing education source.

(9) Existing law, the Automotive Repair Act, provides for the registration and regulation of automotive repair dealers by the Bureau of Automotive Repair. Existing law requires an automotive repair dealer to pay a required fee for each place of business operated by the dealer in this state and to register with the director upon forms prescribed by the director, as prescribed. Existing law requires the forms to include any applicable nationally recognized and industry-accepted educational certifications and any bureau-approved educational certifications.

This bill would revise "bureau-approved educational certifications" to "bureau-accepted educational certifications."

(10) Existing law requires every person who regularly transacts business in this state for profit under a fictitious business name to file a fictitious business name statement, as prescribed, not later than 40 days from the time the registrant commences to transact business, to file a new statement after any change in the facts, and to file a new statement when refiling a fictitious business name statement. Existing law requires the fictitious business name statement to contain specified information and to be substantially in a specified form, including prescribed notice of existing law governing the expiration of a statement.

This bill would conform the notice language to existing law governing the expiration of a statement.

(11) Existing law, the California Private Postsecondary Education Act of 2009 (the act), provides for student protections and regulatory

oversight of private postsecondary institutions in the state. The act is enforced by the Bureau for Private Postsecondary Education. The act imposes various requirements and creates certain exemptions that are based, in part, on the total charges, which the act defines as the sum of institutional and noninstitutional charges. The act further defines "noninstitutional charges" to mean charges for an educational program paid to an entity other than an institution that are specifically required for participation in an educational program.

This bill would narrow the definition of "noninstitutional charges" to include only those specified charges that are paid to such an entity directly.

Existing law requires a private postsecondary educational institution that maintains an internet website to provide on that website specific documents relating to the institution and a link to the bureau's internet website.

This bill would require that those documents and that link be an up-to-date version.

~~(12) Existing law relating to mental health services for minors defines terms for its purposes, including defining "mental health treatment or counseling services" to mean the provision of outpatient mental health treatment or counseling by a professional person. Existing law further defines "professional person" to include, among others, a "registered psychologist" and a "registered psychological assistant," as defined.~~

~~This bill would delete the outdated category of "registered psychologist" and update the category "registered psychological assistant" to "registered psychological associate."~~

(12) Existing law, the Psychology Licensing Law, provides for the licensure and regulation of psychologists and registered psychological associates.

This bill would correct various references in other laws to a "psychological assistant" to instead refer to a "registered psychological associate," and would delete an outdated reference to the category of "registered psychologist."

(13) The bill would make technical and other nonsubstantive changes, including changes relating to obsolete provisions and references and the elimination of gendered pronouns.

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 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

(1) California Board of Accountancy.

(2) State Athletic Commission.

(3) Board of Behavioral Sciences.

(4) Court Reporters Board of California.

(5) Dental Board of California.

(6) California State Board of Pharmacy.

(7) Board of Registered Nursing.

(8) California Veterinary Medical Board.

(9) Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(10) Respiratory Care Board of California.

(11) Physical Therapy Board of California.

(12) Physician Assistant Board.

(13) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(14) Medical Board of California.

(15) California State Board of Optometry.

(16) Acupuncture Board.

(17) Cemetery and Funeral Bureau.

(18) Bureau of Security and Investigative Services.

(19) Division of Investigation.

(20) Board of Psychology.

(21) California Board of Occupational Therapy.

(22) Structural Pest Control Board.

(23) Contractors State License Board.

(24) California Board of Naturopathic Medicine.

(25) Professional Fiduciaries Bureau.

(26) Board for Professional Engineers, Land Surveyors, and Geologists.

(27) Podiatric Medical Board of California.

(28) Osteopathic Medical Board of California.

(29) California Architects Board, beginning January 1, 2021.

(30) Landscape Architects Technical Committee, beginning January 1, 2022.

(31) Bureau of Household Goods and Services with respect to household movers as described in Chapter 3.1 (commencing with Section 19225) of Division 8.

(c) For purposes of paragraph (26) of subdivision (b), the term "applicant" shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.

SEC. 2. Section 205 of the Business and Professions Code, as amended by Section 1 of Chapter 508 of the Statutes of 2023, is amended to read:

205. (a) There is in the State Treasury the Professions and Vocations Fund. The fund shall consist of the following special funds:

(1) Accountancy Fund.

(2) California Architects Board Fund.

(3) Athletic Commission Fund.

(4) Barbering and Cosmetology Contingent Fund.

(5) Cemetery and Funeral Fund.

(6) Contractors License Fund.

(7) State Dentistry Fund.

(8) Home Furnishings and Thermal Insulation Fund.

(9) California Architects Board-Landscape Architects Fund.

(10) Contingent Fund of the Medical Board of California.

(11) Optometry Fund.

(12) Pharmacy Board Contingent Fund.

(13) Physical Therapy Fund.

(14) Private Security Services Fund.

(15) Professional Engineer's, Land Surveyor's, and Geologist's Fund.

(16) Consumer Affairs Fund.

(17) Behavioral Sciences Fund.

(18) Licensed Midwifery Fund.

(19) Court Reporters' Fund.

(20) California Veterinary Medical Board Contingent Fund.
(21) Vocational Nursing and Psychiatric Technicians Fund.
(22) Electronic and Appliance Repair Fund.
(23) Acupuncture Fund.
(24) Physician Assistant Fund.
(25) Board of Podiatric Medicine Fund.
(26) Psychology Fund.
(27) Respiratory Care Fund.
(28) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund.
(29) Board of Registered Nursing Fund.
(30) Animal Health Technician Examining Committee Fund.
(31) State Dental Hygiene Fund.
(32) Structural Pest Control Fund.
(33) Structural Pest Control Education and Enforcement Fund.
(34) Structural Pest Control Research Fund.
(35) Household Movers Fund.
(36) Household Goods and Services Fund.
(37) Naturopathic Doctor's Fund.

(b) For accounting and recordkeeping purposes, the Professions and Vocations Fund shall be deemed to be a single special fund, and each of the several special funds therein shall constitute and be deemed to be a separate account in the Professions and Vocations Fund. Each account or fund shall be available for expenditure only for the purposes as are now or may hereafter be provided by law.

(c) This section shall remain in effect only until July 1, 2026, and as of that date is repealed.

SEC. 3. Section 205 of the Business and Professions Code, as added by Section 2 of Chapter 508 of the Statutes of 2023, is amended to read:

205. (a) There is in the State Treasury the Professions and Vocations Fund. The fund shall consist of the following special funds:
(1) Accountancy Fund.
(2) California Architects Board Fund.
(3) Athletic Commission Fund.
(4) Barbering and Cosmetology Contingent Fund.
(5) Cemetery and Funeral Fund.
(6) Contractors License Fund.

(7) State Dentistry Fund.
(8) California Architects Board-Landscape Architects Fund.
(9) Contingent Fund of the Medical Board of California.
(10) Optometry Fund.
(11) Pharmacy Board Contingent Fund.
(12) Physical Therapy Fund.
(13) Private Security Services Fund.
(14) Professional Engineer's, Land Surveyor's, and Geologist's Fund.
(15) Consumer Affairs Fund.
(16) Behavioral Sciences Fund.
(17) Licensed Midwifery Fund.
(18) Court Reporters' Fund.
(19) California Veterinary Medical Board Contingent Fund.
(20) Vocational Nursing and Psychiatric Technicians Fund.
(21) Acupuncture Fund.
(22) Physician Assistant Fund.
(23) Board of Podiatric Medicine Fund.
(24) Psychology Fund.
(25) Respiratory Care Fund.
(26) Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund.
(27) Board of Registered Nursing Fund.
(28) Animal Health Technician Examining Committee Fund.
(29) State Dental Hygiene Fund.
(30) Structural Pest Control Fund.
(31) Structural Pest Control Education and Enforcement Fund.
(32) Structural Pest Control Research Fund.
(33) Household Goods and Services Fund.
(34) Naturopathic Doctor's Fund.

(b) For accounting and recordkeeping purposes, the Professions and Vocations Fund shall be deemed to be a single special fund, and each of the several special funds therein shall constitute and be deemed to be a separate account in the Professions and Vocations Fund. Each account or fund shall be available for expenditure only for the purposes as are now or may hereafter be provided by law.

(c) This section shall become operative on July 1, 2026.

SEC. 4. Section 208 of the Business and Professions Code is amended to read:

208. (a) Beginning April 1, 2023, a Controlled Substance Utilization Review and Evaluation System (CURES) fee of nine dollars ($9) shall be assessed annually on each of the licensees specified in subdivision (b) to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees. The fee assessed pursuant to this subdivision shall be billed and collected by the regulating agency of each licensee at the time of the licensee's license renewal. If the reasonable regulatory cost of operating and maintaining CURES is less than nine dollars ($9) per licensee, the Department of Consumer Affairs, by regulation, may reduce the fee established by this section to the reasonable regulatory cost.

(b) (1) Licensees authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances or pharmacists licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2.

(2) Licensees issued a license that has been placed in a retired or inactive status pursuant to a statute or regulation are exempt from the CURES fee requirement in subdivision (a). This exemption shall not apply to licensees whose license has been placed in a retired or inactive status if the licensee is at any time authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Wholesalers, third-party logistics providers, nonresident wholesalers, and nonresident third-party logistics providers of dangerous drugs licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2.

(4) Nongovernmental clinics licensed pursuant to Article 13 (commencing with Section 4180) and Article 14 (commencing with Section 4190) of Chapter 9 of Division 2.

(5) Nongovernmental pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2.

(c) The funds collected pursuant to subdivision (a) shall be deposited in the CURES Fund, which is hereby created within the State Treasury. Moneys in the CURES Fund, upon appropriation by the Legislature, shall be available to the Department of Consumer Affairs to reimburse the Department of Justice for costs to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(d) The Department of Consumer Affairs shall contract with the Department of Justice on behalf of the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the California Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Board, the Osteopathic Medical Board of California, the California Board of Naturopathic Medicine, the California State Board of Optometry, and the Podiatric Medical Board of California to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(e) This section shall become operative on April 1, 2023.

SEC. 5. Section 1903 of the Business and Professions Code is amended to read:

1903. (a) (1) The dental hygiene board shall consist of nine members as follows:

(A) Seven members appointed by the Governor as follows:

(i) Two members shall be public members.

(ii) One member shall be a practicing general or public health dentist who holds a current license in California.

(iii) Four members shall be registered dental hygienists who hold current licenses in California. Of the registered dental hygienist members, one shall be licensed either in alternative practice or in extended functions, one shall be a dental hygiene educator, and two shall be registered dental hygienists. No public member shall have been licensed under this chapter within five years of the date of their appointment or have any current financial interest in a dental-related business.

(B) One public member appointed by the Senate Committee on Rules.

(C) One public member appointed by the Speaker of the Assembly.

(2) (A) The first appointment by the Senate Committee on Rules or the Speaker of the Assembly pursuant to this subdivision shall be made upon the expiration of the term of a public member that is scheduled to occur, or otherwise occurs, on or after January 1, 2019.

(B) It is the intent of the Legislature that committee members appointed prior to January 1, 2019, remain as dental hygiene board members until their term expires or except as otherwise provided in law, whichever occurs first.

(3) For purposes of this subdivision, a public health dentist is a dentist whose primary employer or place of employment is in any of the following:

(A) A primary care clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code.

(B) A primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(C) A clinic owned or operated by a public hospital or health system.

(D) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

(b) (1) Except as specified in paragraph (2), members of the dental hygiene board shall be appointed for a term of four years. Each member shall hold office until the appointment and qualification of the member's successor or until one year shall have lapsed since the expiration of the term for which the member was appointed, whichever comes first.

(2) For the term commencing on January 1, 2012, two of the public members, the general or public health dentist member, and two of the registered dental hygienist members, other than the dental hygiene educator member or the registered dental hygienist member licensed in alternative practice or in extended functions, shall each serve a term of two years, expiring January 1, 2014.

(c) Notwithstanding any other provision of law and subject to subdivision (e), the Governor may appoint to the dental hygiene board a person who previously served as a member of the former committee or dental hygiene board even if the person's previous term expired.

(d) The dental hygiene board shall elect a president, a vice president, and a secretary from its membership.

(e) No person shall serve as a member of the dental hygiene board for more than two consecutive terms.

(f) A vacancy in the dental hygiene board shall be filled by appointment to the unexpired term.

(g) Each member of the dental hygiene board shall receive a per diem and expenses as provided in Section 103.

(h) Each appointing authority shall have the power to remove from office at any time any member of the board appointed by that authority pursuant to Section 106.

(i) The dental hygiene board, with the approval of the director, may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the dental hygiene board and vested in the executive officer by this article.

(j) This section shall remain in effect only until January 1, 2028, and as of that date is repealed.

SEC. 6. Section 1905.2 of the Business and Professions Code is amended to read:

1905.2. Recommendations by the dental hygiene board regarding scope of practice issues, as specified in paragraph (8) of subdivision (a) of Section 1905, shall be approved, modified, or rejected by the dental board within 90 days of submission of the recommendation to the dental board. If the dental board rejects or significantly modifies the intent or scope of the recommendation, the dental hygiene board may request that the dental board provide its reasons in writing for rejecting or significantly modifying the recommendation, which shall be provided by the dental board within 30 days of the request.

SEC. 7. Section 1910.5 of the Business and Professions Code is amended to read:

1910.5. (a) In addition to the duties specified in Section 1910, a registered dental hygienist is authorized to perform the following additional duties, as specified:

(1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental hygienist shall follow protocols established by the supervising dentist. This paragraph only applies in the following settings:

(A) In a dental office setting.

(B) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft

material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting.

(ii) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(b) The functions described in subdivision (a) may be performed by a registered dental hygienist only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the dental hygiene board, of having completed a dental hygiene board-approved course in those functions.

(c) No later than January 1, 2018, the dental hygiene board shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental hygienist and registered dental hygienist in alternative practice pursuant to Sections 1910.5 and 1926.05, using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Department of Health Care Access and Information. The dental hygiene board shall use the curriculum submitted by the dental board pursuant to Section 1753.55 to adopt regulatory language for approval of courses of instruction for the interim therapeutic restoration. Any subsequent amendments to the regulations for the interim therapeutic restoration curriculum that are promulgated by the dental hygiene board shall be agreed upon by the dental board and the dental hygiene board.

(d) This section shall become operative on January 1, 2018.

SEC. 8. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The dental hygiene board shall establish by resolution the amount of the fees that relate to the licensing of a registered

dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by dental hygiene board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the dental hygiene board. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for issuance of an original license shall not exceed two hundred fifty dollars ($250).

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(5) The biennial renewal fee shall not exceed five hundred dollars ($500).

(6) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(7) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater.

(8) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(9) The fee for each curriculum review and feasibility study review for educational programs for dental hygienists who are not accredited by a dental hygiene board-approved agency shall not exceed two thousand one hundred dollars ($2,100).

(10) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars ($750).

(11) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars ($500).

(12) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(13) The fee for the dental hygiene board to conduct a site visit to educational programs for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions to ensure compliance of educational program requirements shall not exceed the actual cost incurred by the dental hygiene board for cost recovery of site visit expenditures.

(14) The fee for a retired license shall not exceed one-half of the current license renewal fee.

(b) The renewal and delinquency fees shall be fixed by the dental hygiene board by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars ($5).

(c) Fees fixed by the dental hygiene board by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the dental hygiene board and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund, upon appropriation by the Legislature in the annual Budget Act, shall be used to implement this article.

(e) No fees or charges other than those listed in this section shall be levied by the dental hygiene board in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars ($250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars ($150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars ($250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars ($250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars ($250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(*l*) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out this article.

SEC. 9. Section 2538.3 of the Business and Professions Code is amended to read:

2538.3. A person applying for approval as a speech-language pathology assistant shall have graduated from a speech-language pathology assistant associate degree program, or equivalent course of study, approved by the board. A person who has successfully graduated from a board-approved bachelor's degree program in speech-language pathology or communication disorders shall be deemed to have satisfied an equivalent course of study.

SEC. 10. Section 2538.10 of the Business and Professions Code is amended to read:

2538.10. For the purposes of this article, the following definitions shall apply:

(a) "Advertise" and its variants include the use of a newspaper, magazine, or other publication, book, notice, circular, pamphlet, letter, handbill, poster, bill, sign, placard, card, label, tag, window display, store sign, radio, or television announcement, or any other means or methods now or hereafter employed to bring to the attention of the public the practice of fitting or selling of hearing aids.

(b) "License" means a hearing aid dispenser license issued pursuant to this article and includes a temporary or trainee license.

(c) "Licensee" means a person holding a license.

(d) "Hearing aid" means any wearable instrument or device designed for, or offered for the purpose of, aiding or compensating for impaired human hearing.

(e) "Fund" means the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Fund.

SEC. 11. Section 2538.25 of the Business and Professions Code is amended to read:

2538.25. (a) The board shall prepare, approve, grade, and conduct examinations of applicants for a hearing aid dispenser license. The board may provide that the preparation and grading of the examination be conducted by a competent person or organization other than the board, provided, however, that the board shall establish the guidelines for the examination and shall approve the actual examination.

(b) Each applicant shall take and pass a written examination and a practical examination compiled at the direction of the board covering the critical tasks involved in the practice of fitting and selling hearing aids and the knowledge, skills, and abilities needed to perform those tasks safely and competently.

SEC. 12. Section 2538.27 of the Business and Professions Code is amended to read:

2538.27. (a) An applicant who has fulfilled the requirements of Section 2538.24 and has made application therefor, may have a temporary license issued to them upon satisfactory proof to the board that the applicant holds a hearing aid dispenser license in another state, that the licensee has not been subject to formal disciplinary action by another licensing authority, and that the applicant has been engaged in the fitting and sale of hearing aids for the two years immediately prior to application.

(b) A temporary license issued pursuant to this section shall be valid for one year from date of issuance and is not renewable. A temporary license shall automatically terminate upon issuance of a license prior to expiration of the one-year period.

(c) The holder of a temporary license issued pursuant to this section who fails either license examination shall be subject to and shall comply with the supervision requirements of Section 2538.28 and any regulations adopted pursuant thereto.

SEC. 13. Section 2539.1 of the Business and Professions Code is amended to read:

2539.1. (a) (1) On and after January 1, 2010, in addition to satisfying the licensure and examination requirements described in Sections 2532, 2532.2, and 2532.25, no licensed audiologist shall sell hearing aids unless they complete an application for a dispensing audiology license, pay all applicable fees, and pass an

examination, approved by the board, relating to selling hearing aids.

(2) The board shall issue a dispensing audiology license to a licensed audiologist who meets the requirements of paragraph (1).

(b) (1) On and after January 1, 2010, a licensed audiologist with an unexpired license to sell hearing aids pursuant to Article 8 (commencing with Section 2538.10) may continue to sell hearing aids pursuant to that license until that license expires pursuant to Section 2538.53, and upon that expiration the licensee shall be deemed to have satisfied the requirements described in subdivision (a) and may continue to sell hearing aids pursuant to their audiology license subject to this chapter. Upon the expiration of the audiologist's license to sell hearing aids, the board shall issue them a dispensing audiology license pursuant to paragraph (2) of subdivision (a). This paragraph shall not prevent an audiologist who also has a hearing aid dispenser license from maintaining dual or separate licenses if they choose to do so.

(2) A licensed audiologist whose license to sell hearing aids, issued pursuant to Article 8 (commencing with Section 2538.10), is suspended, surrendered, or revoked shall not be authorized to sell hearing aids pursuant to this subdivision and they shall be subject to the requirements described in subdivision (a) and the other provisions of this chapter.

(c) A licensed hearing aid dispenser who meets the qualifications for licensure as an audiologist shall be deemed to have satisfied the requirements of paragraph (1) of subdivision (a) for the purposes of obtaining a dispensing audiology license.

(d) For purposes of subdivision (a), the board shall provide the hearing aid dispenser examination provided by the former Hearing Aid Dispensers Bureau until the next examination validation and occupational analysis is completed by the Department of Consumer Affairs pursuant to Section 139 and a determination is made that a different examination is to be administered.

SEC. 14. Section 2736 of the Business and Professions Code is amended to read:

2736. (a) An applicant for licensure as a registered nurse shall comply with each of the following:

(1) Have completed general preliminary education requirements as shall be determined by the board.

(2) Have successfully completed the courses of instruction prescribed by the board for licensure, in a program in this state approved by the board for training registered nurses, or have successfully completed courses of instruction in a school of nursing outside of this state that, in the opinion of the board at the time the application is filed with the board, are equivalent to the minimum requirements of the board for licensure established for an approved program in this state.

(3) Not be subject to denial of licensure under Section 480.

(b) An applicant who has received their training from a school of nursing in a country outside the United States and who has complied with subdivision (a), or has completed training equivalent to that required by subdivision (a), shall qualify for licensure by successfully passing the examination prescribed by the board.

SEC. 15. Section 2816 of the Business and Professions Code is amended to read:

2816. The nonrefundable fee to be paid by a registered nurse for an evaluation of their qualifications to use the title "public health nurse" shall not be more than one thousand dollars ($1,000). The fee to be paid upon the application for renewal of the certificate to practice as a public health nurse shall not be more than five hundred dollars ($500). The penalty fee for failure to renew a certificate to practice as a public health nurse within the prescribed time shall be 50 percent of the renewal fee in effect on the date of renewal of the certificate, but not more than two hundred fifty dollars ($250). All fees payable under this section shall be collected by and paid to the Board of Registered Nursing Fund. It is the intention of the Legislature that the costs of carrying out the purposes of this article shall be covered by the revenue collected pursuant to this section. The board shall refund any registered nurse who paid more than three hundred dollars ($300) for an evaluation of their qualifications to use the title "public health nurse" between April 5, 2018, and December 31, 2018.

SEC. 16. Section 3503 of the Business and Professions Code is amended to read:

3503. No person other than one who has been licensed to practice as a physician assistant shall practice as a physician assistant or in a similar capacity to a physician and surgeon or podiatrist or hold themselves out as a "physician assistant," or

shall use any other term indicating or implying that they are a physician assistant.

SEC. 17. Section 3526 of the Business and Professions Code is amended to read:

3526. A person who fails to renew their license or approval within five years after its expiration may not renew it, and it may not be reissued, reinstated, or restored after that time has elapsed, but that person may apply for and obtain a new license or approval if they:

(a) Have not committed any acts or crimes constituting grounds for denial of licensure under Division 1.5 (commencing with Section 475).

(b) Take and pass the examination, if any, that would be required of them if application for licensure was being made for the first time, or otherwise establishes to the satisfaction of the board that, with due regard for the public interest, they are qualified to practice as a physician assistant.

(c) Pay all of the fees that would be required as if application for licensure was being made for the first time.

SEC. 18. Section 3531 of the Business and Professions Code is amended to read:

3531. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge of a felony or of any offense that is substantially related to the qualifications, functions, or duties of the business or profession to which the license was issued is deemed to be a conviction within the meaning of this chapter. The board may order the license suspended or revoked, or shall decline to issue a license 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 a subsequent order under Section 1203.4 of the Penal Code allowing that person to withdraw their 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.

SEC. 19. Section 3534.4 of the Business and Professions Code is amended to read:

3534.4. (a) Criteria for acceptance into the diversion program shall include all of the following:

(1) The applicant shall be licensed as a physician assistant by the board and shall be a resident of California.

(2) The applicant shall be found to abuse dangerous drugs or alcoholic beverages in a manner that may affect their ability to practice medicine safely or competently.

(3) The applicant shall have voluntarily requested admission to the program or shall be accepted into the program in accordance with terms and conditions resulting from a disciplinary action.

(4) The applicant shall agree to undertake any medical or psychiatric examination ordered to evaluate the applicant for participation in the program.

(5) The applicant shall cooperate with the program by providing medical information, disclosure authorizations, and releases of liability as may be necessary for participation in the program.

(6) The applicant shall agree in writing to cooperate with all elements of the treatment program designed for them.

(b) An applicant may be denied participation in the program if the board, the program manager, or a committee determines that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety, or welfare.

SEC. 20. Section 3534.5 of the Business and Professions Code is amended to read:

3534.5. (a) A participant may be terminated from the program for any of the following reasons:

(1) The participant has successfully completed the treatment program.

(2) The participant has failed to comply with the treatment program designated for them.

(3) The participant fails to meet any of the criteria set forth in paragraph (4).

(4) It is determined that the participant has not substantially benefited from participation in the program or that their continued participation in the program creates too great a risk to the public health, safety, or welfare.

(b) Whenever an applicant is denied participation in the program or a participant is terminated from the program for any reason other than the successful completion of the program, and it is determined that the continued practice of medicine by that individual creates too great a risk to the public health and safety,

that fact shall be reported to the executive officer of the board and all documents and information pertaining to and supporting that conclusion shall be provided to the executive officer. The matter may be referred for investigation and disciplinary action by the board.

(c) Each physician assistant who requests participation in a diversion program shall agree to cooperate with the recovery program designed for them. Any failure to comply with that program may result in termination of participation in the program.

(d) The board shall inform each participant in the program of the procedures followed in the program, of the rights and responsibilities of a physician assistant in the program, and the possible results of noncompliance with the program.

SEC. 21. Section 3545 of the Business and Professions Code is amended to read:

3545. The income of a physician assistant corporation attributable to professional services rendered while a shareholder is a disqualified person, as defined in Section 13401 of the Corporations Code, shall not in any manner accrue to the benefit of the shareholder or their shares in the physician assistant corporation.

SEC. 22. Section 3620 of the Business and Professions Code is amended to read:

3620. The board shall enforce and administer this chapter and shall be solely responsible for the implementation of this chapter.

SEC. 23. Section 3620.1 of the Business and Professions Code is amended to read:

3620.1. Protection of the public shall be the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

SEC. 24. Section 3621.5 of the Business and Professions Code is amended to read:

3621.5. The board shall meet at least two times each calendar year and shall conduct additional meetings in appropriate locations that are necessary to transact its business.

SEC. 25. Section 3622 of the Business and Professions Code is amended to read:

3622. (a) The board shall adopt regulations in order to carry out the purposes of this chapter.

(b) Unless contrary to this chapter, regulations adopted by the Bureau of Naturopathic Medicine and the Naturopathic Medicine Committee shall continue to apply to the board and its licensees.

SEC. 26. Section 3623 of the Business and Professions Code is amended to read:

3623. (a) The board shall approve a naturopathic medical education program accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession that has the following minimum requirements:

(1) Admission requirements that include a minimum of three-quarters of the credits required for a bachelor's degree from a regionally accredited or preaccredited college or university or the equivalency, as determined by the council.

(2) Program requirements for its degree or diploma of a minimum of 4,100 total hours in basic and clinical sciences, naturopathic philosophy, naturopathic modalities, and naturopathic medicine. Of the total requisite hours, not less than 2,500 hours shall consist of academic instruction, and not less than 1,200 hours shall consist of supervised clinical training approved by the naturopathic medical school.

(b) A naturopathic medical education program in the United States shall offer graduate-level full-time studies and training leading to the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program shall be an institution, or part of an institution of, higher education that is either accredited or is a candidate for accreditation by a regional institutional accrediting agency recognized by the United States Secretary of Education and the Council on Naturopathic Medical Education, or an equivalent federally recognized accrediting body for naturopathic doctor education.

(c) To qualify as an approved naturopathic medical school, a naturopathic medical program located in Canada or the United States shall offer a full-time, doctoral-level, naturopathic medical education program with its graduates being eligible to apply to the board for licensure and to the North American Board of Naturopathic Examiners that administers the naturopathic licensing examination.

(d) The naturopathic medical program shall evaluate an applicant's education, training, and experience obtained in the armed services, pursuant to Section 35, and provide course credit where applicable.

SEC. 27. Section 3624 of the Business and Professions Code is amended to read:

3624. (a) The board may grant a certificate of registration to practice naturopathic medicine to a person who does not hold a naturopathic doctor's license under this chapter and is offered a faculty position by the dean of a naturopathic medical education program approved by the board, if all of the following requirements are met to the satisfaction of the board:

(1) The applicant submits an application on a form prescribed by the board.

(2) The dean of the naturopathic medical education program demonstrates that the applicant has the requisite qualifications to assume the position to which they are to be appointed.

(3) The dean of the naturopathic medical education program certifies in writing to the board that the applicant will be under their direction and will not be permitted to practice naturopathic medicine unless incident to and a necessary part of the applicant's duties as approved by the board.

(b) The holder of a certificate of registration issued under this section shall not receive compensation for, or practice, naturopathic medicine unless it is incidental to and a necessary part of the applicant's duties in connection with the holder's faculty position.

(c) A certificate of registration issued under this section is valid for two years.

SEC. 28. Section 3627 of the Business and Professions Code is amended to read:

3627. (a) The board shall establish a naturopathic formulary advisory subcommittee to determine a naturopathic formulary based upon a review of naturopathic medical education and training.

(b) The naturopathic formulary advisory subcommittee shall be composed of an equal number of representatives from the clinical and academic settings of physicians and surgeons, pharmacists, and naturopathic doctors.

(c) The naturopathic formulary advisory subcommittee shall review naturopathic education, training, and practice and make

specific recommendations regarding the prescribing, ordering, and furnishing authority of a naturopathic doctor and the required supervision and protocols for those functions.

SEC. 29. Section 3630 of the Business and Professions Code is amended to read:

3630. An applicant for a license as a naturopathic doctor shall file an application with the board on a form provided by the board that shows, to the board's satisfaction, compliance with all of the following requirements:

(a) The applicant has not committed an act or crime that constitutes grounds for denial of a license under Section 480 and has complied with the requirements of Section 144.

(b) The applicant has received a degree in naturopathic medicine from an approved naturopathic medical school where the degree substantially meets the educational requirements in paragraph (2) of subdivision (a) of Section 3623.

SEC. 30. Section 3633 of the Business and Professions Code is amended to read:

3633. The board may grant a license to an applicant who is licensed and in good standing as a naturopathic doctor in another state, jurisdiction, or territory in the United States, if the applicant has met the requirements of Sections 3630 and 3631.

SEC. 31. Section 3633.1 of the Business and Professions Code is amended to read:

3633.1. The board may grant a license to an applicant who meets the requirements of Section 3630, but who graduated before 1986, before the Naturopathic Physicians Licensing Examinations, or NPLEX, and passed a state or Canadian Province naturopathic licensing examination. Applications under this section shall be received no later than December 31, 2007.

SEC. 32. Section 3634 of the Business and Professions Code is amended to read:

3634. A license issued under this chapter shall be subject to renewal biennially, as prescribed by the board, and shall expire unless renewed in that manner. The board may provide by regulation for the late renewal of a license.

SEC. 33. Section 3636 of the Business and Professions Code is amended to read:

3636. (a) Upon a written request, the board may grant inactive status to a naturopathic doctor who is in good standing and who meets the requirements of Section 462.

(b) A person whose license is in inactive status may not engage in any activity for which a license is required under this chapter.

(c) A person whose license is in inactive status shall be exempt from continuing education requirements while their license is in that status.

(d) To restore a license to active status, a person whose license is in inactive status shall fulfill continuing education requirements for the two-year period before reactivation and be current with all licensing fees as determined by the board.

SEC. 34. 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 naturopathic training as determined by the board, 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, and 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.

(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 board may establish regulations regarding ocular or intravenous routes of administration that are consistent with the education and training of a naturopathic doctor.

(f) Nothing in this section shall 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. 35. Section 3640.2 of the Business and Professions Code is amended to read:

3640.2. Notwithstanding any other provision of law, a naturopathic assistant may do all of the following:

(a) Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical support services upon the specific authorization and supervision of a licensed naturopathic doctor. A naturopathic assistant may also perform all these tasks and services in a clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code upon the specific authorization of a naturopathic doctor.

(b) Perform venipuncture or skin puncture for the purposes of withdrawing blood upon specific authorization and under the supervision of a licensed naturopathic doctor if prior thereto the naturopathic assistant has met the educational and training requirements for medical assistants as established in Section 2070. A copy of any related certificates shall be retained as a record by each employer of the assistant.

(c) Perform the following naturopathic technical support services:

(1) Administer medications orally, sublingually, topically, vaginally, or rectally, or by providing a single dose to a patient for immediate self-administration. Administer medication by inhalation if the medications are patient-specific and have been or will be

repetitively administered to the patient. In every instance, prior to administration of medication by the naturopathic assistant, the naturopathic doctor shall verify the correct medication and dosage.

(2) Apply and remove bandages.

(3) Collect by noninvasive techniques and preserve specimens for testing, including urine, sputum, semen, and stool.

(4) Assist patients to and from a patient examination room or examination table.

(5) As authorized by the naturopathic doctor, provide patient information and instructions.

(6) Collect and record patient data, including height, weight, temperature, pulse, respiration rate, and blood pressure, and basic information about the presenting and previous conditions.

(7) Perform simple laboratory and screening tests customarily performed in a medical office.

(d) Perform additional naturopathic technical support services under the regulations and standards established by the board. The board, before the adoption of any regulations, shall request recommendations regarding these standards from appropriate public agencies, including, but not limited to, the Osteopathic Medical Board of California, the Medical Board of California, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the Laboratory Field Services division of the State Department of Public Health, and the Physical Therapy Board of California. The California Board of Naturopathic Medicine shall also request recommendations regarding these standards from associations of medical assistants, physicians, and others, as appropriate, including, but not limited to, the Osteopathic Physicians and Surgeons of California, the California Medical Association, the California Society of Medical Assistants, and the California Medical Assistants' Association. Nothing in this subdivision shall be construed to supersede or modify that portion of the Administrative Procedure Act that relates to the procedure for the adoption of regulations set forth in Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 36. Section 3640.3 of the Business and Professions Code is amended to read:

3640.3. (a) Nothing in this chapter shall be construed as authorizing the licensure of naturopathic assistants. Nothing in this chapter shall be construed as authorizing the administration of local anesthetic agents by a naturopathic assistant. Nothing in this chapter shall be construed as authorizing the California Board of Naturopathic Medicine to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(b) Nothing in this chapter shall be construed as authorizing a naturopathic assistant to perform any clinical laboratory test or examination for which they are not authorized under Chapter 3 (commencing with Section 1200).

(c) Notwithstanding any other law, a naturopathic assistant may not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

SEC. 37. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. Nothing in this chapter or any other law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when all of the following apply:

(a) The drugs are furnished or ordered by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and their supervising physician and surgeon.

(b) The naturopathic doctor is functioning pursuant to standardized procedure, as defined by subdivisions (a), (b), (d), (e), (h), and (i) of Section 2836.1 and paragraph (1) of subdivision (c) of Section 2836.1, 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 their designee.

(c) The standardized procedure or protocol covering the furnishing of drugs shall specify which naturopathic doctors may furnish or order drugs, which drugs may be furnished or ordered under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the naturopathic doctor's competence, including peer review, and review of the standardized procedure.

(d) The furnishing or ordering of drugs by a naturopathic doctor occurs 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.

(e) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(f) Drugs furnished or ordered by a naturopathic doctor may include Schedule III through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are furnished or ordered by a naturopathic doctor, the controlled substances shall be furnished or ordered 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 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) The board has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this subdivision.

(h) 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:

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(i) 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.

(j) Notwithstanding any other law, the following apply:

(1) A 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.

SEC. 38. Section 3640.8 of the Business and Professions Code is amended to read:

3640.8. (a) To qualify to administer intravenous (IV) therapy in their practice pursuant to Section 3640.7, a naturopathic doctor shall demonstrate that they have complied with both of the following requirements:

(1) Have a current naturopathic doctor's license in this state.

(2) Have completed a qualifying course on IV therapy from a course provider approved by the board.

(b) The qualifying course shall consist of a minimum of 25 classroom hours on IV administration through injection of applicable naturopathic formulary substances, of which at least 14 classroom hours shall be identified as practicum. At a minimum, the qualifying course shall have covered all of the following topics:

(1) Evaluation of laboratory results, including, but not limited to, the fluid status, cardiovascular status, and kidney function of the patient.

(2) The use of IV fluids, including, but not limited to, osmolarity calculations, diluents, and admixtures pertinent to IV therapeutics.

(3) Sterile techniques and admixing.

(4) Vein and site selection, site preparation, and insertion techniques.

(5) Complications with therapies, nutrient and drug interactions, errors and adverse reactions, reporting errors to appropriate agencies, error prevention, and followup with patient complications.

(6) Emergency protocols, management, and referral.

(7) Pharmacology, indications, preparation, and IV administration of vitamins, minerals, amino acids, glutathione, botanicals and their extracts, homeopathic medicines, electrolytes, sugars, and diluents.

(8) Practicum, including, but not limited to, the following:

(A) Observation of at least 10 IV setups, including administration and management.

(B) Successful completion of at least 10 IV setups, including administration and management.

(9) Successful completion of an examination with 70 percent or greater correct answers to a minimum of 50 questions, where 10 percent or more of the questions have direct content to the California formulary.

(c) For the purposes of the qualifying course required by this section, one classroom hour is defined as 50 minutes out of each 60-minute segment and may include time devoted to examinations. No credit shall be granted for distance education, including, but not limited to, correspondence courses, internet courses, or video or remote television offerings.

(d) Pursuant to subdivision (e) of Section 3640, the board may establish regulations regarding IV administration that are consistent with the education and training of a naturopathic doctor.

SEC. 39. Section 3641 of the Business and Professions Code is amended to read:

3641. (a) A naturopathic doctor shall document their observations, diagnosis, and summary of treatment in the patient record. Patient records shall be maintained for a period of not less than seven years following the discharge of the patient. The records of an unemancipated minor shall be maintained until at least one year after the minor has reached 18 years of age or seven years following the discharge of the minor, whichever is longer.

(b) A naturopathic doctor shall have the same authority and responsibility as a licensed physician and surgeon with regard to public health laws, including laws governing reportable diseases and conditions, communicable disease control and prevention, recording vital statistics, and performing health and physical examinations consistent with their education and training.

SEC. 40. Section 3644 of the Business and Professions Code is amended to read:

3644. This chapter does not prevent or restrict the practice, services, or activities of any of the following:

(a) A person licensed, certified, or otherwise recognized in this state by any other law or regulation if that person is engaged in the profession or occupation for which they are licensed, certified, or otherwise recognized.

(b) A person employed by the federal government in the practice of naturopathic medicine while the person is engaged in the performance of duties prescribed by laws and regulations of the United States.

(c) A person rendering aid to a family member or in an emergency, if no fee or other consideration for the service is charged, received, expected, or contemplated.

(d) (1) A person who makes recommendations regarding or is engaged in the sale of food, extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and their extracts, botanical medicines, homeopathic medicines, dietary supplements, and nonprescription drugs or other products of nature, the sale of which is not otherwise prohibited under state or federal law.

(2) An unlicensed person described in this subdivision may represent that they "practice naturopathy" if they comply with Section 2053.6. However, an unlicensed person may not use the title "naturopathic doctor" unless they have been issued a license by the board.

(e) A person engaged in good faith in the practice of the religious tenets of any church or religious belief without using prescription drugs.

(f) A person acting in good faith for religious reasons as a matter of conscience or based on a personal belief, while obtaining or providing information regarding health care and the use of any product described in subdivision (d).

(g) A person who provides the following recommendations regarding the human body and its function:

(1) Nonprescription products.

(2) Natural elements such as air, heat, water, and light.

(3) Class I or class II nonprescription, approved medical devices, as defined in Section 360c of Title 21 of the United States Code.

(4) Vitamins, minerals, herbs, homeopathics, natural food products and their extracts, and nutritional supplements.

(h) A person who is licensed in another state, territory, or the District of Columbia to practice naturopathic medicine if the person is incidentally called into this state for consultation with a naturopathic doctor.

(i) A student enrolled in an approved naturopathic medical program whose services are performed pursuant to a course of instruction under the supervision of a naturopathic doctor.

SEC. 41. Section 3650 of the Business and Professions Code is amended to read:

3650. A naturopathic doctor may perform naturopathic childbirth attendance if they have completed additional training and have been granted a certificate of specialty practice by the board.

SEC. 42. Section 3651.5 of the Business and Professions Code is amended to read:

3651.5. A naturopathic doctor certified for the specialty practice of naturopathic childbirth attendance shall do both of the following:

(a) Maintain current certification in neonatal resuscitation and cardiopulmonary resuscitation.

(b) File with the board a written plan for the following:

(1) Consultation with other health care providers.

(2) Supervision by 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. The plan shall provide that all complications shall be referred to a physician and surgeon immediately.

(3) Emergency transfer and transport of an infant or a maternity patient, or both, to an appropriate health care facility, and access to neonatal intensive care units and obstetrical units or other patient care areas.

SEC. 43. Section 3652 of the Business and Professions Code is amended to read:

3652. (a) A certificate of specialty practice in naturopathic childbirth attendance shall expire concurrently with the licensee's naturopathic doctor's license.

(b) The certificate may be renewed upon submission of the renewal fee set by the board and evidence, to the board's satisfaction, of the completion of 30 hours of continuing education credits in naturopathic childbirth, midwifery, or obstetrics. Fifteen

hours may be applied to the 60 hours of continuing education required for naturopathic doctors.

(c) Licensing or disciplinary action by the board or a judicial authority shall be deemed to have an equal effect upon the specialty certificate to practice naturopathic childbirth issued to a licensee, unless otherwise specified in the licensing or disciplinary action. When the subject of a licensing or disciplinary action relates specifically to the practice of naturopathic childbirth by a licensee holding a specialty certificate, the action may, instead of affecting the entire scope of the licensee's practice, suspend, revoke, condition, or restrict only the licensee's authority under the specialty certificate.

SEC. 44. Section 3660 of the Business and Professions Code is amended to read:

3660. Except as provided in subdivision (h) of Section 3644, a person shall have a valid, unrevoked, or unsuspended license issued under this chapter to do any of the following:

(a) To claim to be a naturopathic doctor, licensed naturopathic doctor, doctor of naturopathic medicine, doctor of naturopathy, or naturopathic medical doctor.

(b) To use the professional designation "N.D." or other titles, words, letters, or symbols with the intent to represent that they practice, are authorized to practice, or are able to practice naturopathic medicine as a naturopathic doctor.

SEC. 45. Section 3661 of the Business and Professions Code is amended to read:

3661. A naturopathic doctor who uses the term or designation "Dr." shall further identify themselves as "Naturopathic Doctor," "Licensed Naturopathic Doctor," "Doctor of Naturopathic Medicine," or "Doctor of Naturopathy" and shall not use any term or designation that would tend to indicate the practice of medicine, other than naturopathic medicine, unless otherwise licensed as a physician and surgeon, osteopathic doctor, or doctor of chiropractic.

SEC. 46. Section 3663 of the Business and Professions Code is amended to read:

3663. (a) The board shall have the responsibility for reviewing the quality of the practice of naturopathic medicine carried out by persons licensed as naturopathic doctors pursuant to this chapter.

(b) The board may discipline a naturopathic doctor for unprofessional conduct. After a hearing conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), the board may deny, suspend, revoke, or place on probation the license of, or reprimand, censure, or otherwise discipline a naturopathic doctor in accordance with Division 1.5 (commencing with Section 475).

SEC. 47. Section 3663.5 of the Business and Professions Code is amended to read:

3663.5. (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet website, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet website.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) A violation of this section shall not be punishable as a crime.

SEC. 48. Section 3670 of the Business and Professions Code is amended to read:

3670. A naturopathic corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, if the corporation and its shareholders, officers, directors, and employees rendering professional services who are naturopathic doctors are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this chapter, and all other statutes and regulations now or hereafter enacted or adopted pertaining to that corporation and the conduct of its affairs. With respect to a naturopathic corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the board.

SEC. 49. Section 3672 of the Business and Professions Code is amended to read:

3672. The income of a naturopathic corporation attributable to professional services rendered while a shareholder is a disqualified person, as defined in Section 13401 of the Corporations Code, shall not in any manner accrue to the benefit of the shareholder or their shares in the naturopathic corporation.

SEC. 50. Section 3675 of the Business and Professions Code is amended to read:

3675. The board may adopt and enforce regulations to carry out the purposes and objectives of this article, including, but not limited to, regulations requiring the following:

(a) That the bylaws of a naturopathic corporation include a provision whereby the capital stock of the corporation owned by a disqualified person, as defined in Section 13401 of the Corporations Code, or a deceased person, shall be sold to the corporation or to the remaining shareholders of the corporation within any time as the regulations may provide.

(b) That a naturopathic corporation shall provide adequate security by insurance or otherwise for claims against it by its patients arising out of the rendering of professional services.

SEC. 51. Section 3681 of the Business and Professions Code is amended to read:

3681. All fees collected by the board shall be paid into the State Treasury and shall be credited to the Naturopathic Doctor's Fund which is hereby created in the State Treasury. The money in the fund shall be available to the board for expenditure for the purposes of this chapter only upon appropriation by the Legislature.

SEC. 52. Section 3685 of the Business and Professions Code is amended to read:

3685. Notwithstanding any other law, the repeal of this chapter renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 53. Section 4175 of the Business and Professions Code is amended to read:

4175. (a) The California State Board of Pharmacy shall promptly forward to the appropriate licensing entity, including the Medical Board of California, the California Veterinary Medical Board, the Dental Board of California, the California State Board of Optometry, the Podiatric Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the California Board of Naturopathic Medicine, or the Physician Assistant Board, all complaints received related to dangerous drugs or dangerous devices dispensed by a prescriber, certified nurse-midwife, nurse practitioner, naturopathic doctor, or physician assistant pursuant to Section 4170.

(b) All complaints involving serious bodily injury due to dangerous drugs or dangerous devices dispensed by prescribers, certified nurse-midwives, nurse practitioners, naturopathic doctors, or physician assistants pursuant to Section 4170 shall be handled by the Medical Board of California, the Dental Board of California, the California State Board of Optometry, the Podiatric Medical Board of California, the Osteopathic Medical Board of California, the California Board of Naturopathic Medicine, the Board of Registered Nursing, the California Veterinary Medical Board, or the Physician Assistant Board as a case of greatest potential harm to a patient.

SEC. 54. Section 4800 of the Business and Professions Code is amended to read:

4800. (a) There is in the Department of Consumer Affairs a California Veterinary Medical Board in which the administration of this chapter is vested. The board shall consist of the following eight members:

(1) Four licensed veterinarians.

(2) One registered veterinary technician.

(3) Three public members.

(b) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

(c) Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature. However, the review of the board shall be limited to those issues identified by the appropriate policy committees of the Legislature and shall involve the preparation or submission of a sunset review document or evaluative questionnaire.

SEC. 55. Section 4800.1 of the Business and Professions Code is amended to read:

4800.1. Protection of the public shall be the highest priority for the California Veterinary Medical Board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

SEC. 56. Section 4809.6 of the Business and Professions Code is amended to read:

4809.6. The enforcement of Sections 4809.5 and 4854 of this chapter is a function exclusively reserved to the California

Veterinary Medical Board and the state has preempted and occupied this field of enforcing the cleanliness and sanitary requirements of this chapter.

SEC. 57. Section 4810 of the Business and Professions Code is amended to read:

4810. As used in this chapter:

(a) "Board" means the California Veterinary Medical Board.

(b) "Multidisciplinary committee" means the Veterinary Medicine Multidisciplinary Advisory Committee established pursuant to Section 4809.8.

(c) "Regulations" means the rules and regulations set forth in Division 20 (commencing with Section 2000) of Title 16 of the California Code of Regulations.

SEC. 58. Section 4811 of the Business and Professions Code is amended to read:

4811. This chapter shall be known and may be cited as the "California Veterinary Medicine Practice Act."

SEC. 59. Section 4826.7 of the Business and Professions Code is amended to read:

4826.7. (a) For purposes of this section, "veterinarian" means a California licensed veterinarian.

(b) A veterinarian may authorize a registered veterinary technician to act as an agent of the veterinarian for the purpose of establishing the veterinarian-client-patient relationship to administer preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites if all of the following conditions are met:

(1) The registered veterinary technician administers preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites in a registered veterinary premises when the veterinarian is physically present at the registered veterinary premises.

(2) If working at a location other than a registered veterinary premises, the registered veterinary technician administers preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites when the veterinarian is in the general vicinity or available by telephone and is quickly and easily available. At this location, the registered veterinary technician shall have equipment and drugs necessary to provide immediate emergency care at a level

commensurate with the provision of preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites.

(3) The registered veterinary technician examines the animal patient and administers preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites in accordance with written protocols and procedures established by the veterinarian, which shall include, at a minimum, all of the following:

(A) Obtaining the animal patient's history from the client in order to reasonably ensure that the administration of preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites is appropriate.

(B) Data that must be collected by physical examination of the animal patient in order to reasonably ensure that the administration of preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites is appropriate.

(C) Information in the patient history or physical examination results that would preclude the administration of preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites.

(D) Criteria that would disqualify the animal patient from receiving the preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites.

(E) Vaccination protocols for each animal species for which preventive or prophylactic vaccines are administered, that include, at a minimum, handling and administration of vaccines in accordance with manufacturer label recommendations and what to do in the event of an adverse reaction or other emergency.

(F) Preventative procedures for parasite control for each animal species for which medications for the control or eradication of apparent or anticipated internal or external parasites are being administered, which shall include, at a minimum, handling and administration of medications in accordance with manufacturer label recommendations and what to do in the event of an adverse reaction or other emergency.

(G) Documentation of all of the following animal patient information:

(i) Name or initials of the person responsible for entries.

(ii) Name, address, and phone number of the client.

(iii) Name or identity of the animal, herd, or flock.

(iv) Except for herds or flocks, age, sex, breed, species, and color of the animal.

(v) Beginning and ending dates of custody of the animal, if applicable.

(vi) A history or pertinent information as it pertains to each animal, herd, or flock's medical status.

(vii) Data, including that obtained by instrumentation, from the physical examination.

(viii) Treatment and intended treatment plan, including medications, dosages, route of administration, and frequency of use.

(ix) Diagnosis or assessment before performing a treatment or procedure.

(x) If relevant, a prognosis of the animal's condition.

(xi) All medications and treatments prescribed and dispensed, including strength, dosage, route of administration, quantity, and frequency of use.

(4) The veterinarian and the registered veterinary technician sign and date a statement containing an assumption of risk by the veterinarian for all acts of the registered veterinary technician related to examining the animal patient and administering preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasite, short of willful acts of animal cruelty, gross negligence, or gross unprofessional conduct on behalf of the registered veterinary technician.

(5) The veterinarian and the registered veterinary technician sign and date a statement containing authorization for the registered veterinary technician to act as the agent of the veterinarian only to establish the veterinarian-client-patient relationship for purposes of administering preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites when acting in compliance with the protocols and procedures specified in paragraph (3), and only until the date

the veterinarian terminates authorization for the registered veterinary technician to act as the agent of the veterinarian.

(6) (A) Before the registered veterinary technician examines or administers any preventive or prophylactic vaccines or medications for the control or eradication of apparent or anticipated internal or external parasites to the animal patient, the registered veterinary technician informs the client ~~orally~~ *verbally* or in writing that the registered veterinary technician is acting as an agent of the veterinarian for purposes of administering to the animal patient preventive or prophylactic vaccines or medications, as applicable, and provides the veterinarian's name and license number to the client.

(B) After providing the disclosure specified in subparagraph (A), the registered veterinary technician records in the animal patient's medical record the ~~oral~~ *verbal* or written authorization of the client to proceed with the registered veterinary technician's examination of the animal patient and administration of the specified vaccine or medication.

(c) (1) Documentation relating to satisfaction of the requirements of paragraphs (4) and (5) of subdivision (b) shall be retained by the veterinarian for the duration of the registered veterinary technician's work as an agent of that veterinarian and until three years from the date of the termination of the veterinarian's relationship with the registered veterinary technician.

(2) Documentation relating to satisfaction of subparagraph (G) of paragraph (3) of subdivision (b) shall be retained by the veterinarian for a minimum of three years after the animal patient's last visit.

~~SEC. 59.~~

SEC. 60. Section 4836.1 of the Business and Professions Code is amended to read:

4836.1. (a) Notwithstanding any other law, a registered veterinary technician or a veterinary assistant may administer a drug, including, but not limited to, a drug that is a controlled substance, under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of a licensed veterinarian. However, no person, other than a licensed veterinarian, may induce anesthesia unless authorized by regulation of the California Veterinary Medical Board.

(b) A veterinary assistant may obtain or administer a controlled substance pursuant to the order, control, and full professional responsibility of a licensed veterinarian, only if they meet both of the following conditions:

(1) Is designated by a licensed veterinarian to obtain or administer controlled substances.

(2) Holds a valid veterinary assistant controlled substance permit issued pursuant to Section 4836.2.

(c) Notwithstanding subdivision (b), if the California Veterinary Medical Board, in consultation with the California State Board of Pharmacy, identifies a dangerous drug, as defined in Section 4022, as a drug that has an established pattern of being diverted, the California Veterinary Medical Board may restrict access to that drug by veterinary assistants.

(d) For purposes of this section, the following definitions apply:

(1) "Controlled substance" has the same meaning as that term is defined in Section 11007 of the Health and Safety Code.

(2) "Direct supervision" has the same meaning as that term is defined in subdivision (e) of Section 2034 of Title 16 of the California Code of Regulations.

(3) "Drug" has the same meaning as that term is defined in Section 11014 of the Health and Safety Code.

(4) "Indirect supervision" has the same meaning as that term is defined in subdivision (f) of Section 2034 of Title 16 of the California Code of Regulations.

(e) This section shall become operative on the date Section 4836.2 becomes operative.

~~SEC. 60.~~

SEC. 61. Section 4842.2 of the Business and Professions Code is amended to read:

4842.2. All funds collected by the board under this article shall be deposited in the California Veterinary Medical Board Contingent Fund.

~~SEC. 61.~~

SEC. 62. Section 4846 of the Business and Professions Code is amended to read:

4846. (a) In order to obtain a license to practice veterinary medicine in California, an individual shall meet the following requirements:

(1) Graduate from a veterinary college recognized by the board or receive a certificate from the Educational Commission for Foreign Veterinary Graduates (ECFVG) or the Program for the Assessment of Veterinary Education Equivalence (PAVE). Proof of graduation shall be directly submitted to the board by the veterinary college or from the American Association of Veterinary State Boards (AAVSB). Proof of certificate shall be directly submitted to the board by ECFVG or PAVE.

(2) Complete a board-approved license application.

(3) Pay the applicable fees specified in Section 4905.

(4) As directed by the board pursuant to Section 144, submit a full set of fingerprints for the purpose of conducting a criminal history record check and undergo a state and federal criminal offender record information search conducted through the Department of Justice, pursuant to subdivision (u) of Section 11105 of the Penal Code. The Department of Justice shall provide a state or federal response to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(5) Pass an examination consisting of the following:

(A) A licensing examination that is administered on a national basis. If the applicant passed the national licensing examination over five years from the date of submitting the California veterinarian license application, the applicant shall satisfy one of the following:

(i) Retake and pass the national licensing examination.

(ii) Submit proof of having practiced clinical veterinary medicine for a minimum of two years and completed a minimum of 2,500 hours of clinical practice in another state, Canadian province, or United States territory within the three years immediately preceding filing an application for licensure in this state.

(iii) Complete the minimum continuing education requirements of Section 4846.5 for the current and preceding year.

(B) A veterinary law examination administered by the board concerning the statutes and regulations of this chapter. The examination may be administered by regular mail, email, or by other electronic means. The applicant shall certify that the applicant personally completed the examination. Any false statement is a violation subject to Section 4831. Every applicant who obtains a score of at least 80 percent on the veterinary law examination shall be deemed to have passed. University of California and Western

University of Health Sciences veterinary medical students who have successfully completed a board-approved course on veterinary law and ethics covering this chapter shall be exempt from this subparagraph.

(b) The applicant shall disclose each state, Canadian province, or United States territory in which the applicant currently holds or has ever held a license to practice veterinary medicine. License verification, including any disciplinary or enforcement history, shall be confirmed through electronic means or direct submission from each state, Canadian province, or United States territory in which the applicant has identified the applicant holds or has ever held a license to practice veterinary medicine.

(c) A veterinarian license application shall be subject to denial pursuant to Sections 480, 4875, and 4883.

~~SEC. 62.~~

SEC. 63. Section 4848.1 of the Business and Professions Code is amended to read:

4848.1. (a) A veterinarian engaged in the practice of veterinary medicine, as defined in Section 4826, employed by the University of California and engaged in the performance of duties in connection with the School of Veterinary Medicine or employed by the Western University of Health Sciences and engaged in the performance of duties in connection with the College of Veterinary Medicine shall be issued a university license pursuant to this section or hold a license to practice veterinary medicine in this state.

(b) An individual may apply for and be issued a university license if all of the following are satisfied:

(1) The applicant is currently employed by the University of California or Western University of Health Sciences, as defined in subdivision (a).

(2) The applicant passes an examination concerning the statutes and regulations of this chapter, administered by the board, pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 4848.

(3) The applicant completes and submits the application specified by the board and pays the application and the initial license fee, pursuant to Section 4905.

(c) A university license:

(1) Shall automatically cease to be valid upon termination or cessation of employment by the University of California or by the Western University of Health Sciences.

(2) Shall be subject to the license renewal provisions in Section 4900 and the payment of the renewal fee pursuant to subdivision (g) of Section 4905.

(3) Shall be subject to denial, revocation, or suspension pursuant to Sections 480, 4875, and 4883.

(4) Authorizes the holder to practice veterinary medicine only at an educational institution described in subdivision (a) and any locations formally affiliated with those institutions.

(d) An individual who holds a university license is exempt from satisfying the license renewal requirements of Section 4846.5.

~~SEC. 63.~~

SEC. 64. Section 4857 of the Business and Professions Code is amended to read:

4857. (a) A veterinarian licensed under this chapter shall not disclose any information concerning an animal patient receiving veterinary services, the client responsible for the animal patient receiving veterinary services, or the veterinary care provided to an animal patient, except under any one of the following circumstances:

(1) Upon written or witnessed verbal authorization by knowing and informed consent of the client.

(2) Upon authorization received by electronic transmission when originated by the client.

(3) In response to a valid court order or subpoena.

(4) As may be required to ensure compliance with any federal, state, county, or city law or regulation, including, but not limited to, the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(5) If the care or service was for a horse that has participated in the previous year, or is intended to participate, in a licensed horse race. In these situations, the entire medical record for the horse shall be made available upon request to anyone responsible for the direct medical care of the horse, including the owner, trainer, or veterinarian, the California Horse Racing Board or any other state or local governmental entity, and the racing association or fair conducting the licensed horse race.

(6) As otherwise provided in this section.

(b) This section shall not apply to the extent that the client responsible for an animal patient or an authorized agent of the client responsible for the animal patient has filed or caused to be filed a civil or criminal complaint that places the veterinarian's care and treatment of the animal patient or the nature and extent of the injuries to the animal patient at issue, or when the veterinarian is acting to comply with federal, state, county, or city laws or regulations.

(c) A veterinarian shall be subject to the criminal penalties set forth in Section 4831 or any other provision of this code for a violation of this section. In addition, any veterinarian who negligently releases confidential information shall be liable in a civil action for any damages caused by the release of that information.

(d) Nothing in this section is intended to prevent the sharing of veterinary medical information between veterinarians and peace officers, humane society officers, or animal control officers who are acting to protect the welfare of animals.

(e) Nothing in this section is intended to prevent the sharing of veterinary medical information between veterinarians and facilities for the purpose of diagnosis or treatment of the animal patient that is the subject of the medical records.

~~SEC. 64.~~

SEC. 65. Section 4860 of the Business and Professions Code is amended to read:

4860. It is the intent of the Legislature that the board seek ways and means to identify and rehabilitate veterinarians and registered veterinary technicians with impairment due to abuse of dangerous drugs or alcohol, affecting competency so that veterinarians and registered veterinary technicians so afflicted may be treated and returned to the practice of veterinary medicine in a manner that will not endanger the public health and safety.

~~SEC. 65.~~

SEC. 66. Section 4875 of the Business and Professions Code is amended to read:

4875. The board may revoke or suspend for a certain time the license or registration of any person to practice veterinary medicine or any branch of veterinary medicine in this state after notice and hearing for any of the causes provided in this article. In addition to its authority to suspend or revoke a license or registration, the

board shall have the authority to assess a fine not in excess of five thousand dollars ($5,000) against a licensee or registrant for any of the causes specified in Section 4883. A fine may be assessed in lieu of or in addition to a suspension or revocation. The proceedings under this article 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 the powers granted in that chapter. Notwithstanding Section 4903, all fines collected pursuant to this section shall be deposited to the credit of the California Veterinary Medical Board Contingent Fund.

~~SEC. 66.~~

SEC. 67. Section 4886 of the Business and Professions Code is amended to read:

4886. In reinstating a license or registration that has been revoked or suspended under Section 4883, the board may impose terms and conditions to be followed by the licensee or registrant after the license or registration has been reinstated. The authority of the board to impose terms and conditions includes, but is not limited to, the following:

(a) Requiring the licensee or registrant to obtain additional professional training and to pass an examination upon completion of the training.

(b) Requiring the licensee or registrant to pass a verbal, written, practical, or clinical examination, or any combination of those examinations, to determine their present fitness to engage in the practice of veterinary medicine or to practice as a veterinary technician.

(c) Requiring the licensee or registrant to submit to a complete diagnostic examination by one or more physicians appointed by the board. If the board requires the licensee or registrant to submit to that examination, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians of the licensee’s or registrant’s choice.

(d) Restricting or limiting the extent, scope, or type of practice of the licensee or registrant.

~~SEC. 67.~~

SEC. 68. Section 4903 of the Business and Professions Code is amended to read:

4903. Of all fines or forfeitures of bail in any case where a person is charged with a violation of this chapter, 50 percent shall be paid upon collection by the proper officer of the court to the State Treasurer, to be deposited to the credit of the California Veterinary Medical Board Contingent Fund. The other 50 percent shall be paid as provided by law, for the payment of fines or forfeitures of bail in misdemeanor cases.

~~SEC. 68.~~

SEC. 69. Section 4904 of the Business and Professions Code is amended to read:

4904. All fees collected on behalf of the board and all receipts of every kind and nature shall be reported each month for the month preceding to the Controller and at the same time the entire amount shall be paid into the State Treasury and shall be credited to the California Veterinary Medical Board Contingent Fund. The California Veterinary Medical Board Contingent Fund shall be available, upon appropriation by the Legislature, for the use of the board.

~~SEC. 69.~~

SEC. 70. Section 4905 of the Business and Professions Code is amended to read:

4905. The following fees shall be collected by the board and shall be credited to the California Veterinary Medical Board Contingent Fund:

(a) The veterinarian license application fee shall be three hundred fifty dollars ($350).

(b) The California Veterinary Medicine Practice Act course fee shall be set by the board in an amount it determines reasonably necessary to provide sufficient funds to carry out the purpose of this chapter, not to exceed one hundred dollars ($100).

(c) The initial veterinarian license fee shall be set by the board not to exceed five hundred dollars ($500).

(d) The biennial veterinarian license renewal fee shall be five hundred dollars ($500).

(e) The university licensee application fee shall be three hundred fifty dollars ($350).

(f) The initial university license fee shall be five hundred dollars ($500).

(g) The biennial university licensee renewal fee shall be five hundred dollars ($500).

(h) The delinquency fee shall be fifty dollars ($50).

(i) The fee for issuance of a duplicate license, registration, or permit shall be twenty-five dollars ($25).

(j) Any charge made for duplication or other services shall be set at the cost of rendering the service, except as specified in subdivision (i).

(k) The fee for failure to report a change in the mailing address shall be twenty-five dollars ($25).

(*l*) The initial veterinary premises registration fee shall be five hundred dollars ($500) annually.

(m) The annual veterinary premises registration renewal fee shall be five hundred twenty-five dollars ($525).

(n) The registered veterinary technician application fee shall be two hundred twenty-five dollars ($225).

(o) The initial registered veterinary technician registration fee shall be two hundred twenty-five dollars ($225).

(p) The biennial registered veterinary technician renewal fee shall be two hundred twenty-five dollars ($225).

(q) The veterinary assistant controlled substance permit application fee shall be one hundred dollars ($100).

(r) The veterinary assistant controlled substance permit fee shall be one hundred dollars ($100).

(s) The biennial veterinary assistant controlled substance permit renewal fee shall be one hundred dollars ($100).

(t) The veterinary assistant controlled substance permit delinquency fee shall be 50 percent of the renewal fee for such permit in effect on the date of the renewal of the permit, but shall not be less than twenty-five dollars ($25) nor more than one hundred fifty dollars ($150).

(u) The fee for filing an application for approval of a school or institution offering a curriculum for training registered veterinary technicians pursuant to Section 4843 shall be set by the board at an amount not to exceed three hundred dollars ($300). The school or institution shall also pay for the reasonable regulatory costs incident to an onsite inspection conducted by the board pursuant to Section 2065.6 of Title 16 of the California Code of Regulations.

(v) If the money transferred from the California Veterinary Medical Board Contingent Fund to the General Fund pursuant to the Budget Act of 1991 is redeposited into the California Veterinary Medical Board Contingent Fund, the fees assessed by the board

shall be reduced correspondingly. However, the reduction shall not be so great as to cause the California Veterinary Medical Board Contingent Fund to have a reserve of less than three months of annual authorized board expenditures. The fees set by the board shall not result in a California Veterinary Medical Board Contingent Fund reserve of more than 10 months of annual authorized board expenditures.

~~SEC. 70.~~

SEC. 71. Section 4910 of the Business and Professions Code is amended to read:

4910. A veterinary corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are licensed veterinarians are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and all other statutes and regulations pertaining to the corporation and the conduct of its affairs. With respect to a veterinary corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the board.

~~SEC. 71.~~

SEC. 72. Section 4920.2 of the Business and Professions Code is amended to read:

4920.2. Each veterinarian who is licensed in California and engages in the production of animal blood and blood component products solely for use in their own practice or for a community blood bank operating under this article shall meet all of the following conditions:

(a) Follow current and best practices on community animal blood banking, which may include those developed pursuant to Section 9255 of the Food and Agricultural Code.

(b) Operate under conditions, and use methods of production, that are consistent with current standards of care and practice for the field of veterinary transfusion medicine to ensure that the animal blood and blood component products will not be contaminated, dangerous, or harmful.

(c) Ensure that the production of blood and blood component products is safe and not injurious to the donor animal’s health.

(d) Follow, to the extent possible, the latest blood banking standards, which may include the latest published edition of the American Association of Blood Banks' standards, and maintain responsibility over all veterinary and technical policies and procedures that relate to the safety of staff members and donor animals.

(e) Utilize bloodborne pathogen testing for all canine and feline blood donors in accordance with the best clinical practices in the veterinary field, which may include the most recent Consensus Statement on blood donor infectious disease screening by the American College of Veterinary Internal Medicine.

(f) Ensure that the production of animal blood and blood component products complies with all applicable federal laws and regulations, including, but not limited to, Chapter 5 (commencing with Section 151) of Title 21 of the United States Code.

(g) Maintain onsite records available for inspection by the board, including information documenting any history of blood draws or use of anesthesia on the animal, the number and date of donations collected, the estimated milliliters of blood collected per donation based on weight in grams, any adverse events, and any complaints from owners regarding animals who donate blood or blood component products.

(h) Obtain the informed written consent of the owner of the animal blood donor and keep a record of that consent.

~~SEC. 72.~~

SEC. 73. Section 4920.4 of the Business and Professions Code is amended to read:

4920.4. The board may establish a community blood bank registration fee and annual renewal fee to be paid by community blood banks to cover costs associated with oversight and inspection of the premises. The fee shall not exceed the reasonable regulatory costs of administering, implementing, and enforcing this article.

~~SEC. 73.~~

SEC. 74. Section 4920.8 of the Business and Professions Code is amended to read:

4920.8. A violation of this article by a community blood bank shall constitute a cause for corrective action, suspension, restriction, or the nonrenewal or revocation of a license or registration by the board pursuant to Article 4 (commencing with Section 4875).

~~SEC. 74.~~

SEC. 75. Section 4980.54 of the Business and Professions Code is amended to read:

4980.54. (a) The Legislature recognizes that the education and experience requirements in this chapter constitute only minimal requirements to ensure that an applicant is prepared and qualified to take the licensure examinations as specified in subdivision (d) of Section 4980.40 and, if an applicant passes those examinations, to begin practice.

(b) In order to continuously improve the competence of licensed and registered marriage and family therapists and as a model for all psychotherapeutic professions, the Legislature encourages all licensees and registrants to regularly engage in continuing education related to the profession or scope of practice as defined in this chapter.

(c) (1) Except as provided in subdivision (e), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of marriage and family therapy in the preceding two years, as determined by the board.

(2) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education on the subject of California law and ethics during the preceding year.

(d) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as defined by the board.

(f) The continuing education shall be obtained from one of the following sources:

(1) A school, college, or university that is accredited or approved, as defined in Section 4980.03. Nothing in this paragraph

shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

(g) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (f), shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(h) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of marriage and family therapy.

(2) Aspects of the discipline of marriage and family therapy in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy.

(i) A system of continuing education for licensed marriage and family therapists shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(j) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

~~SEC. 75.~~

SEC. 76. Section 9884 of the Business and Professions Code is amended to read:

9884. (a) An automotive repair dealer shall pay the fee required by this chapter for each place of business operated by the dealer in this state and shall register with the director upon forms prescribed by the director.

(b) (1) The forms shall contain sufficient information to identify the automotive repair dealer, including all of the following:

(A) Name.

(B) Telephone number.

(C) Email address.

(D) Address of each location.

(E) A statement by the dealer that each location is in an area that, pursuant to local zoning ordinances, permits the operation of a facility for the repair of motor vehicles.

(F) The dealer's retail seller's permit number, if a permit is required under the Sales and Use Tax Law (Part 1 (commencing with Section 6001) of Division 2 of the Revenue and Taxation Code).

(G) Motor vehicle license plate number, if engaged in mobile automotive repairs.

(H) Other identifying data that are prescribed by the director.

(2) If the business is to be carried on under a fictitious name, the fictitious name shall be stated.

(3) To the extent prescribed by the director, an automotive repair dealer shall identify the owners, directors, officers, partners, members, trustees, managers, and any other persons who directly or indirectly control or conduct the business.

(4) The forms shall include any applicable nationally recognized and industry-accepted educational certifications and any bureau-accepted educational certifications.

(5) The forms shall include a statement signed by the dealer under penalty of perjury that the information provided is true.

(c) A state agency is not authorized or required by this section to enforce a city, county, regional, air pollution control district, or air quality management district rule or regulation regarding the site or operation of a facility that repairs motor vehicles.

~~SEC. 76.~~

SEC. 77. Section 17913 of the Business and Professions Code is amended to read:

17913. (a) The fictitious business name statement shall contain all of the information required by this subdivision and shall be substantially in the following form:

FICTITIOUS BUSINESS NAME STATEMENT

The following person (persons) is (are) doing business as

* _____

at ** _____:

*** _____

_____

_____

_____

This business is conducted by ****_____

The registrant commenced to transact business under the fictitious business name or names listed above on

***** _____

I declare that all information in this statement is true and correct. (A registrant who declares as true any material matter pursuant to Section 17913 of the Business and Professions Code that the registrant knows to be false is guilty of a misdemeanor punishable by a fine not to exceed one thousand dollars ($1,000).)

Registrant signature _____

Statement filed with the County Clerk of ____ County on _____

NOTICE—IN ACCORDANCE WITH SUBDIVISION (a) OF SECTION 17920, A FICTITIOUS NAME STATEMENT GENERALLY EXPIRES AT THE END OF FIVE YEARS FROM THE DATE ON WHICH IT WAS FILED IN THE OFFICE OF THE COUNTY CLERK, EXCEPT, AS PROVIDED IN SUBDIVISION (b) OF SECTION 17920, WHERE IT EXPIRES 40 DAYS AFTER ANY CHANGE IN THE FACTS SET FORTH IN THE STATEMENT PURSUANT TO SECTION 17913. A NEW FICTITIOUS BUSINESS NAME STATEMENT MUST BE FILED BEFORE THE EXPIRATION.

THE FILING OF THIS STATEMENT DOES NOT OF ITSELF AUTHORIZE THE USE IN THIS STATE OF A FICTITIOUS BUSINESS NAME IN VIOLATION OF THE RIGHTS OF ANOTHER UNDER FEDERAL, STATE, OR COMMON LAW (SEE SECTION 14411 ET SEQ., BUSINESS AND PROFESSIONS CODE).

(b) The fictitious business name statement shall contain the following information set forth in the manner indicated in the form provided by subdivision (a):

(1) Where the asterisk (*) appears in the form, insert the fictitious business name or names. Only those businesses operated at the same address and under the same ownership may be listed on one fictitious business name statement.

(2) Where the two asterisks (**) appear in the form: If the registrant has a place of business in this state, insert the street address, and county, of the registrant's principal place of business

in this state. If the registrant has no place of business in this state, insert the street address, and county, of the registrant's principal place of business outside this state.

(3) Where the three asterisks (***) appear in the form: If the registrant is an individual, insert the registrant's full name and business mailing address if it differs from the business address. If the registrants are a married couple, insert the full name and business mailing address of both parties to the marriage if it differs from the business address. If the registrant is a general partnership, copartnership, joint venture, or limited liability partnership, insert the full name and business mailing address of each general partner if it differs from the business address. If the registrant is a limited partnership, insert the full name and business mailing address of each general partner. If the registrant is a limited liability company, insert the name and business mailing address of the limited liability company, as set out in its articles of organization on file with the California Secretary of State, and the state of organization. If the registrant is a trust, insert the full name and business mailing address of each trustee. If the registrant is a corporation, insert the name and address of the corporation, as set out in its articles of incorporation on file with the California Secretary of State, and the state of incorporation. If the registrants are state or local registered domestic partners, insert the full name and business mailing address of each domestic partner if it differs from the business address. If the registrant is an unincorporated association other than a partnership, insert the name of each person who is interested in the business of the association and whose liability with respect to the association is substantially the same as that of a general partner.

(4) Where the four asterisks (****) appear in the form, insert whichever of the following best describes the nature of the business: (i) "an individual," (ii) "a general partnership," (iii) "a limited partnership," (iv) "a limited liability company," (v) "an unincorporated association other than a partnership," (vi) "a corporation," (vii) "a trust," (viii) "copartners," (ix) "a married couple," (x) "joint venture," (xi) "state or local registered domestic partners," or (xii) "a limited liability partnership."

(5) Where the five asterisks (*****) appear in the form, insert the date on which the registrant first commenced to transact business under the fictitious business name or names listed, if

already transacting business under that name or names. If the registrant has not yet commenced to transact business under the fictitious business name or names listed, insert the statement, "Not applicable."

(c) The registrant shall declare that all of the information in the fictitious business name statement is true and correct. A registrant who declares as true any material matter pursuant to this section that the registrant knows to be false is guilty of a misdemeanor punishable by a fine not to exceed one thousand dollars ($1,000).

(d) (1) At the time of filing of the fictitious business name statement, the registrant filing on behalf of the registrant shall present personal identification in the form of a California driver's license or other government identification acceptable to the county clerk to adequately determine the identity of the registrant filing on behalf of the registrant as provided in subdivision (e) and the county clerk may require the registrant to complete and sign an affidavit of identity.

(2) In the case of a registrant utilizing an agent for submission of the registrant's fictitious business name statement for filing, at the time of filing of the fictitious business name statement, the agent filing on behalf of the registrant shall present personal identification in the form of a California driver's license or other government identification acceptable to the county clerk to adequately determine the identity of the agent filing on behalf of the registrant as provided in subdivision (e). The county clerk may also require the agent to submit a notarized statement signed by the registrant declaring the registrant has authorized the agent to submit the filing on behalf of the registrant.

(e) If the registrant is a corporation, a limited liability company, a limited partnership, or a limited liability partnership, the county clerk may require documentary evidence issued by the California Secretary of State and deemed acceptable by the county clerk, indicating the current existence and good standing of that business entity to be attached to a completed and notarized affidavit of identity, for purposes of subdivision (d).

(f) (1) The county clerk may require a registrant that mails a fictitious business name statement to a county clerk's office for filing to submit a completed and notarized affidavit of identity. A registrant that is a corporation, limited liability company, limited partnership, or limited liability partnership, if required by the

county clerk to submit an affidavit of identity, shall also submit documentary evidence issued by the California Secretary of State indicating the current existence and good standing of that business entity.

(2) The county clerk may accept an electronic acknowledgment verifying the identity of the registrant using a remote identity proofing process ensuring the registrant's identification. The identity proofing process shall follow, to the extent reasonable, the federal guidelines for security and privacy and shall include dynamic knowledge-based authentication or an identity proofing method consistent with, at least, level 3 identity assurance, as described in the electronic authentication guidelines of the National Institute of Standards and Technology.

(g) A county clerk that chooses to establish procedures pursuant to this section shall prescribe the form of affidavit of identity for filing by a registrant in that county.

~~SEC. 77.~~

SEC. 78. Section 94816 of the Education Code is amended to read:

94816. "Applicant" means a person, as defined in Section 94855, who has submitted an application to the bureau for an approval to operate or for a renewal of an approval to operate. An approval to operate shall be issued only to an applicant.

~~SEC. 78.~~

SEC. 79. Section 94850 of the Education Code is amended to read:

94850. "Noninstitutional charges" means charges for an educational program paid directly to an entity other than an institution that are specifically required for participation in an educational program.

~~SEC. 79.~~

SEC. 80. Section 94856 of the Education Code is amended to read:

94856. "Person in control" means a person who, by the authority or conduct of their position, directs the management of an institution.

~~SEC. 80.~~

SEC. 81. Section 94876 of the Education Code is amended to read:

94876. (a) The powers and duties set forth in this chapter are vested in the Director of Consumer Affairs, who may delegate them to a bureau chief, subject to this section. The bureau chief shall work in collaboration with the director. The director is responsible for the implementation of this chapter and they shall ensure that the protection of the public is the bureau's highest priority.

(b) The bureau chief shall be appointed by the Governor, subject to confirmation by the Senate, and is exempt from the State Civil Service Act pursuant to Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code.

(c) Each power granted to, or duty imposed upon, the bureau under this chapter shall be exercised and performed in the name of the bureau, subject to any conditions and limitations the director may prescribe. The bureau chief may delegate any powers or duties to a designee.

(d) As may be necessary to carry out this chapter, the director, in accordance with the State Civil Service Act, may appoint and fix the compensation of personnel.

~~SEC. 81.~~

SEC. 82. Section 94883 of the Education Code is amended to read:

94883. (a) Any individual serving on a visiting committee who provides information to the bureau, or its staff, in the course of evaluating any institution, or who testifies in any administrative hearing arising under this chapter, is entitled to a defense and indemnification in any action arising out of the information or testimony provided as if they were a public employee.

(b) Any defense and indemnification shall be solely with respect to the action pursuant to Article 4 (commencing with Section 825) of Chapter 1 of Part 2 of, and Part 7 (commencing with Section 995) of, Division 3.6 of Title 1 of the Government Code.

~~SEC. 82.~~

SEC. 83. Section 94899.5 of the Education Code is amended to read:

94899.5. (a) Institutions that offer short-term programs designed to be completed in one term or four months, whichever is less, may require payment of all tuition and fees on the first day of instruction.

(b) For those programs designed to be greater than four months, an institution shall not require more than one term or four months of advance payment of tuition at a time. When 50 percent of the program has been offered, the institution may require full payment.

(c) The limitations in this section shall not apply to any funds received by an institution through federal and state student financial aid grant and loan programs, or through any other federal or state programs.

(d) An institution that provides private institutional loan funding to a student shall ensure that the student is not obligated for indebtedness that exceeds the total charges for the current period of attendance.

(e) At the student's option, an institution may accept payment in full for tuition and fees, including any funds received through institutional loans, after the student has been accepted and enrolled and the date of the first class session is disclosed on the enrollment agreement.

~~SEC. 83.~~

SEC. 84. Section 94901 of the Education Code is amended to read:

94901. (a) An institution's recruiters shall be employees.

(b) (1) An institution shall issue identification to each recruiter identifying the recruiter and the institution.

(2) The recruiter shall have the issued identification with them while recruiting.

~~SEC. 84.~~

SEC. 85. Section 94906 of the Education Code is amended to read:

94906. (a) An enrollment agreement shall be written in language that is easily understood. If English is not the student's primary language, and the student is unable to understand the terms and conditions of the enrollment agreement, the student shall have the right to obtain a clear explanation of the terms and conditions and all cancellation and refund policies in their primary language.

(b) If the recruitment leading to enrollment was conducted in a language other than English, the enrollment agreement, disclosures, and statements shall be in that language.

~~SEC. 85.~~

SEC. 86. Section 94913 of the Education Code is amended to read:

94913. (a) An institution that maintains an internet website shall provide on that internet website up-to-date versions of all of the following:

(1) The school catalog.

(2) A School Performance Fact Sheet for each educational program offered by the institution.

(3) Student brochures offered by the institution.

(4) A link to the bureau's internet website.

(5) The institution's most recent annual report submitted to the bureau.

(b) An institution shall include information concerning where students may access the bureau's internet website anywhere the institution identifies itself as being approved by the bureau.

~~SEC. 86.~~

SEC. 87. Section 94949.71 of the Education Code is amended to read:

94949.71. (a) The duties of the office shall be vested in a chief, who shall be appointed by the director. The chief, and each staff employee of the office, shall have experience and expertise, commensurate with their position, advocating on behalf of students and consumers and shall have knowledge in the state and federal laws governing student protection, student financial aid and loan programs, and the policies and practices of private postsecondary educational institutions.

(b) For purposes of this article, "office" means the Office of Student Assistance and Relief.

SEC. 88. Section 1374.72 of the Health and Safety Code is amended to read:

1374.72. (a) (1) Every health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(2) For purposes of this section, "mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical

Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3) (A) For purposes of this section, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an enrollee or subscriber under this chapter.

(4) For purposes of this section, "health care provider" means any of the following:

(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.

(E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

(F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

(G) A registered psychological ~~assistant,~~ *associate,* as described in Section 2913 of the Business and Professions Code.

(H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

(5) For purposes of this section, "generally accepted standards of mental health and substance use disorder care" has the same meaning as defined in paragraph (1) of subdivision (f) of Section 1374.721.

(6) A health care service plan shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.

(7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 1374.721. This paragraph does not deprive an enrollee of the other protections of this chapter, including, but not limited to, grievances, appeals, independent medical review, discharge, transfer, and continuity of care.

(8) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract, or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.

(b) The benefits that shall be covered pursuant to this section shall include, but not be limited to, the following:

(1) Basic health care services, as defined in subdivision (b) of Section 1345.

(2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.

(3) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, all of the following patient financial responsibilities:

(1) Maximum annual and lifetime benefits, if not prohibited by applicable law.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(4) Out-of-pocket maximums.

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(f) (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental

health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health care service plan shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.

(3) Notwithstanding any other law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 1374.76 of this code, and Section 2052 of the Business and Professions Code.

(g) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter.

(h) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(i) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

~~SEC. 87.~~

SEC. 89. Section 124260 of the Health and Safety Code is amended to read:

124260. (a) As used in this section:

(1) "Mental health treatment or counseling services" means the provision of outpatient mental health treatment or counseling by a professional person, as defined in paragraph (2).

(2) "Professional person" means any of the following:

(A) A person designated as a mental health professional in Sections 622 to 626, inclusive, of Title 9 of the California Code of Regulations.

(B) A marriage and family therapist, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(C) A licensed educational psychologist, as defined in Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code.

(D) A credentialed school psychologist, as described in Section 49424 of the Education Code.

(E) A clinical psychologist licensed under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

(F) Either of the following persons, while working under the supervision of a licensed professional specified in Section 2902 of the Business and Professions Code:

(i) A registered psychological associate, as defined in Section 2913 of the Business and Professions Code.

(ii) A psychology trainee, as defined in Section 1387 of Title 16 of the California Code of Regulations.

(G) A licensed clinical social worker, as defined in Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code.

(H) An associate clinical social worker, or a social work intern, as defined in Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in Section 4996.20 of the Business and Professions Code.

(I) A person registered as an associate marriage and family therapist or a marriage and family therapist trainee, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the

Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (g) of Section 4980.03 of the Business and Professions Code.

(J) A board certified, or board eligible, psychiatrist.

(K) A licensed professional clinical counselor, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

(L) A person registered as an associate professional clinical counselor or a clinical counselor trainee, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (h) of Section 4999.12 of the Business and Professions Code.

(b) (1) Notwithstanding any law to the contrary, a minor who is 12 years of age or older may consent to mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services.

(2) A marriage and family therapist trainee, a clinical counselor trainee, a psychology trainee, or a social work intern, as specified in paragraph (2) of subdivision (a), shall notify their supervisor or, if the supervisor is unavailable, an on-call supervisor at the site where the trainee or intern volunteers or is employed within 24 hours of treating or counseling a minor pursuant to paragraph (1). If, upon the initial assessment of the minor, the trainee or intern believes that the minor is a danger to self or to others, the trainee or intern shall notify the supervisor or, if the supervisor is unavailable, the on-call supervisor immediately after the treatment or counseling session.

(3) Nothing in paragraph (2) is intended to supplant, alter, expand, or remove any other reporting responsibilities required of trainees or interns under law.

(c) Notwithstanding any law to the contrary, the mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor’s parent or guardian, unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor’s parent or

guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

(d) The minor's parent or guardian is not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian.

(e) This section does not authorize a minor to receive convulsive treatment or psychosurgery, as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

SEC. 90. Section 128454 of the Health and Safety Code is amended to read:

128454. (a) There is hereby created the Licensed Mental Health Service Provider Education Program within the Department of Health Care Access and Information.

(b) For purposes of this article, the following definitions shall apply:

(1) "Licensed mental health service provider" means a psychologist licensed by the Board of Psychology, registered psychologist, ~~postdoctoral psychological assistant,~~ *registered psychological associate,* postdoctoral psychology trainee employed in an exempt setting pursuant to Section 2910 of the Business and Professions Code or employed pursuant to a State Department of Health Care Services waiver pursuant to Section 5751.2 of the Welfare and Institutions Code, marriage and family therapist, associate marriage and family therapist, licensed clinical social worker, associate clinical social worker, licensed professional clinical counselor, and associate professional clinical counselor.

(2) "Mental health professional shortage area" means an area designated as such by the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services.

(c) Commencing January 1, 2005, any licensed mental health service provider, including a mental health service provider who is employed at a publicly funded mental health facility or a public or nonprofit private mental health facility that contracts with a

county mental health entity or facility to provide mental health services, who provides direct patient care in a publicly funded facility or a mental health professional shortage area may apply for grants under the program to reimburse their educational loans related to a career as a licensed mental health service provider.

(d) The department shall adopt all of the following:

(1) A standard contractual agreement to be signed by the director and any licensed mental health service provider who is serving in a publicly funded facility or a mental health professional shortage area that would require the licensed mental health service provider who receives a grant under the program to work in the publicly funded facility or a mental health professional shortage area for at least one year.

(2) The maximum allowable total grant amount per individual licensed mental health service provider.

(3) The maximum allowable annual grant amount per individual licensed mental health service provider.

(e) The department shall develop the program, which shall comply with all of the following requirements:

(1) The total amount of grants under the program per individual licensed mental health service provider shall not exceed the amount of educational loans related to a career as a licensed mental health service provider incurred by that provider.

(2) The program shall keep the fees from the different licensed providers separate to ensure that all grants are funded by those fees collected from the corresponding licensed provider groups.

(3) A loan forgiveness grant may be provided in installments proportionate to the amount of the service obligation that has been completed.

(4) The number of persons who may be considered for the program shall be limited by the funds made available pursuant to Section 128458.

(f) This section shall become operative on July 1, 2018.

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Senate Business, Professions and Economic Development Committee
COMMITTEE BILL: PROPOSED LEGISLATION

Note: Submit the completed form to the Committee electronically by email and attach any additional information or documentation as necessary.

REQUESTOR & CONTACT INFORMATION:

Antonette Sorrick
Antonette.Sorrick@dca.ca.gov
(916) 574-8938

DATE SUBMITTED:

January 2, 2024

SUMMARY:

In the passing of Senate Bill 816, which increased the Board of Psychology (Board) fees related to licensure, registration, and renewals; the $25 fee associated with a request to change supervisors for psychological testing technicians was inadvertently removed from the amendments of Business and Professions Code (BPC) 2987. The fee was included in the passing of Senate Bill 1428 which established the registration category. By amending BPC 2987, all fees associated will be applied as established in the prior year approval of SB 1428 (Archuleta, Chapter 622, Statutes of 2022).

The current language in BPC 2913 related to the requirements of a foreign master's degree, and the advancement to candidacy has created confusion to not only applicants seeking registration as a psychological associate but, to also Licensing Staff when processing applications and answering inquiries from applicants. In amending BPC 2913 the Board believes it will alleviate any further confusion for both staff and applicants.

The current language in Health and Safety Code (HSC) 124260 references the registration categories for "registered psychologist" and "psychological assistant." The registration category for "registered psychologist" was eliminated, and the title of "registered psychological assistant" was amended to "registered psychological associate". These changes were effective January 1, 2022, with the passing of Senate Bill 801 (Archuleta, Chaptered 647, Statutes of 2021). By amending HSC 124260 to reflect current registration categories, the Board believes any confusion or errors on what qualifies as a "professional person" can be avoided.

IDENTIFICATION OF PROBLEM:

In reviewing the anticipated workload related to the new registration category of psychological testing technicians and the workload associated with registrants changing their supervisors, the Board discovered that the language in SB 816 related the change of supervisor fee was deleted, as previously approved in SB 1428.

The Board has received inquiries from applicants that the language and placement as currently provided in BPC 2913, as related to the advancement to candidacy and the acceptance of a foreign master's degree is confusing. Licensing Staff has also expressed their concerns with the current language and placement currently provided in BPC 2913.

In reviewing the language in HSC 124260, Board staff discovered that the language had outdated registration categories when referencing BCP 2902.

PROPOSED SOLUTION:

Amend sections of BPCs 2987, 2913 and HCS 124260 as described and provided below.

PROGRAM BACKGROUND & LEGISLATIVE HISTORY:

The Board regulates psychologists, registered psychological associates, and psychological testing technicians. The Board protects consumers of psychological and associated services, regulates the practice of psychology, and supports the evolution of the profession.

SB 801 (Archuleta, Chapter 647, Statutes of 2021) repealed BCP 2909.5 by eliminating the registration category for Registered Psychologist, and amended BCP 2913 to amend the title of "registered psychological assistant" to "registered psychological associate"

SB 1428 (Archuleta, Chapter 622, Statutes of 2022) added Article 10 to the Psychology Licensing Law, commencing with BPC Section 2999.100 to create a new registration within the Board for psychological testing technicians.

SB 816 (Roth, Chapter 723, Statutes of 2023) amended BPC 2987 to increase the fees related to licensure, registration, and renewals.

JUSTIFICATION:

This technical non-substantive proposal will allow the Board to continue the processing of psychological testing technician applications, change of supervisor forms, and registered psychological associate applications, and removes outdated terms in HSC 124260.

ARGUMENTS PRO & CON:

Amending BPC 2987:

Pro:

- Allow the Board to charge the fee that is necessary to process the change supervisor form that was approved in SB 1428.

Con:

- The Board will not be able to charge the fee associated with the change of supervisor and in turn, there is no funding for the process.

Amending BPC 2913:

Pro:

- Will provide clarification for applicants seeking registration, and to Licensing Staff who are processing applications and responding to applicants.

Con:

- Applicants and Licensing Staff will continue to be unclear on the requirements, which will continue to cause unnecessary delays in the application process.

Amending HSC 124260:

Pro:

- Reflects current registration categories and registration title.

Con:

- Continues to reference an eliminated registration category and an incorrect registration title.

PROBABLE SUPPORT & OPPOSITION:

The Board believes there will be support from the California Psychological Association (CPA) for amendments to BPC 2987 and 2913. CPA sponsored SB 1428 which established the psychological testing technician registration and related fees associated with the registration. CPA generally supports amendments that will decrease applicant confusion and delays in the application process. CPA also supported AB 665 (Carrillo, chapter 338, Statutes of 2023) which amended the current law to authorize minors to consent to mental health treatment or counseling services, which also referenced HSC 124260.

FISCAL IMPACT:

The Board currently has processes and procedures in place to review and process the change of supervisor forms for psychological testing technicians. Amending BPC 2987 will fund the specific process to change a registrant's supervisor.

The Board currently has processes and procedures in place to review and process the applications for registered psychological associates. Amending BPC 2913 will provide clarification to applicants and licensing staff. In doing so, will make the application process more efficient.

All changes required in SB 801 have been implemented by the Board, and all required application and procedures changes have been made. Amending HSC 124260 will make the language consistent with current registration categories.

ECONOMIC IMPACT:

This proposal does not impact new or existing businesses within the State of California. The proposal would only impact psychological testing technicians who are requesting to change their current supervisor, provide clarification regarding degree requirements to individuals who are applying to become registered psychological associates, and updates language in HSC 124260.

FINDINGS FROM OTHER STATES:

Not Applicable.

PROPOSED TEXT (use underline & strikeout):

Section 2913 of the Business and Professions Code is amended to read:

2913.

A person other than a licensed psychologist may perform psychological functions in preparation for licensure as a psychologist only if all of the following conditions are met:

(a) The person is registered with the board as a "registered psychological associate." This registration shall be renewed annually in accordance with regulations adopted by the board.

(b)(1) The person has completed or is any of the following:

(A) Completed a master's degree in psychology. This degree shall be obtained from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education.

(B) Completed a master's degree in education with the field of specialization in educational psychology, counseling psychology, or school psychology. This degree shall be obtained from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education.

(C) Is an admitted candidate for a doctoral degree and after having satisfactorily completed three or more years of postgraduate education in psychology and having passed preliminary doctoral examinations, and that doctoral degree having been completed in any of the following:

(i) Psychology with the field of specialization in clinical, counseling, school, consulting, forensic, industrial, or organizational psychology.

(ii) Education, with the field of specialization in educational psychology, counseling psychology, or school psychology.

(iii) A field of specialization designed to prepare graduates for the professional practice of psychology ~~after having satisfactorily completed three or more years of postgraduate education in psychology and having passed preliminary doctoral examinations~~.

(D) Completed a doctoral degree that qualifies for licensure under Section 2914.

(2) The board shall make the final determination as to whether a degree meets the requirements of this subdivision.

(c)(1) The registered psychological associate is supervised by a licensed psychologist. Any supervision may be provided in real time, which is defined as through in-person or synchronous audiovisual means, in compliance with federal and state laws related to patient health confidentiality. The registered psychological associate's primary supervisor shall be responsible for ensuring that the extent, kind, and quality of the psychological services performed are consistent with the registered psychological associate's and the primary supervisor's training and experience. The primary supervisor shall be responsible for the registered psychological associate's compliance

with this chapter and regulations. A primary supervisor may delegate supervision as prescribed by the board's regulations.

(2) A licensed psychologist shall not supervise more than three registered psychological associates at any given time.

(d) A registered psychological associate shall not do either of the following:

(1) Provide psychological services to the public except as a trainee pursuant to this section.

(2) Receive payments, monetary or otherwise, directly from clients.

Section 2987 of the Business and Professions Code is amended to read:

2987.

The amount of the fees prescribed by this chapter shall be determined by the board, and shall be as follows:

(a) The application fee for a psychologist shall be two hundred thirty-six dollars ($236).

(b) The examination and reexamination fees for the examinations shall be the actual cost to the board of developing, purchasing, and grading of each examination, plus the actual cost to the board of administering each examination.

(c) The application fee for the California Psychology Law and Ethics Examination (CPLEE) shall be one hundred twenty-seven dollars ($127).

(d) The initial license fee for a psychologist shall be two hundred thirty-one dollars ($231).

(e) The biennial renewal fee for a psychologist shall be seven hundred ninety-five dollars ($795). The board may adopt regulations to set the fee at a higher amount, up to a maximum of one thousand one hundred dollars ($1,100).

(f) The application fee for registration as a registered psychological associate under Section 2913 shall be four hundred twenty-four dollars ($424).

(g) The annual renewal fee for registration of a psychological associate shall be two hundred twenty-four dollars ($224). The board may adopt regulations to set the fee at a higher amount, up to a maximum of four hundred dollars ($400).

(h) The duplicate license or registration fee is five dollars ($5).

(i) The delinquency fee is 50 percent of the renewal fee for each license type, not to exceed three hundred ninety-seven dollars and fifty cents ($397.50).

(j) The endorsement fee is five dollars ($5).

(k) The file transfer fee is ten dollars ($10).

(l) The registration fee for a psychological testing technician shall be seventy-five dollars ($75).

(m) The annual renewal fee for a psychological testing technician is seventy-five dollars ($75).

(n) ~~The fee for Fingerprint Hard Card Processing for Out of State Applicants shall be one hundred eighty-four dollars ($184). Applicants shall also pay the actual cost to the board of processing the fingerprint hard card with the Department of Justice and Federal Bureau of Investigation.~~ The fee to add or change a supervisor for a psychological testing technician is twenty-five dollars ($25).

(o) ~~The fee for a psychological associate to add or change their supervisor shall be two hundred ten dollars ($210). The fee shall be the actual cost to the board of processing the addition or change.~~ The fee for Fingerprint Hard Card Processing for Out of State Applicants shall be one hundred eighty-four dollars ($184). Applicants shall also pay the actual cost to the board of processing the fingerprint hard card with the Department of Justice and Federal Bureau of Investigation.

(p) ~~Notwithstanding any other provision of law, the board may reduce any fee prescribed by this section, when, in its discretion, the board deems it administratively appropriate.~~ The fee for a psychological associate to add or change their supervisor shall be two hundred ten dollars ($210). The fee shall be the actual cost to the board of processing the addition or change.

(q) Notwithstanding any other provision of law, the board may reduce any fee prescribed by this section, when, in its discretion, the board deems it administratively appropriate.

Section 124260 of the Health and Safety Code is amended to read:

124260.

(a) As used in this section:

(1) “Mental health treatment or counseling services” means the provision of outpatient mental health treatment or counseling by a professional person, as defined in paragraph (2).

(2) “Professional person” means any of the following:

(A) A person designated as a mental health professional in Sections 622 to 626, inclusive, of Title 9 of the California Code of Regulations.

(B) A marriage and family therapist, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.

(C) A licensed educational psychologist, as defined in Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code.

(D) A credentialed school psychologist, as described in Section 49424 of the Education Code.

(E) A clinical psychologist licensed under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

(F) Any of the following persons, while working under the supervision of a licensed professional specified in Section 2902 of the Business and Professions Code:

~~(i) A registered psychologist, as defined in Section 2909.5 of the Business and Professions Code.~~

~~(ii)~~ (i) A registered psychological ~~assistant~~ associate, as defined in Section 2913 of the Business and Professions Code.

~~(iii)~~ (ii) A psychology trainee, as defined in Section 1387 of Title 16 of the California Code of Regulations.

(G) A licensed clinical social worker, as defined in Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code.

(H) An associate clinical social worker, or a social work intern, as defined in Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in Section 4996.20 of the Business and Professions Code.

(I) A person registered as an associate marriage and family therapist or a marriage and family therapist trainee, as defined in Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (g) of Section 4980.03 of the Business and Professions Code.

(J) A board certified, or board eligible, psychiatrist.

(K) A licensed professional clinical counselor, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

(L) A person registered as an associate professional clinical counselor or a clinical counselor trainee, as defined in Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, while working under the supervision of a licensed professional specified in subdivision (h) of Section 4999.12 of the Business and Professions Code.

(b) (1) Notwithstanding any provision of law to the contrary, a minor who is 12 years of age or older may consent to mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services.

(2) A marriage and family therapist trainee, a clinical counselor trainee, a psychology trainee, or a social work intern, as specified in paragraph (2) of subdivision (a), shall notify his or her supervisor or, if the supervisor is unavailable, an on-call supervisor at the site where the trainee or intern volunteers or is employed within 24 hours of treating or counseling a minor pursuant to paragraph (1). If upon the initial assessment of the minor the trainee or intern believes that the minor is a danger to self or to others, the trainee or intern shall notify the supervisor or, if the supervisor is unavailable, the on-call supervisor immediately after the treatment or counseling session.

(3) Nothing in paragraph (2) is intended to supplant, alter, expand, or remove any other reporting responsibilities required of trainees or interns under law.

(c) Notwithstanding any provision of law to the contrary, the mental health treatment or counseling of a minor authorized by this section shall include involvement of the minor's parent or guardian, unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

(d) The minor's parent or guardian is not liable for payment for mental health treatment or counseling services provided pursuant to this section unless the parent or guardian participates in the mental health treatment or counseling, and then only for services rendered with the participation of the parent or guardian.

(e) This section does not authorize a minor to receive convulsive treatment or psychosurgery, as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of the minor's parent or guardian.

2913.

A person other than a licensed psychologist may perform psychological functions in preparation for licensure as a psychologist only if all of the following conditions are met:

(a) The person is registered with the board as a "registered psychological associate." This registration shall be renewed annually in accordance with regulations adopted by the board.

(b)(1) The person has completed or is any of the following:

(A) Completed a master's degree in psychology. This degree shall be obtained from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education.

(B) Completed a master's degree in education with the field of specialization in educational psychology, counseling psychology, or school psychology. This degree shall be obtained from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education.

(C) Is an admitted candidate for a doctoral degree and after having satisfactorily completed three or more years of postgraduate education in psychology ~~and having passed preliminary doctoral examinations,~~ and that doctoral degree having been completed in any of the following:

(i) Psychology with the field of specialization in clinical, counseling, school, consulting, forensic, industrial, or organizational psychology.

(ii) Education, with the field of specialization in educational psychology, counseling psychology, or school psychology.

(iii) A field of specialization designed to prepare graduates for the professional practice of psychology ~~after having satisfactorily completed three or more years of postgraduate education in psychology and having passed preliminary doctoral examinations~~.

(D) An applicant for registration trained in an educational institution outside the United States or Canada shall demonstrate to the satisfaction of the board that the applicant possesses a master's degree in psychology or education as specified in paragraphs (A) and (B) that is equivalent to a degree earned from a regionally accredited academic institution in the United States or Canada by providing the board with an evaluation of the degree by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES), or by the National Register of Health Services Psychologists (NRHSP), and any other documentation the board deems necessary. The member of the NACES or the NRHSP shall submit the evaluation to the board directly and shall include in the evaluation all of the following:

(1) A transcript in English, or translated into English by the credential evaluation service, of the degree used to qualify for licensure.

(2) An indication that the degree used to qualify for licensure is verified using primary sources.

(3) A determination that the degree is equivalent to a degree that qualifies for registration pursuant to paragraphs (A) or (B)

(~~D~~)(E) Completed a doctoral degree that qualifies for licensure under Section 2914.

(2) The board shall make the final determination as to whether a degree obtained outside the United States or Canada meets the requirements of this subdivision.

(c)(1) The registered psychological associate is supervised by a licensed psychologist. Any supervision may be provided in real time, which is defined as through in-person or synchronous audiovisual means, in compliance with federal and state laws related to patient health confidentiality. The registered psychological associate's primary supervisor shall be responsible for ensuring that the extent, kind, and quality of the psychological services performed are consistent with the registered psychological associate's and the primary supervisor's training and experience. The primary supervisor shall be responsible for the registered psychological associate's compliance with this chapter and regulations. A primary supervisor may delegate supervision as prescribed by the board's regulations.

(2) A licensed psychologist shall not supervise more than three registered psychological associates at any given time.

(d) A registered psychological associate shall not do either of the following:

(1) Provide psychological services to the public except as a trainee pursuant to this section.

(2) Receive payments, monetary or otherwise, directly from clients.

California Board of PSYCHOLOGY

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April 12, 2023

The Honorable Angelique V. Ashby
Chair, Senate Committee on Business, Professions and Economic Development
State Capitol, Room 3320
Sacramento, CA 95814

RE: **SB 1526 – Consumer Affairs - SUPPORT**

Dear Senator Ashby:

The Board of Psychology (Board) protects consumers of psychological services by licensing psychologists, and associated professionals, regulating the practice of psychology, and supporting the ethical evolution of the profession.

The Board is in **SUPPORT** of SB 1526. This bill would amend Health and Safety Code (HSC) 124260 by removing the outdated registration category for "registered psychologist" and amend the registration title "psychological assistant" by replacing the category with the current title of "psychological associate." By amending HSC 124260, the Board believes any confusion or errors on what qualifies as a "professional person" will be avoided under the specific code.

The Board asks for your support of SB 1526 when it is heard in the Senate Committee on Committee on Business, Professions and Economic Development. If you have any questions or concerns, please feel free to contact the Board's Executive Officer, Antonette Sorrick, at (916) 574-8938 or Antonette.Sorrick@dca.ca.gov. Thank you.

Sincerely,

Lea Tate, PsyD
President, Board of Psychology

cc: Senator Janet Nguyen (Vice Chair)
Members of the Senate Committee on Business, Professions and Economic Development
Elissa Silva, Consultant, Senate Committee on Business, Professions and Economic Development
Kayla Williams, Senate Republican Caucus

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(b)(1) - Review of Bills for Review and Consideration for Action Position Recommendation to the Board – AB 236 (Holden) Health care coverage: provider directories

Background

At the May 10, 2024, Board meeting, members of the California Psychological Association requested the Board to review and consider AB 236 for a possible position.

AB 236 would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028.

Action Requested

Staff Recommendation: Watch AB 236

Attachment #1: AB 236 Bill Text
Attachment #2: AB 236 – Assembly Floor Analyses

AMENDED IN ASSEMBLY JANUARY 22, 2024

AMENDED IN ASSEMBLY MARCH 20, 2023

AMENDED IN ASSEMBLY FEBRUARY 14, 2023

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 236

Introduced by Assembly Member Holden
~~(Coauthor: Assembly Member Arambula)~~
(Coauthors: Assembly Members Arambula and Boerner)
(Coauthors: Senators Allen and Wiener)

January 13, 2023

An act to amend Section 1367.27 of the Health and Safety Code, and to amend Section 10133.15 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 236, as amended, Holden. Health care coverage: provider directories.

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 the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified.

Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories.

This bill would require a plan or insurer to annually ~~audit~~ *verify* and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on ~~January 1, 2024,~~ *July 1, 2025,* with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before ~~January 1, 2027.~~ *July 1, 2028.* The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed ~~benchmarks and for each inaccurate listing in its directories.~~ *benchmarks.* If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, ~~2024,~~ *2025,* unless specified criteria applies. *The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing.* The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. ~~Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.~~

This bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to use to request directory information from providers and would authorize the departments to establish a methodology and processes to ensure accuracy of provider directories. The bill would require the health plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate.

Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose 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.

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. The Legislature finds and declares all of the following:

(a) It has been the responsibility of each health care service plan and health insurer to maintain an accurate provider directory since the enactment of Chapter 649 of the Statutes of 2015. Despite the requirement in existing law that provider directories be accurate, both academic studies and reports of individual consumers indicate that inaccuracies in provider directories are common. Individual consumers and their representatives should be able to obtain care, including an appointment as a new patient, based on accurate information in the provider directory maintained by the health care service plan or health insurer.

(b) Too often consumers find "ghost" networks in which the provider directories of health care service plans and health insurers include doctors, hospitals, and other providers who are not accepting new patients, not accepting patients for that network of the plan or insurer, have not been compensated by the carrier in the past year, or are inaccessible to consumers because of inaccurate contact information in the provider directory. Some health care service plans and insurers advertise that there are thousands or even tens of thousands of doctors, hospitals, and other providers of care in their network, but when a consumer tries to contact a health care provider, basic information such as name and address are too often inaccurate. Even if the consumer can reach the provider who appears to be in-network for that network of the carrier, too often the consumer discovers either that the provider is not accepting new patients or not accepting patients for that

network of the carrier, putting the burden of the inaccurate provider directory on the consumer, not the health care service plan or insurer. These barriers to care are most problematic for those consumers who need care the most, such as persons with disabilities or behavioral health conditions, as well as those with other barriers to seeking care, such as limited English proficiency or lack of health care literacy.

(c) To encourage the development of a provider directory utility that could be used by all health care service plans, in 2015, the Department of Managed Health Care required an undertaking to fund the development of such a provider directory utility as a condition of the department's approval of the acquisition of CareFirst by Blue Shield of California. In the years from 2015 to the introduction of this act, the Integrated Healthcare Association, an association of health care service plans, health insurers, provider groups, and hospitals with no consumer representation, held numerous meetings and workgroups with health care industry entities to develop a provider directory utility. The Integrated Healthcare Association states that as of 2019, the provider directory utility was operational and able to assist health care service plans and health insurers in verifying and crosschecking the accuracy of provider directory information. There are also efforts by the federal Centers for Medicare and Medicaid Services to aid in the accuracy of provider updates to improve provider directories.

(d) Inclusion in a health care service plan or health insurer directory is a form of marketing for health care providers, including hospitals, laboratory services, imaging, provider groups, and individual providers because those directories provide individual consumers information about whether or not the health care provider is available through the network of the plan or insurer. Removal from the provider directory of a health care service plan or health insurer constitutes a financial penalty for a health care provider because a consumer seeking in-network care or to receive referrals from other health care providers for in-network care is less likely to seek care from a provider not included in the provider directory.

(e) It is the intent of the Legislature in enacting this act to ensure that provider directories of health care service plans and health insurers are substantially accurate and that consumers are able to rely on the information provided in those directories, including

such basic information as the name of the provider, the telephone number, and the address where care may be sought. It is also the intent of the Legislature to require the improvement of accuracy of provider directories over a number of years. In addition to the financial penalties on providers for failure to provide accurate and timely information for inclusion in the provider directory of a health care service plan or health insurer, it is the intent of the Legislature that the relevant departments have the authority to impose financial penalties on health care service plans and insurers for any failure of a plan or insurer to maintain the accuracy of its own directory.

SEC. 2. Section 1367.27 of the Health and Safety Code is amended to read:

1367.27. (a) ~~Commencing July 1, 2016, a~~ *A* health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan or that has not been compensated by the plan in the prior year, except as provided in this section. *Commencing July 1, 2025, a health care service plan shall comply with this section as it read on January 1, 2025.*

(b) A health care service plan shall provide the directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, *contracting providers,* the department, and other state or federal agencies can easily identify the networks and plan products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, a health care service plan shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c) (1) An online provider directory or directories shall be available on the plan's internet website to the public, potential enrollees, enrollees, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the plan, indicate interest

in obtaining coverage with the plan, provide a member identification or policy number, provide any other identifying information, or create or access an account.

(2) The online provider directory or directories shall be accessible on the plan's public internet website through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the plan's public internet website shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate, and the information provided shall be verified and accurate, consistent with this section.

(d) (1) A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) A health care service plan shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e) (1) The plan shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the plan of any of the following:

(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.

(B) A provider is no longer under contract for a particular plan product.

(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.

(D) Upon *the* completion of the investigation described in subdivision (o), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(E) Any other information that affects the content or accuracy of the provider directory or directories.

(2) Upon confirmation of any of the following, the plan shall delete and remove a provider from the directory or directories when:

(A) A provider has retired or otherwise has ceased to practice.

(B) A provider or provider group is no longer under contract with the plan for any reason.

(C) The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

(D) Beginning July 1, ~~2024,~~ *2025,* for a health care service plan contract issued, renewed, or amended on ~~January 1, 2024,~~ *or after January 1, 2025,* the plan cannot confirm that the plan has financially ~~compensated~~ *compensated, as defined in this section,* the provider for the purpose of providing covered benefits to enrollees for the designated network in the prior year unless one of the following applies:

(i) The plan has newly contracted with the provider within the prior six months.

(ii) The plan has a newly approved network approved within the prior six months.

(iii) A special circumstance requires inclusion of the provider in the directory consistent with regulations or other guidance by the department. A special circumstance may ~~include~~ *include, but is not limited to,* a provider in a rural area or a highly specialized specialist who ~~is~~ *was* not used by an enrollee in the prior year or other circumstances as determined by the department through the regulatory or other rulemaking process. *The department may issue guidance to implement, interpret, or make specific the requirements under this clause. The guidance shall be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with*

Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(iv) A special circumstance occurs particular to a specific provider and subject to prior approval of the department at least 30 days before the inclusion of the provider in the directory.

~~(E) If a provider has been deleted from the provider directory, the deleted provider shall not be used for timely access monitoring, determination of network, or compliance with this chapter.~~

~~(F)~~

(E) For purposes of this subdivision, "financially compensated" means having paid ~~five~~ *one* or more claims to a provider for that network or otherwise demonstrably financially compensated that provider for the purposes of providing covered benefits to enrollees covered by the relevant network.

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's internet website.

(g) The provider directory or directories shall include the following disclosures informing enrollees that they are entitled to both of the following:

(1) Language interpreter services, at no cost to the enrollee, including how to obtain interpretation services in accordance with Section 1367.04.

(2) Full and equal access to covered services, including enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

(h) A full service health care service plan and a specialized mental health plan shall include all of the following information in the provider directory or directories:

(1) The provider's name, practice location or locations, and contact information, including telephone number.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) The provider's office email address, if available to an enrollee or the public.

(7) The population served, meaning adult, pediatric, or both.

(8) The name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees.

(9) A listing for each of the following providers that are under contract with the plan:

(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, *dispensing optometrists and opticians,* podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse-midwives, and dentists.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and the name of the federally qualified health center or clinic.

(E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

(F) Pharmacies, clinical laboratories, imaging centers, *optical dispensaries,* and other facilities providing contracted health care services.

(10) The provider directory or directories may note that authorization or referral may be required to access some providers.

(11) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(12) Identification of providers who no longer accept new patients for some or all of the plan's products.

(13) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this

section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(14) The provider's contract termination date, if any. The plan shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

(15) If the provider has affirmed that they offer and have provided gender-affirming services, in accordance with Section 1367.28.

(16) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).

(i) A vision, dental, or other specialized health care service plan, except for a specialized mental health plan, shall include all of the following information for each provider directory or directories used by the plan for its networks:

(1) The provider's name, practice location or locations, and contact information, including telephone number.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license, if applicable.

(5) The area of specialty, including board certification, or other accreditation, if any.

(6) The provider's office email address, if available to an enrollee or the public.

(7) The population served, meaning adult, pediatric, or both.

(8) The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees.

(9) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan.

(10) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(11) Identification of providers who no longer accept new patients for some or all of the plan's products.

(12) The provider's contract termination date, if any. The plan shall delete the provider from the directory within five days after

the termination date of the provider's contract if there is a termination date.

(13) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occurs:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

(3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory or directories, the plan shall promptly ~~investigate,~~ *investigate* and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a ~~multiplan directory~~ *central utility* by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.

(4) On or before January 1, 2025, the department may develop a uniform format with standardized naming conventions and other aspects for each plan to use to request directory information from its providers.

(5) On or before January 1, 2026, the department may establish a methodology and processes to ensure accuracy of provider directories. The department shall take into account existing methods, including surveys, plan-reported information, and benchmarks or submission information from a central utility by another entity. The department may require a health care service plan to use a central utility or designate a central utility for those providers included in the directory. In developing the methodology under this section, the department shall seek input from interested parties and may hold one or more public meetings. Standards developed pursuant to paragraph (4) and this paragraph shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until January 1, 2028.

(*l*) (1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.

(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of

networks and plan products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.

(4) If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the 10-business-day notice period. A provider shall not be removed from the provider directory or directories if the provider responds before the end of the 10-business-day notice period. ~~If the plan cannot verify that the information that is required by subdivisions (h) and (i) in the listing is accurate, the provider shall be deleted and removed from the directory at the next required update. Deleted provider information shall not be used for timely access monitoring, solicitation, network adequacy reporting, including time and distance standards, or compliance with this chapter.~~

(5) If a provider that was previously removed from the provider directory or directories requests to be added back to the provider directory or directories, or if a plan requests that a provider that was previously removed from the provider directory or directories be added back to the provider directory or directories, the health plan shall ensure the accuracy of the information required under this section and approve the request within 10 business days of receipt if accurate.

~~(5)~~

(6) General acute care hospitals shall be exempt from the requirements in paragraphs (3)~~ and (4)~~*. to (5), inclusive.*

(m) A plan shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under this subdivision shall be submitted by a plan annually to the department for approval and in a format described by the department pursuant to Section 1367.035.

(2) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the health care service plan. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the health care service plan.

(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory internet website linking to a form where the information can be reported directly to the plan through its internet website.

(n) ~~The~~ *A* plan shall be responsible for maintaining an accurate provider directory.

(1) An accurate provider directory maintains accurate information for all information to be included in the directories pursuant to subdivisions (h) and (i).

(2) The accuracy percentage of a directory shall be determined by the percentage of providers for which all information required in subdivision (h) or (i) is accurate. If there is one error on a listing for a provider, that listing is considered inaccurate.

(A) On ~~January 1, 2024,~~ *July 1, 2025*, a plan's directories shall be at least 60-percent accurate.

(B) On or before ~~January 1, 2025,~~ *July 1, 2026*, a plan's directories shall be at least 80-percent accurate.

(C) On or before ~~January 1, 2026,~~ *July 1, 2027*, a plan's directories shall be at least 90-percent accurate.

(D) On or before ~~January 1, 2027,~~ *July 1, 2028*, a plan's directories shall be at least 95-percent accurate.

(3) A plan shall annually ~~audit and~~ verify its provider directories for accuracy of all of the information required pursuant to subdivisions (h) and (i). *If the department develops a methodology and standards that permit the use of a central utility, and if a health care service plan uses the central utility for some or all of the plan's provider directory, the plan shall ensure that information derived from the central utility is incorporated in the plan's provider directory unless the plan can demonstrate that the information is inaccurate. The plan using a central utility shall continue to retain responsibility for ensuring that the requirements of this section are satisfied, including in any contract or other agreement with the central utility.* The department shall develop procedures and policies on how a plan shall conduct the ~~audits.~~ *verifications.* In addition to verifying the information required under subdivisions (h) and (i), the plan shall do all of the following:

(A) In verifying the accuracy of information in the provider directory or directories, determine whether a provider has submitted claims or otherwise been compensated for covered benefits for enrollees in that product or network. If the provider received no compensation in the last year for that product or network, the plan shall remove that provider from their directory pursuant to subparagraph (D) of paragraph (2) of subdivision (e).

(B) ~~Submit its accuracy audit reports annually~~ *Annually submit its accuracy verification reports and a declaration that the accuracy verification report is true and correct* to the department to ensure compliance with this section.

(C) Publicly post its accuracy ~~audit~~ *verification* reports annually on its internet website.

(4) Failure by a health care service plan to comply with this section, including failure to meet the required benchmarks for accuracy, shall result in an administrative penalty consistent with this section and this chapter. In determining the appropriate amount of an administrative penalty, a listing inaccuracy shall be treated as a denial of access to care for covered benefits. For purposes of determining an administrative penalty based on an inaccuracy, required accurate information shall include, but not be limited to, the provider name, address, and telephone number, whether the provider is accepting new patients, whether the provider was financially compensated by the plan consistent with this section, and any other information as determined by the department.

~~(4)~~

(5) Failure to meet the required benchmarks in paragraph (2) shall result in an administrative penalty of *not less than five hundred dollars ($500) per 1,000 enrollees and* up to five thousand dollars ($5,000) per 1,000 enrollees, and failure to meet the benchmark in the subsequent year shall result in an administrative penalty of *not less than one thousand dollars ($1,000) per 1,000 enrollees and* up to ten thousand dollars ($10,000) per 1,000 enrollees for each year following the first year that the plan failed to meet the benchmark.

~~(5) The plan shall be liable for an administrative penalty of up to one thousand dollars ($1,000) for each inaccurate listing in its directory. An inaccurate listing means a listing with at least one error in the information required under subdivision (h) or (i).~~

(6) When assessing administrative penalties against a health care service plan, the director shall determine the appropriate penalty amount for each violation based on one or more factors as applicable, including the factors outlined in subdivision (d) of Section 1386.

(7) Beginning January 1, 2028, and every five years thereafter, the penalty amounts specified in this section shall be adjusted

based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

(o) (1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.

(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (q) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the plan that the provider should be deleted from the provider group in the plan directory or directories.

(5) Section 1375.7, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

(p) (1) Whenever a health care service plan receives a report indicating that information listed in its provider directory or directories is inaccurate, the plan shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information

or update the information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the plan shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to a plan's provider directory or directories are required as a result of the plan's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

(q) (1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (*l*). The plan shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. A plan may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business-day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.

(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month beginning on the first day of the following month.

(2) A plan shall notify the provider or provider group 10 business days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the plan delays a payment or reimbursement pursuant to this subdivision, the plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the plan receives the information required to be submitted by the provider or provider group pursuant to subdivision (*l*).

(B) At the end of the one-calendar-month delay described in subparagraph (A) or (B) of paragraph (1), as applicable, if the provider or provider group fails to provide the information required to be submitted to the plan pursuant to subdivision (*l*).

(3) A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a change in the information required to be in the directory or directories pursuant to this section.

(4) A plan that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department pursuant to Section 1367.035. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(5) With respect to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code, this subdivision shall be implemented only to the extent consistent with federal law and guidance.

(r) (1) In circumstances where the department finds that an enrollee reasonably relied upon ~~materially~~ inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories, the ~~department may require the health plan to~~ *health care service plan shall arrange care and* provide coverage for all covered health care services provided to the ~~enrollee and to~~ *enrollee,* reimburse the enrollee for any amount beyond what

the enrollee would have paid, had the services been delivered by an in-network provider under the enrollee's plan ~~contract.~~ *contract, and reimburse the provider the contracted amount for those health care services under the contract. The provider shall not collect any additional amount from the enrollee other than the applicable in-network cost sharing.* Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the enrollee were covered services under the enrollee's plan contract. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-plan provider shall not be used as a basis to deny reimbursement to the enrollee.

(2) If an enrollee, by telephone call or electronic means, requests information on whether or not a provider is contracted as an in-network provider to provide covered benefits, the health care service plan ~~shall respond~~ *shall, if the request is by telephone, tell the enrollee verbally and follow up* in writing or electronic format no later than one business day after receiving the request. *If the request is by electronic means, the plan shall respond in writing or electronic format no later than one business day after receiving the request.* The plan shall also provide information on whether or not the provider is accepting new patients. The plan shall retain a record of the request and the plan's response in the enrollee's file for at least two years after the date of the request.

(3) For covered benefits, if an enrollee obtained information through the plan's online directory or a request consistent with paragraph (2) that a provider was an in-network provider, the enrollee shall pay no more than in-network cost sharing if any of the following apply:

(A) The provider is not contracting with the health care service plan as an in-network provider for that product.

(B) The contracting provider is not accepting new patients for that product.

(C) The information provided is otherwise ~~materially~~ inaccurate, misleading, or incomplete.

(D) The online provider directory of the health care service plan is not accessible to enrollees at the time the enrollee seeks information and the enrollee requests information consistent with paragraph (2).

(4) If the health care service plan contract includes more than one tier of cost sharing, the plan shall document the cost-sharing tier that the provider is contracted to accept and shall provide that information to the enrollee when the enrollee seeks information about the provider. If the plan provides information indicating that a provider is on a lower cost-sharing tier and that information is not accurate, then the enrollee shall owe no more than the cost sharing for the cost-sharing tier included in the information received by the enrollee from the plan.

(5) For purposes of this subdivision, the in-network cost sharing amount for a contracted provider includes copayments, deductibles, coinsurance, and any other form of cost sharing. If the health care service plan contract includes more than one tier of cost sharing and if the enrollee was not informed accurately of the applicable cost-sharing tier, then the lowest cost-sharing tier shall apply.

(6) For purposes of this subdivision, "information" is inaccurate, incomplete, or misleading if any information in subdivision (h) or (i) is inaccurate, incomplete, or misleading.

(s) *(1)* Whenever a plan determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(2) For a health care service plan issued, amended, or renewed on or after July 1, 2025, if a provider has not been financially compensated consistent with this section or if the provider has failed to respond timely consistent with this section, and those providers amount to a change of 10 percent or greater in the network for a product in a region, then the plan shall file an amendment to the plan application consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(3) A plan shall not use information about a provider for purposes of compliance with timely access requirements, network adequacy determination, or compliance with any other provision of this chapter if the plan cannot demonstrate to the department that the provider is contracting with the plan and the provider has been financially compensated by the plan consistent with this section or the provider has failed to respond timely consistent with

this section. This paragraph shall apply whether or not the provider has been deleted from the directory.

(4) Consistent with Section 1360, a plan shall not advertise or otherwise represent the extent of its network, including the number or type of contracting providers, unless it is able to demonstrate that each provider is contracting and has been compensated consistent with this section.

(t) (1) This section applies to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code to the extent consistent with federal law and guidance and state law guidance issued after January 1, 2016.

(2) Notwithstanding any other provision to the contrary in a plan contract with the State Department of Health Care Services, and to the extent consistent with federal law and guidance and state guidance issued after January 1, 2016, a Medi-Cal managed care plan that complies with the requirements of this section shall not be required to distribute a printed provider directory or directories, except as required by paragraph (1) of subdivision (d). All other provisions of this section apply to plans with Medi-Cal managed care contracts.

(u) A health plan that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall meet the requirements of this section.

(v) This section shall not be construed to alter a provider's obligation to provide health care services to an enrollee pursuant to the provider's contract with the plan.

(w) As part of the department's routine examination of the fiscal and administrative affairs of a health care service plan pursuant to Section 1382, the department shall include a review of the health care service plan's compliance with subdivision (q).

(x) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

SEC. 3. Section 10133.15 of the Insurance Code is amended to read:

10133.15. (a) ~~Commencing July 1, 2016, a~~ *A* health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall publish and maintain *a* provider directory or directories with information on contracting providers that deliver health care services to the insurer's insureds, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the insurer or that has not been compensated by the insurer in the prior year, except as provided in this section. *Commencing July 1, 2025, a health care service plan shall comply with this section as it read on January 1, 2025.*

(b) An insurer shall provide the online directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, insureds, potential insureds, *contracting providers,* the department, and other state or federal agencies can easily identify the networks and insurer products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, an insurer shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c) (1) An online provider directory or directories shall be available on the insurer's internet website to the public, potential insureds, insureds, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the insurer, indicate interest in obtaining coverage with the insurer, provide a member identification or policy number, provide any other identifying information, or create or access an account.

(2) The online provider directory or directories shall be accessible on the insurer's public internet website through an identifiable link or tab and in a manner that is accessible and searchable by insureds, potential insureds, the public, and providers. By July 1, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the insurer's public internet website shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier

number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate, and the information provided shall be verified and accurate, consistent with this section.

(d) (1) An insurer shall allow insureds, potential insureds, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the insurer through the insurer's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) An insurer shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e) (1) The insurer shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the insurer of any of the following:

(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.

(B) A contracted provider is no longer under contract for a particular product.

(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.

(D) Upon the completion of the investigation described in subdivision (o), a change is necessary based on an insured complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.

(E) Any other information that affects the content or accuracy of the provider directory or directories.

(2) Upon confirmation of any of the following, the insurer shall delete and remove a provider from the directory or directories when:

(A) A provider has retired or otherwise has ceased to practice.

(B) A provider or provider group is no longer under contract with the insurer for any reason.

(C) The contracting provider group has informed the insurer that the provider is no longer associated with the provider group and is no longer under contract with the insurer.

(D) Beginning July 1, ~~2024,~~ *2025,* for a health insurance policy issued, renewed, or amended on ~~January 1, 2024,~~ *or after January 1, 2025,* the insurer cannot confirm that the insurer has financially ~~compensated~~ *compensated, as defined in this section,* the provider for the purpose of providing covered benefits to insureds for the designated network in the prior year unless one of the following applies:

(i) The insurer has newly contracted with the provider within the prior six months.

(ii) The insurer has a newly approved network approved within the prior six months.

(iii) A special circumstance requires inclusion of the provider in the directory consistent with regulations or other guidance by the department. A special circumstance may ~~include~~ *include, but is not limited to,* a provider in a rural area or a highly specialized specialist who ~~is~~ *was* not used by an insured in the prior year or other circumstances as determined by the department through the regulatory or other rulemaking process. *The commissioner may issue guidance to implement, interpret, or make specific the requirements under this clause. The guidance shall be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).*

(iv) A special circumstance occurs particular to a specific provider and subject to prior approval of the department at least 30 days before the inclusion of the provider in the directory.

~~(E) If a provider has been deleted from the provider directory, the deleted provider shall not be used for timely access monitoring, determination of network, or compliance with this chapter.~~

~~(F)~~

(E) For purposes of this subdivision, "financially compensated" means having paid ~~five~~ *one* or more claims to a provider for that network, paid capitation, or otherwise demonstrably financially

compensated that provider for the purposes of providing covered benefits to ~~enrollees~~ *insureds* covered by the relevant network.

(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the insurer if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the insurer's internet website.

(g) The provider directory or directories shall include the following disclosures informing insureds that they are entitled to both of the following:

(1) Language interpreter services, at no cost to the insured, including how to obtain interpretation services in accordance with Section 10133.8.

(2) Full and equal access to covered services, including insureds with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

(h) The insurer and a specialized mental health insurer shall include all of the following information in the provider directory or directories:

(1) The provider's name, practice location or locations, and contact information, including telephone number.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license.

(5) The area of specialty, including board certification, if any.

(6) The provider's office email address, if available to an insured or the public.

(7) The population served, meaning adult, pediatric, or both.

(8) The name of each affiliated provider group currently under contract with the insurer through which the provider sees insureds.

(9) A listing for each of the following providers that are under contract with the insurer:

(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the insurer.

(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, *dispensing optometrists and opticians,* podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified

autism service providers, as defined in Section 10144.51, nurse-midwives, and dentists.

(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.

(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the insurer, the name of the provider, and the name of the federally qualified health center or clinic.

(E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.

(F) Pharmacies, clinical laboratories, imaging centers, *optical dispensaries,* and other facilities providing contracted health care services.

(10) The provider directory or directories may note that authorization or referral may be required to access some providers.

(11) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8, if any, on the provider's staff.

(12) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(13) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.

(14) The provider's contract termination date, if any. The insurer shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

(15) If the provider has affirmed that they offer and have provided gender-affirming services, in accordance with Section 10133.14.

(16) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).

(i) A vision, dental, or other specialized insurer, except for a specialized mental health insurer, shall include all of the following

information for each provider directory or directories used by the insurer for its networks:

(1) The provider's name, practice location or locations, and contact information, including telephone number.

(2) Type of practitioner.

(3) National Provider Identifier number.

(4) California license number and type of license, if applicable.

(5) The area of specialty, including board certification, or other accreditation, if any.

(6) The provider's office email address, if available to an insured or the public.

(7) The population served, meaning adult, pediatric, or both.

(8) The name of each affiliated provider group or specialty insurer practice group currently under contract with the insurer through which the provider sees insureds.

(9) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the insurer.

(10) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 10133.8, if any, on the provider's staff.

(11) Identification of providers who no longer accept new patients for some or all of the insurer's products.

(12) The provider's contract termination date, if any. The insurer shall delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date.

(13) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the insurer and a provider shall include a requirement that the provider inform the insurer within five business days when either of the following occurs:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an insured or potential insured seeking to become a new patient, the provider shall direct the insurer or potential insured to both the insurer for additional assistance in finding a provider and to the

department to report any inaccuracy with the insurer's directory or directories.

(3) If an insured or potential insured informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall promptly investigate and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a ~~multiplan directory~~ *central utility* by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, an insurer shall use the standards developed by the department for each product offered by the insurer.

(4) On or before January 1, 2025, the department may develop a uniform format with standardized naming conventions and other aspects for each insurer to use to request directory information from its providers.

(5) On or before January 1, 2026, the department may establish a methodology and processes to ensure accuracy of provider directories. The department shall take into account existing methods, including surveys, plan-reported information, and benchmarks or submission information from a central utility by another entity. The department may require an insurer to use a

central utility or designate a central utility for those providers included in the directory. In developing the methodology under this section, the department shall seek input from interested parties and may hold one or more public meetings. Standards developed pursuant to paragraph (4) and this paragraph shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until January 1, 2028.

(*l*) (1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the insurer shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the insurer shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the insurer shall notify its contracted providers to ensure that all of the providers are contacted by the insurer at least once annually.

(2) The notification shall include all of the following:

(A) The information the insurer has in its directory or directories regarding the provider or provider group, including a list of networks and products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The insurer shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether

or not the provider group is accepting new patients for each product.

(4) If the insurer does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the insurer shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The insurer shall document the receipt and outcome of each attempt to verify the information. If the insurer is unable to verify whether the provider's information is correct or requires updates, the insurer shall notify the provider 10 business days in advance of removal that the provider will be removed from the directory or directories. The provider shall be removed from the directory or directories at the next required update of the provider directory or directories after the 10-business-day notice period. A provider shall not be removed from the provider directory or directories if the provider responds before the end of the 10-business-day notice period. ~~If the insurer cannot verify that the information that is required by subdivisions (h) and (i) in the listing is accurate, the provider shall be deleted and removed from the directory at the next required update. Deleted provider information shall not be used for timely access monitoring, solicitation, network adequacy reporting, including time and distance standards, or compliance with this chapter.~~

(5) If a provider that was previously removed from the provider directory or directories requests to be added back to the provider directory or directories, or if an insurer requests that a provider that was previously removed from the provider directory or directories be added back to the provider directory or directories, the insurer shall ensure the accuracy of the request and approve the request within 10 business days of receipt if accurate.

~~(5)~~

(6) General acute care hospitals shall be exempt from the requirements in paragraphs (3) ~~and (4).~~ *to (5), inclusive.*

(m) An insurer shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(1) The policies and procedures described under this subdivision shall be submitted by an insurer annually to the department for approval and in a format described by the department.

(2) Every insurer shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the insurer. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the insurer.

(3) The insurer shall establish and maintain a process for insureds, potential insureds, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the insurer's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the insurer will accept these reports, as well as a hyperlink on the insurer's provider directory internet website linking to a form where the information can be reported directly to the insurer through its internet website.

(n) An insurer shall be responsible for maintaining an accurate provider directory.

(1) An accurate provider directory maintains accurate information for all information to be included in the directories pursuant to subdivisions (h) and (i).

(2) The accuracy percentage of a directory shall be determined by the percentage of providers for which all information required in subdivision (h) or (i) is accurate. If there is one error on a listing for a provider, that listing is considered inaccurate.

(A) On ~~January 1, 2024,~~ *July 1, 2025*, an insurer's directories shall be at least 60-percent accurate.

(B) On or before ~~January 1, 2025,~~ *July 1, 2026*, an insurer's directories shall be at least 80-percent accurate.

(C) On or before ~~January 1, 2026,~~ *July 1, 2027*, an insurer's directories shall be at least 90-percent accurate.

(D) On or before ~~January 1, 2027,~~ *July 1, 2028*, an insurer's directories shall be at least 95-percent accurate.

(3) An insurer shall annually ~~audit and~~ verify its provider directories for accuracy of all of the information required pursuant

to subdivisions (h) and (i). *If the department develops a methodology and standards that permit the use of a central utility, and if an insurer uses the central utility for some or all of the insurer's provider directory, the insurer shall ensure that information derived from the central utility is incorporated in the insurer's provider directory unless the insurer can demonstrate that the information is inaccurate. The insurer using a central utility shall continue to retain responsibility for ensuring that the requirements of this section are satisfied, including in any contract or other agreement with the central utility.* The department shall develop procedures and policies on how an insurer shall conduct the ~~audits.~~ *verifications*. In addition to verifying the information required under subdivisions (h) and (i), the insurer shall do all of the following:

(A) In verifying the accuracy of information in the provider directory or directories, determine whether a provider has submitted claims or otherwise been compensated for covered benefits for insureds in that product or network. If the provider received no compensation in the last year for that product or network, the insurer shall remove that provider from their directory pursuant to subparagraph (D) of paragraph (2) of subdivision (e).

(B) ~~Submit its accuracy audit reports annually~~ *Annually submit its accuracy verification reports and a declaration that the accuracy verification report is true and correct* to the department to ensure compliance with this section.

(C) Publicly post its accuracy ~~audit~~ *verification* reports annually on its internet website.

(4) Failure by an insurer to comply with this section, including failure to meet the required benchmarks for accuracy, shall result in an administrative penalty consistent with this section and this chapter. In determining the appropriate amount of an administrative penalty, a listing inaccuracy shall be treated as a denial of access to care for covered benefits. For purposes of determining an administrative penalty based on an inaccuracy, required accurate information shall include, but not be limited to, the provider name, address, and telephone number, whether the provider is accepting new patients, whether the provider was financially compensated by the insurer consistent with this section, and any other information as determined by the department.

~~(4)~~

(5) Failure to meet the required benchmarks in paragraph (2) shall result in an administrative penalty of *not less than five hundred dollars ($500) per 1,000 insureds and* up to five thousand dollars ($5,000) per 1,000 insureds, and failure to meet the benchmark in the subsequent year shall result in an administrative penalty of *not less than one thousand dollars ($1,000) per 1,000 insureds and* up to ten thousand dollars ($10,000) per 1,000 insureds for each year following the first year that the insurer failed to meet the benchmark.

~~(5) The insurer shall be liable for an administrative penalty of up to one thousand dollars ($1,000) for each inaccurate listing in its directory. An inaccurate listing means a listing with at least one error in the information required under subdivision (h) or (i).~~

(6) When assessing administrative penalties against a health insurer, the department shall determine the appropriate penalty amount for each violation based on one or more factors as applicable.

(7) Beginning January 1, ~~2028,~~ *2029,* and every five years thereafter, the penalty amounts specified in this section shall be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment.

(o) (1) This section does not prohibit an insurer from requiring its provider groups or contracting specialized health insurers to provide information to the insurer that is required by the insurer to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health insurer. This responsibility shall be specifically documented in a written contract between the insurer and the provider group or contracting specialized health insurer.

(2) If an insurer requires its contracting provider groups or contracting specialized health insurers to provide the insurer with information described in paragraph (1), the insurer shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (q) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the insurer that the provider should be deleted from the provider group in the insurer's provider directory or directories.

(5) Section 10133.65, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.

(p) (1) Whenever an insurer receives a report indicating that information listed in its provider directory or directories is inaccurate, the insurer shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the insurer shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the insurer's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to an insurer's provider directory or directories are required as a result of the insurer's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

(q) (1) Notwithstanding Sections 10123.13 and 10123.147, an insurer may delay payment or reimbursement owed to a provider or provider group for any claims payment made to a provider or provider group for up to one calendar month beginning on the first day of the following month, if the provider or provider group fails to respond to the insurer's attempts to verify the provider's information as required under subdivision (*l*). The insurer shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. An insurer may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business-day notice period described in paragraph (4) of subdivision (*l*) has lapsed.

(2) An insurer shall notify the provider or provider group 10 days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the insurer delays a payment or reimbursement pursuant to this subdivision, the insurer shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the insurer receives the information required to be submitted by the provider or provider group pursuant to subdivision (*l*).

(B) At the end of the one-calendar-month delay described in paragraph (1), if the provider or provider group fails to provide the information required to be submitted to the insurer pursuant to subdivision (*l*).

(3) An insurer may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the insurer to a change in the information required to be in the directory or directories pursuant to this section.

(4) An insurer that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department. This information shall be submitted along with the policies and

procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(r) (1) In circumstances where the department finds that an insured reasonably relied upon ~~materially~~ inaccurate, incomplete, or misleading information contained in an insurer's provider directory or directories, the ~~department may require the insurer to~~ *insurer shall arrange care and* provide coverage for all covered health care services provided to the ~~insured and to~~ *insured*, reimburse the insured for any amount beyond what the insured would have paid, had the services been delivered by an in-network provider under the insured's health insurance ~~policy.~~ *policy, and reimburse the provider the contracted amount for those health care services under the policy. The provider shall not collect any additional amount from the insured other than the applicable in-network cost sharing.* Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the insured were covered services under the insured's health insurance policy. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the insured.

(2) If an insured, by telephone call or electronic means, requests information on whether or not a provider is contracted as an in-network provider to provide covered benefits, the insurer *shall, if the request is by telephone, tell the insured verbally and follow up in writing or electronic format no later than one business day after receiving the request. If the request is by electronic means, the insurer* shall respond in writing or electronic format no later than one business day after receiving the request. The insurer shall also provide information on whether or not the provider is accepting new patients. The insurer shall retain a record of the request and the insurer's response in the insured's file for at least two years after the date of the request.

(3) For covered benefits, if an insured obtained information through the plan's online directory or a request consistent with paragraph (2) that a provider was an in-network provider, the group insured shall pay no more than in-network cost sharing if any of the following apply:

(A) The provider is not contracting with the insurer as an in-network provider for that product.

(B) The contracting provider is not accepting new patients for that product.

(C) The information provided is otherwise ~~materially~~ inaccurate, misleading, or incomplete.

(D) The online provider directory of the insurer is not accessible to insureds at the time the insured seeks information and the insured requests information consistent with paragraph (2).

(4) If the health insurance policy includes more than one tier of cost sharing, the insurer shall document the cost-sharing tier that the provider is contracted to accept and shall provide that information to the insured when the insured seeks information about the provider. If the insurer provides information indicating that a provider is on a lower cost-sharing tier and that information is not accurate, then the insured shall owe no more than the cost sharing for the cost-sharing tier included in the information received by the insured from the insurer.

(5) For purposes of this subdivision, the in-network cost sharing amount for a contracted provider includes copayments, deductibles, coinsurance, and any other form of cost sharing. If the health insurance policy includes more than one tier of cost sharing and if the insured was not informed accurately of the applicable cost-sharing tier, then the lowest cost-sharing tier shall apply.

(6) For purposes of this subdivision, "information" is inaccurate, incomplete, or misleading if any information in subdivision (h) or (i) is inaccurate, incomplete, or misleading.

(s) *(1)* Whenever an insurer determines as a result of this section that there has been a 10-percent change in the network for a product in a region, the insurer shall file a statement with the commissioner.

(2) For an insurance policy issued, amended, or renewed on or after July 1, 2025, if a provider has not been financially compensated consistent with this section or if the provider has failed to respond timely consistent with this section, and those providers amount to a change of 10 percent or greater in the network for a product in a region, then the insurer shall file an amendment to the policy application consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.

(3) An insurer shall not use information about a provider for purposes of compliance with timely access requirements, network adequacy determination, or compliance with any other provision

of this chapter if the insurer cannot demonstrate to the department that the provider is contracting with the insurer and the provider has been financially compensated by the insurer consistent with this section or the provider has failed to respond timely consistent with this section. This paragraph shall apply whether or not the provider has been deleted from the directory.

(4) Consistent with Section 1360 of the Health and Safety Code, an insurer shall not advertise or otherwise represent the extent of its network, including the number or type of contracting providers, unless it is able to demonstrate that each provider is contracting and has been compensated consistent with this section.

(t) An insurer that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the requirements of this section.

(u) This section shall not be construed to alter a provider's obligation to provide health care services to an insured pursuant to the provider's contract with the insurer.

(v) As part of the department's routine examination of a health insurer pursuant to Section 730, the department shall include a review of the health insurer's compliance with subdivision (q).

(w) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

SEC. 4. 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.

O

ASSEMBLY THIRD READING
AB 236 (Holden)
As Amended January 22, 2024
Majority vote

SUMMARY

Requires a health care service plan (health plan) or insurer to annually verify and delete inaccurate listings from its provider directories, and requires a provider directory to be 60% accurate on July 1, 2025 and 95% accurate on or before July 1, 2028. Subjects a health plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. Requires the health plan or insurer to delete the provider from its directory beginning July 1, 2025, if a plan or insurer has not financially compensated a provider in the prior year unless specified criteria applies. Requires a health plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and limits the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. Authorizes the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), on or before January 1, 2025, to develop uniform formats for health plans and insurers to use when requesting directory information from providers. Authorizes the DMHC and CDI, on or before January 1, 2026, to establish a methodology and processes to ensure accuracy of provider directories, including requiring a health plan or insurer, to use a central utility or designate a central utility for those providers included in the directory.

COMMENTS

1) *California's Provider Directory***.** Provider directories help patients identify clinicians based on specialty, location, and hours. California was one of the first states to enact laws related to provider directories, in SB 137 (Hernandez), Chapter 649, Statutes of 2015, which requires health plans and insurers to maintain accurate online and paper directories as of July 1, 2016. SB 137 also requires some of the following:

   a) The DMHC and CDI to develop uniform provider directory standards and to take appropriate steps to ensure the accuracy of the information contained in the plan or health insurer's directory or directories, and requires the plan or insurer, at least annually, to review and update the entire provider directory or directories for each product offered;

   b) A plan or insurer, at least weekly, to update its online provider directory or directories, and requires a plan or insurer, at least quarterly, to update its printed provider directory or directories; and,

   c) A plan or insurer to reimburse an enrollee or insured for any amount beyond what the enrollee or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory and authorizes a plan or health insurer to delay payment or reimbursement owed to a provider or provider group, as specified, if the provider or provider group fails to respond to the plan's or health insurer's attempts to verify the provider's or provider group's information.

2) *Federal Provider Directory Requirements*. In a secret shopper Health Affairs study of California qualified health plans (QHPs) (offered on Covered California – California's state based exchange) in 2015, 73% of calls to providers listed in network directories were unable

to secure appointments. Failures generally related to inaccurate phone numbers or addresses for listed providers, inaccurate specialty listings, or listed providers who were not actually in the network. As part of its annual compliance review, the Centers for Medicare & Medicaid Services selects a small sample of issuers and reviews the machine-readable provider directory to verify accuracy. The 2020 Plan Year Federally-Facilitated Exchange Issuer Compliance Review Summary Report found inaccuracies in all directories examined in 2020, with similar compliance problems observed in prior years.

Beginning in 2022, the federal No Surprises Act requires all private health plans, including QHPs, to maintain accurate provider directories and requires providers to regularly update plans about any changes in their information. Plans must verify and update directories at least every 90 days and, on an ongoing basis, post any changes within two business days. Plans are also required to apply in-network cost sharing for covered services provided by facilities or providers mistakenly listed as in-network.

3) *Enforcement*. The *Yale Law & Policy Review (Yale Review)* entitled, *"*Laying ghost networks to rest: Combatting deceptive health plan provider directories," also revealed high error rates. Even the lowest error rate, 21%, means that one out of five provider listings will lead enrollees seeking care to a dead end. At the high end, more than half of all provider listings lead to a dead end. While consumers can theoretically seek out correct addresses and phone numbers, search engines are at best a partial replacement for accurate directories. Furthermore, the provider directories examined had higher error rates for psychiatrists than for other types of specialists, underlining the particular burden placed on people who need behavioral care. According to the *Yale Review*, when states do carry out enforcement actions, they tend to result in minimal or no fines, removing any incentive for insurers to increase the accuracy of their plans. Despite SB 137's broad scope and detailed requirements, the *Yale Review* indicated that California continues to have high levels of directory errors. California does not directly collect data about directory errors. However, to comply with California's timely access standards, health plans regulated by the DMHC must submit yearly surveys of all providers that take appointments from enrollees to assess how soon an appointment can be scheduled. According to the *Yale Review*, DMHC only uses this data to compile timely access reports, but this survey also functions as a directory accuracy survey: the raw data notes when providers could not complete the timely access questionnaire because their address was incorrect, their phone number was incorrect, their specialty was incorrect, they do not take appointments at that location, they are not actually in-network, or they are no longer practicing. This bill builds upon California's provider directory by requiring plans and insurers to annually audit, delete inaccurate listings, and requires a 95% accuracy by July 1, 2028. Failure to meet these required benchmarks will result increased administrative penalties.

According to the Author
Despite California having one of the nation's strongest laws on health plan provider directories, compliance is at an unbelievable low. Recent studies have found that some health plans have inaccuracy rates as high as 80%, and major plans like Anthem and Kaiser have inaccurate information for 20%-38% of providers. According to the author, these inaccuracies in provider referral lists are often referred to as 'ghost networks' because the referrals simply do not exist. As a result, consumers bear the responsibility of sorting through these grossly inaccurate lists, sifting through directories in an effort to find care, calling provider after provider, only to be told the provider is no longer in-network, no longer accepting new patients, or even no longer in

practice. This is especially harmful to those already suffering from health care inequity, such as those with limited English proficiency and persons with disabilities. The author concludes that ghost networks contribute to inequity in health care by leaving Californians to fend for themselves in their most vulnerable time.

Arguments in Support
Health Access California (HAC), sponsors of this bill, references the same *Yale Review* study cited above that found the following: Kaiser was 12-38% inaccurate; Molina was 54-80% inaccurate; Blue Cross 20-25% inaccurate; and, CenCal Health Plan was 39-62% inaccurate. According to HAC, consumers depend on a provider directory to find an in-network provider whether it be a doctor, specialist, dentist, hospital, laboratory, imaging center, or another provider. A consumer's right to timely access to care is affected by a provider directory; if a consumer is unable to find a provider, they waste necessary time simply searching for one. According to HAC, timely access to care monitoring by DMHC routinely finds that 20%-30% of providers are unreachable by the health plan, often because of inaccuracies in the health plan's own provider directory. If a provider directory is replete with doctors and other professionals who are not actually seeing patients covered by that health plan, it raises serious questions about the plan's assertions about an adequate network of doctors and other providers that are available to provide timely access to care.

Arguments in Opposition
The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) state that provider directories act as an essential guide that health plans and insurers rely upon to help our enrollees and insureds access timely and appropriate care but state that this bill does nothing to address the root cause of the issue, and instead simply places the full responsibility of the database accuracy on health plans and insurers, without fully appreciating that this endeavor was always intended to be a shared responsibility between contracted providers and health plans/insurers. Without that consideration being included in this bill, plans and insurers will continue to struggle to meet the expectations set forth by the Legislature. Additionally, this bill does not recognize the existing work being done by both the DMHC and the Integrated Health Association around provider directory accuracy. The DMHC is still in the process of official rulemaking for SB 137, demonstrating how difficult it is to obtain accuracy. According to CAHP, ACLHIC, and AHIP, currently, commercial health plans and insurers spend over 2.1 billion dollars annually to maintain provider databases, clearly demonstrating the commitment health plans and insurers have to supporting accurate provider directories. Lastly, this bill attaches enormous financial penalties solely on health plans and insurers if the directories are inaccurate, even when a provider fails to disclose updated or accurate information to the plan or insurer.

The California State Association of Psychiatrists (CSAP), in oppose unless amended, would like this bill language to clarify that the burden to maintain accurate provider directories is the responsibility of the health plan and that any burden on a physician should be minimized. CSAP also wants to make sure that when a patient sees an out-of-network physician and only pays in-network cost-sharing amounts, the physician is made whole or compensated at a fair rate. Other suggestions are to include on every provider directory information about an enrollee's right to timely access to care and who they can contact if the health plan is not meeting that requirement, and to clarify that a physician is not obligated to disclose whether they provide gender-affirming care due to safety, security and privacy concerns. Lastly, CSAP wants to ensure that there is due

process for a provider if they are mistakenly removed from a plan's provider directory or if the health plan wrongly concludes the information provided to them is inaccurate.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, DMHC estimates ongoing annual costs of up to $12 million for additional staff to do the following: develop a methodology to measure provider directory accuracy and determine "special circumstances" necessitating a provider's continued inclusion in the provider directory; promulgate new regulations and modify existing regulations; develop infrastructure, such as template language for plan responses, spreadsheets, report forms, and instruction manuals; review costs, and review new filings from plans regarding accuracy of provider directories (Managed Care Fund).

CDI estimates this bill will require $72,000 in fiscal year (FY) 2023-24, $168,000 FY 2024-25, and $88,000 ongoing for additional staff time (Insurance Fund).

VOTES

ASM HEALTH: 10-1-4
YES: Wood, Aguiar-Curry, Arambula, Boerner Horvath, Maienschein, McCarty, Rodriguez, Santiago, Villapudua, Weber
NO: Waldron
ABS, ABST OR NV: Wendy Carrillo, Flora, Lackey, Joe Patterson

ASM APPROPRIATIONS: 12-2-2
YES: Holden, Arambula, Wood, Calderon, Connolly, Mike Fong, Grayson, Haney, Hart, Lowenthal, Pellerin, Villapudua
NO: Sanchez, Dixon
ABS, ABST OR NV: Megan Dahle, Ta

UPDATED

VERSION: January 22, 2024

CONSULTANT: Kristene Mapile / HEALTH / (916) 319-2097 FN: 0002600

California Board of PSYCHOLOGY

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(b)(2) - Review of Bills for Review and Consideration for Action Position Recommendation to the Board – SB 294 (Wiener) Health care coverage: independent medical review.

Background

At the May 10, 2024, Board meeting, members of the California Psychological Association requested the Board to review and consider SB 294 for a possible position:

SB 294 would be effective July 1, 2025, this bill would establish an automatic grievance process and automatic Independent Medical Review (IMR) process when a health plan or insurer that provides coverage for medically necessary mental health or substance use disorders modifies, delays, or denies an authorization request for coverage of treatment for a mental health or substance use disorder for an enrollee or insured who is younger than 26 years of age.

Action Requested

Staff Recommendation: Watch SB 294.

Attachment #1: SB 294 Bill Text
Attachment #2: SB 294 – Senate Floor Analyses

AMENDED IN SENATE JANUARY 11, 2024

AMENDED IN SENATE JANUARY 3, 2024

AMENDED IN SENATE SEPTEMBER 13, 2023

SENATE BILL No. 294

Introduced by Senator Wiener

February 2, 2023

An act to add Sections 1368.012 and 1374.37 to the Health and Safety Code, and to add Sections 10169.4 and 10169.6 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 294, as amended, Wiener. Health care coverage: independent medical review.

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 the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.

This bill, commencing July 1, 2025, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a

decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.

This bill, commencing July 1, 2025, would require a health care service plan or disability insurer that provides ~~treatment~~ *coverage* for mental health or substance use disorders to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee or insured. The bill would require a plan or insurer to provide a written acknowledgment of a grievance that is automatically generated and would specify the circumstances under which that grievance is required to be submitted automatically to independent medical review.

The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose 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.

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. The Legislature finds and declares all of the following:

(a) Disputed health care service decisions under commercial health care coverage are already subject to review like the state's Independent Medical Review System, but appeals must be initiated by enrollees and insureds.

(b) Mental health resources in California are disproportionately hard to access for low-income and minority children, and the online form to file an independent medical review is in English and Spanish only.

(c) The Legislature recently approved Chapter 151 of the Statutes of 2020, a mental health parity law that requires commercial health care service plan contracts and disability insurance policies to provide medically necessary mental health treatment.

(d) In California, 13 percent of children 3 to 17 years of age, inclusive, reported having at least one mental, emotional, developmental, or behavioral health problem, and 8 percent of children have a serious emotional disturbance that limits participation in daily activity.

(e) In 2021, mental health disorder diagnosis cases made up 48 percent of all total youth independent medical reviews, up from 36 percent in 2017.

(f) Since 2017, the percentage of health care service plan and disability insurer decisions about youth mental health disorders that were overturned by the Independent Medical Review System has more than doubled to 79 percent.

(g) Like older adults, children and youth represent a vulnerable population. However, children and youth covered by commercial health care coverage do not have the protections afforded by Medicare procedures. If a Medicare Advantage (Part C) health plan upholds its initial adverse organization determination to deny a drug or service, the plan must automatically submit the case file and its decision for review by the Part C Independent Review Entity.

SEC. 2. Section 1368.012 is added to the Health and Safety Code, to read:

1368.012. (a) Commencing July 1, 2025, a health care service plan that provides ~~treatment~~ *coverage* for mental health or substance use disorders pursuant to Section 1374.72 shall treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an enrollee up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee in accordance with Sections 1368, 1368.01, and 1368.015.

(b) *(1)* A grievance automatically generated pursuant to subdivision (a) shall be treated by the plan and the department in the same manner as a grievance seeking to appeal the decision of the health care service plan to modify, delay, or deny the requested treatment for the enrollee, and shall be considered to have been submitted by the enrollee or the enrollee's representative to the plan on the same date as the decision to modify, delay, or deny the requested treatment is issued by the plan. The plan shall not require the enrollee or the enrollee's representative to take any additional action to initiate or continue the grievance processing procedure. ~~The~~

(2) The plan shall provide ~~the~~ *a* written acknowledgment of the grievance generated pursuant to subdivision (a) as required pursuant to paragraph (4) of subdivision (a) of Section 1368 concurrent with the notification to the enrollee of the decision to modify, delay, or deny the requested treatment. The acknowledgment shall include an explanation of the grievance process and relevant timeframes for completion, criteria *under subdivision (c) of Section 1374.33* for treatment of a grievance as an expedited case, including whether the present grievance is to be processed on an expedited ~~basis,~~ *basis and automatically submitted to the independent medical review system under Section 1374.37,* contact information for the plan, including a telephone number through which the enrollee may receive a status update on the grievance or withdraw the automatically generated grievance, and contact information for the department.

(c) The acknowledgment described in subdivision (b) shall include a statement that the enrollee may choose to withdraw the automatically generated grievance. A withdrawal by the enrollee or their representative of a grievance automatically generated pursuant to this section before the health care service plan's determination on the grievance shall not, by itself, disqualify the

enrollee or their representative from later submitting a grievance related to the same underlying modification, delay, or denial of the requested mental health or substance use disorder treatment.

(d) Grievances automatically generated pursuant to subdivision (a) that are pending or unresolved upon expiration of the relevant timeframe specified in Sections 1368.01 and 1374.30 or for which the health care service plan upholds its decision to modify, delay, or deny the requested treatment are subject to automatic submission to independent medical review pursuant to Section 1374.37.

(e) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 1374.37 is added to the Health and Safety Code, to read:

1374.37. (a) (1) Commencing July 1, 2025, a health care service plan that, itself or through its delegates, upholds its decision, in whole or in part, to modify, delay, or deny a health care service in response to a grievance submitted by an enrollee or processed pursuant to Section 1368.012, or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe specified in Sections 1368.01 and 1374.30, shall automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System and all information that informed the health care service plan's conclusion if the health care service plan's decision is to deny, modify, or delay either of the following with respect to an enrollee up to 26 years of age:

(A) A mental health care or substance use disorder service based on the lack of medical necessity of the requested covered health care service, in whole or in part.

(B) The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies, if the enrollee has a seriously debilitating or life-threatening mental health or substance use disorder condition, as defined in Section 1370.4. The independent medical review for experimental or investigational therapies, drugs, devices, procedures, or other therapies shall be consistent with Section 1370.4.

(2) An independent medical review required under this subdivision is subject to any relevant provisions of this article that do not otherwise conflict with the express requirements of this section, including notice ~~requirements~~ *requirements, the assessment fee system under Section 1374.35,* and provisions regarding the department's authority to determine the nature of a grievance as a matter of coverage or medical necessity, in whole or in part.

(3) The requirement that an enrollee complete the health care service plan grievance process before automatic submission of a decision to the Independent Medical Review System pursuant to paragraph (1) shall not apply to cases involving an imminent and serious threat to the health of the ~~patient,~~ *enrollee,* as described in subparagraph (A) of paragraph (1) of subdivision (b) of Section 1368. In those circumstances, the health care service plan shall immediately submit the case to the Independent Medical Review System and coordinate with the enrollee or the enrollee's representative on the submission of all information and documentation required by the department to process the expedited independent medical review.

(b) (1) Within 24 hours after submitting its decision to the Independent Medical Review System pursuant to subdivision (a), the health care service plan shall provide notice to the department, the enrollee, the enrollee's representative, if any, and the enrollee's provider. The notice shall include both of the following:

(A) Notification to the enrollee that the enrollee or their representative may cancel the independent medical review at any time before the rendering of a determination and may provide additional information or documentation as described in paragraph (3) of subdivision (m) of Section 1374.30.

(B) Instructions for canceling the independent medical review and submitting additional information or documentation.

(C) The department's application for independent medical review.

(D) Any other content that is required by the department.

(2) Concurrent with the notice specified in paragraph (1), the health care service plan shall provide the enrollee and the enrollee's provider with copies of all documents described in subdivision (n) of Section 1374.30. The health care service plan shall coordinate with the enrollee and provider for the completion of a signed independent medical review application *that includes consent to*

release medical records and, if necessary, an authorized ~~assistant~~ *representative* form.

(3) The department may close independent medical review cases submitted automatically pursuant to this section if the enrollee or authorized ~~assistant~~ *representative* fails to complete an independent medical review application within 30 days of the department notifying the enrollee or authorized ~~assistant~~ *representative* and provider of the incomplete application.

(c) Sections 1374.72, 1374.721, 1374.724, and 1374.73 apply for purposes of this section.

(d) If an enrollee or their representative cancels the independent medical review consistent with this section, they may seek an independent medical review consistent with Section 1370.4 or this article.

(e) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(f) The department shall provide a quarterly public report on the number of automatic ~~grievance cases,~~ *independent medical review cases that are received*, the number of automatic ~~grievance cases resolved and closed, and the number of Independent Medical Review applications sent from the Department of Managed Health Care and returned to the Department of Managed Health Care.~~ *independent medical review cases that are resolved, the outcome of resolved cases, and the number of automatic independent medical review cases that are canceled and closed.*

SEC. 4. Section 10169.4 is added to the Insurance Code, to read:

10169.4. (a) Commencing July 1, 2025, a disability insurer that provides ~~treatment~~ *coverage* for mental health or substance use disorders pursuant to Section ~~1374.72~~ *10144.5* shall treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the insured in accordance with this article.

(b) *(1)* A grievance automatically generated pursuant to subdivision (a) shall be treated by the insurer and the department

in the same manner as a grievance seeking to appeal the decision of the disability insurer to modify, delay, or deny the requested treatment for the insured, and shall be considered to have been submitted by the insured or the insured's representative to the insurer on the same date as the decision to modify, delay, or deny the requested treatment is issued by the insurer. The insurer shall not require the insured or the insured's representative to take any additional action to initiate or continue the grievance processing procedure. ~~The~~

(2) The insurer shall provide ~~the~~ *a* written acknowledgment of the grievance generated pursuant to subdivision (a) concurrent with the notification to the insured *under subdivision (h) of Section 10123.135* of the decision to modify, delay, or deny the requested treatment. The acknowledgment shall include an explanation of the grievance process and relevant timeframes for completion, criteria *under subdivision (c) of Section 10169.3* for treatment of a grievance as an expedited case, including whether the present grievance is to be processed on an expedited ~~basis,~~ *basis and automatically submitted to the Independent Medical Review System under Section 10169.6*, contact information for the insurer, including a telephone number through which the insured may receive a status update on the grievance or withdraw the automatically generated grievance, and contact information for the department.

(c) The acknowledgment described in subdivision (b) shall include a statement that the insured may choose to withdraw the automatically generated grievance. A withdrawal by the insured or their representative of a grievance automatically generated pursuant to this section before the disability insurer's determination on the grievance shall not, by itself, disqualify the insured or their representative from later submitting a grievance related to the same underlying modification, delay, or denial of the requested mental health or substance use disorder treatment.

(d) Grievances automatically generated pursuant to subdivision (a) that are pending or unresolved upon expiration of the relevant timeframe specified in Section 10169 or for which the disability insurer upholds its decision to modify, delay, or deny the requested treatment are subject to automatic submission to independent medical review pursuant to Section 10169.6.

SEC. 5. Section 10169.6 is added to the Insurance Code, immediately following Section 10169.5, to read:

10169.6. (a) (1) Commencing July 1, 2025, a disability insurer that, itself or through its delegates, upholds its decision, in whole or in part, to modify, delay, or deny a health care service in response to a grievance submitted by an insured or processed pursuant to Section 10169.4, or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe specified in Section 10169, shall automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System and all information that informed the disability insurer's conclusion if the disability insurer's decision is to deny, modify, or delay either of the following with respect to an insured up to 26 years of age:

(A) A mental health care or substance use disorder service based on the lack of medical necessity of the requested covered health care service, in whole or in part.

(B) The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies, if the insured has a seriously debilitating or life-threatening mental health or substance use disorder condition, as defined in Section 10145.3. The independent medical review for experimental or investigational therapies, drugs, devices, procedures, or other therapies shall be consistent with Section 10145.3.

(2) An independent medical review required under this subdivision is subject to any relevant provisions of this article that do not otherwise conflict with the express requirements of this section, including notice ~~requirements~~ *requirements, the assessment fee system under Section 10169.5,* and provisions regarding the department's authority to determine the nature of a grievance as a matter of coverage or medical necessity, in whole or in part.

(3) The requirement that an insured complete the disability insurer grievance process before automatic submission of a decision to the Independent Medical Review System pursuant to paragraph (1) shall not apply to cases involving an imminent and serious threat to the health of the ~~patient,~~ *insured,* as described in subdivision (c) of Section 10169.3. In those circumstances, the disability insurer shall immediately submit the case to the Independent Medical Review System and coordinate with the insured or the insured's representative on the submission of all

information and documentation required by the department to process the expedited independent medical review.

(b) (1) Within 24 hours after submitting its decision to the Independent Medical Review System pursuant to subdivision (a), the disability insurer shall provide notice to the department, the insured, the insured's representative, if any, and the insured's provider. The notice shall include both of the following:

(A) Notification to the insured that the insured or their representative may cancel the independent medical review at any time before the rendering of a determination and may provide additional information or documentation as described in paragraph (3) of subdivision (m) of Section 10169.

(B) Instructions for canceling the independent medical review and submitting additional information or documentation.

(C) The department's application for independent medical review.

(D) Any other content that is required by the department.

(2) Concurrent with the notice specified in paragraph (1), the disability insurer shall provide the insured and the insured's provider with copies of all documents described in subdivision (n) of Section 10169. The ~~disability~~ insurer shall coordinate with the insured and provider for the completion of a signed independent medical review application *that includes consent to release medical records* and, if necessary, an authorized ~~assistant~~ *representative* form.

(3) The department may close independent medical review cases submitted automatically pursuant to this section if the insured or authorized ~~assistant~~ *representative* fails to complete an independent medical review application within 30 days of the department notifying the insured or authorized ~~assistant~~ *representative* and provider of the incomplete application.

(c) Sections 10144.5, 10144.51, 10144.52, and 10144.57 apply for purposes of this section.

(d) If an insured or their representative cancels the independent medical review consistent with this section, they may seek an independent medical review consistent with Section 10145.3 or this article.

(e) The commissioner may promulgate regulations subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government

Code) to implement and enforce this ~~section.~~ *section and Section 10169.4.*

(f) The department shall provide a quarterly public report on the number of automatic ~~grievance cases,~~ *independent medical review cases that are received,* the number of automatic ~~grievance cases resolved and closed, and the number of Independent Medical Review applications sent from the Department of Managed Health Care and returned to the Department of Managed Health Care.~~ *independent medical review cases that are resolved, the outcome of resolved cases, and the number of automatic independent medical review cases that are canceled and closed.*

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.

O

Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 294
Author: Wiener (D)
Amended: 1/11/24
Vote: 21

SENATE HEALTH COMMITTEE: 9-2, 1/10/24
AYES: Eggman, Glazer, Gonzalez, Hurtado, Limón, Menjivar, Rubio, Wahab, Wiener
NOES: Nguyen, Grove
NO VOTE RECORDED: Roth

SENATE APPROPRIATIONS COMMITTEE: 4-2, 1/18/24
AYES: Portantino, Bradford, Wahab, Wiener
NOES: Jones, Seyarto
NO VOTE RECORDED: Ashby

SUBJECT: Health care coverage: independent medical review

SOURCE: Children Now

DIGEST: This bill establishes an automatic grievance process and automatic Independent Medical Review process, commencing July 1, 2025, when a health plan or disability insurer that provides coverage for medically necessary mental health or substance use disorders modifies, delays, or denies an authorization request for coverage of treatment for a mental health or substance use disorder for an enrollee or insured who is younger than 26 years of age.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the California Department of Insurance (CDI) to regulate health and other insurers, and, the Department of Health Care Services (DHCS)

to administer the Medi-Cal program. (HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.)

2) Requires every health plan to establish and maintain a grievance system, including an online process, and acknowledge in writing within five calendar days receipt of the grievance, with some exceptions based on the nature of the grievance. Grievances generally should be resolved by the plan within 30 days, and grievances may be appealed to DMHC. (HSC §1368, §1368.01, and §1368.015)

3) Establishes, in DMHC and CDI, the Independent Medical Review (IMR) System which reviews disputed health care services that a plan, or one of its contracting entities, or insurer determines is not medically necessary.

This bill:

1) Requires, commencing July 1, 2025, a health plan or disability insurer that provides coverage for medically necessary mental health or substance use disorders to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an enrollee up to age 26 years of age, as a grievance, as specified.

2) Requires the automatically generated grievance to be treated by the plan and DMHC, or insurer and CDI, in the same manner as a grievance seeking to appeal the decision of the plan or insurer, to be considered to have been submitted on the same date as the decision of the plan or insurer, and require no additional action by the enrollee, insured, or representative. Requires a written acknowledgment by the plan or insurer, as specified, including a description of the process and timeframes, and information on how the grievance can be withdrawn.

3) Requires these automatically generated grievances that are pending or unresolved upon expiration of the relevant timeframe, as specified, or for which the plan or insurer upholds its decision, to be subject to automatic submission to IMR.

4) Requires, commencing July 1, 2025, a health plan or insurer, either itself or through a delegate that upholds its decision to modify, delay, or deny a health care service in response to a grievance submitted by an enrollee or insured or processed pursuant to 1) through 3) immediately above, or, when the grievance is otherwise pending or unresolved upon the expiration of the relevant

timeframes, as specified, to automatically submit within 24 hours a decision regarding a disputed health care service to the IMR and all information that informed the plan's or insurer's conclusion with respect to an enrollee or insured up to 26 years of age:

a) A mental health care or substance use disorder service based on the lack of medical necessity of the requested covered health care service, in whole or in part; and,
b) The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies, if the enrollee has a seriously debilitating or life-threatening mental health or substance use disorder condition, as defined.

5) Requires an IMR subject to this bill to also be subject to any relevant provisions of law that do not conflict with this bill, including notice requirements.

6) Exempts cases involving an imminent and serious threat to the health of the patient from the requirement to complete the grievance process before automatic submission to IMR.

7) Requires a plan or insurer to provide notice to DMHC or CDI, the enrollee or insured, the enrollee's or insured's representative, if any, and the enrollee's or insured's provider within 24 hours after submitting its decision to the IMR system. Requires the notice to the enrollee, insured, or representative that the IMR may be canceled by the enrollee, insured, or representative at any time before the rendering of a determination, how to provide additional information, as specified, how to cancel the IMR, and concurrent with the notice, copies of specified document, such as medical records, that the plan or insurer is required to send DMHC or CDI.

8) Requires the plan or insurer to coordinate with the insured and provider for the completion of a signed IMR application that includes consent to release medical records and if necessary, an authorized assistant form.

9) Permits DMHC or CDI to close the automatic IMR if the enrollee, insured or authorized assistant fails to complete an IMR application within 30 days of notification from DMHC or CDI that the application is incomplete.

Comments

Author's statement. According to the author, this bill will ensure that young people receive faster access to treatment by requiring mental health treatment

denials made by commercial insurance plans for children and young people under the age of 26 in California to automatically be referred to the state's existing IMR process in life threatening cases and to an auto-grievance process followed by an IMR review if treatment is still denied in non-life threatening cases. Unfortunately, many young people are denied mental health coverage by their insurance companies, but a very high percentage of those who seek review get their denial overturned. Nearly all families that do seek review are English speakers, signifying that almost no multilingual speakers are seeking review. By requiring automatic review of denials, this bill will remove burdensome barriers that prevent families from accessing care and will ensure no child is denied care because of an insurance company's decision to maximize its profits at their expense.

IMR Process. An enrollee or insured can apply for IMR when they have filed a grievance with the plan, provider or insurer and the decision was upheld or remains unresolved after 30 days. A grievance requiring expedited review can go to IMR after three days of the grievance process. Enrollees and insureds can apply for IMR when 1) the provider has recommended a health care service as medically necessary; 2) the enrollee or insured has received urgent care or emergency services that a provider determined was medically necessary; 3) the enrollee has received experimental or investigational treatment for a serious condition; or, 4) the enrollee or insured has been seen by an in-network provider for the diagnosis or treatment of the medical condition and the disputed health care service has been denied, modified, or delayed by the plan or insurer or by one of its contracting providers, based on a decision that it is not medical necessary. IMR is free to the enrollee or insured, and in most cases decided within 30 days of IMR qualification and receipt of all required documentation. For more urgent situations, an expedited IMR can be requested and is usually decided within seven days after the supporting documentation is provided. If the IMR decision is in favor of the enrollee, the health plan must authorize the service or treatment within five business days. Both health plans and insurers must comply with the IMR requirements.

Related/Prior Legislation

SB 238 (Wiener, 2023) requires a health plan or a disability insurer that modifies, delays, or denies a mental health or substance use disorder service based on medical necessity, to submit within 24 hours the decision to the IMR System, without requiring the enrollee or insured to file a grievance, for an enrollee or insured up to 26 years of age. (SB 238 is in the Assembly Appropriations Committee suspense file)

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- Unknown ongoing costs for DMHC for staffing and resources due to an increase in the number of IMRs to be processed under this bill, likely in the low tens of millions annually (Managed Care Fund).

- Unknown ongoing costs for CDI, likely hundreds of thousands, for state administration (Insurance Fund).

SUPPORT: (Verified 1/18/24)

Children Now (source)
American Academy of Pediatrics, California
California Alliance of Child and Family Services
California Association of Social Rehabilitation Agencies
California Children's Hospital Association
California Pan-Ethnic Health Network
Courage California
Foster Care Counts
Friends Committee on Legislation of California
Health Access California
Jewish Family and Children's Services of San Francisco Bay Area
National Health Law Program
Steinberg Institute
The Kennedy Forum
Western Center on Law & Poverty, Inc.

OPPOSITION: (Verified 1/18/24)

Americas Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

ARGUMENTS IN SUPPORT: Children Now, the sponsor of this bill, argues that too many families must fight health plans to get mental health care for their children, and while the IMR process is available, a consumer must first file a grievance/complaint with their health plan and participate in a 30-day process. If the issue is not resolved, consumers may file an IMR/complaint. The number of IMRs for the diagnosis category "Mental Disorder" has steadily increased in 2017-2022 for youth ages 0-20 years. In 2021, more than 50% of all youth IMR cases

were for a "mental disorder" diagnosis. While the IMR process allows for greater oversight of health plans, it places the burden on the consumer and delays or prevents children and youth in California from accessing critical, timely mental health treatment. Language barriers, health literacy, and demanding jobs may prevent some parents from filing IMRs, furthering mental health access inequities. Health Access California argues in support that they would support future efforts to expand the requirement of automatic IMRs beyond children and youth as well as for other health service denials beyond behavioral health but believes that this bill is a place to start to ensure that children and youth seeking behavioral health treatment with CDI-regulated and DMHC-regulated plans can access IMRs to appeal denial of treatment for behavioral health conditions. Health Access would also support expansion of automatic IMRs to consumers with coverage through Medi-Cal. The Steinberg Institute argues that in 2019, 13% of California's children three to 17 years of age reported having at least one mental, emotional, developmental, or behavioral health problem, and eight percent of children have a serious emotional disturbance that limits participation in daily activity. This bill is fiscally sound allowing minimal additional costs to the state. Under current law all IMR costs are to be borne by health plans; therefore, special fund costs to both departments will be offset.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans, Association of California Life and Health Insurance Companies, and America's Health Insurance Plans argue that they are concerned that this bill will substantially alter a health plan/insurer's internal review structure by creating a new bifurcated process for the purpose of reviewing youth mental health services. As drafted, this bill creates a unique two-tiered review system which requires health plans/insurers to automatically review all youth related mental health services when the plan has issued an initial denial and/or modification. They are also concerned that this bill lacks consideration with respect to patient privacy. Currently, the federal Privacy Rule expressly prohibits covered entities from sharing psychotherapy notes without direct consent from the enrollee. Psychotherapy notes may be required for plans/insurers to adequately assess medical necessity. Automatically referring cases to IMR and requiring the plans to provide clinical notes, which may include psychotherapy notes, may not be something the patient is comfortable with. Lastly, opponents believe this bill is premature, as there has been a considerable amount of work done in this area the last few years related to the recent requirements for plan/insurers to cover services originated from 988 calls, CARE Court, as well as the imminent implementation of the Children and Youth Behavioral Health Initiative, which will alter the way that children/youth access care, these mandates

require plan/insurers to cover mental health and substance use disorder services without prior authorization and zero cost share.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
1/22/24 15:22:45

****** END ******

California Board of PSYCHOLOGY

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(b)(3) - Review of Bills for Review and Consideration for Action Position Recommendation to the Board – SB 999 (Wiener) Health care coverage: mental health and substance use disorders

Background

At the May 10, 2024, Board meeting, members of the California Psychological Association requested the Board to review and consider SB 999 for a possible position:

SB 999 would Require health plans and insurers that provide coverage for medically necessary treatment of mental health and substance use disorders to ensure that utilization review determinations and appeals are determined by a health care provider that has appropriate training and relevant experience in the clinical specialty and diagnosis; maintain telephone and other direct access during California business hours for a provider to request authorization and conduct peer-to-peer discussions; and, disclose the name and credentials of the reviewer, the basis for a denial, including a citation to the clinical guidelines reviewed, and, an analysis of why the patient did not meet the clinical criteria.

Action Requested

Staff Recommendation: Watch SB 999

Attachment #1: SB 999 Bill Text
Attachment #2: SB 999 – Senate Floor Analyses

AMENDED IN SENATE APRIL 8, 2024

AMENDED IN SENATE MARCH 7, 2024

SENATE BILL No. 999

Introduced by Senator Cortese
(Coauthor: Senator Wiener)
(Coauthors: Assembly Members Pellerin and Waldron)

February 1, 2024

An act to amend Section 1374.721 of the Health and Safety Code, and to amend Section 10144.52 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 999, as amended, Cortese. Health coverage: mental health and substance use disorders.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care.

This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including

maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose 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.

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. This act shall be known, and may be cited, as the California Mental Health and Substance Use Disorder Treatment Patient Safety and Fairness Act.

SEC. 2. The Legislature finds and declares all of the following:

(a) The federal Patient Protection and Affordable Care Act (PPACA) includes mental health and addiction coverage as one of the 10 essential health benefits, but it does not contain a definition for medical necessity, and despite the PPACA, needed mental health and addiction coverage can be denied through overly restrictive medical necessity determinations.

(b) When medically necessary mental health and substance use disorder care is not covered, individuals with mental health and substance use disorders often have their conditions worsen, ending up on Medicaid, in the criminal justice system, or on the streets, resulting in harm to individuals and communities and higher costs to taxpayers.

(c) In two court decisions, Harlick v. Blue Shield of California (9th Cir. 2012) 686 F.3d. 699, cert. den., (2013) 133 S.Ct. 1492, and Rea v. Blue Shield of California (2014) 226 Cal.App.4th 1209, 1227, the California Mental Health Parity Act was interpreted to require coverage of medically necessary residential treatment.

(d) Coverage of intermediate levels of care such as residential treatment, which are essential components of the level of care

continuum called for by nonprofit organizations, and clinical specialty associations such as the American Society of Addiction Medicine, are often denied through overly restrictive medical necessity determinations.

(e) California law defines medically necessary treatment of a mental health or substance use disorder and generally accepted standards of mental health and substance use disorder care, and prohibits health care service plans and health insurers from limiting benefits or coverage to short-term or acute treatment. California law establishes requirements on plans for conducting utilization review of covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders. These requirements also apply to any entity acting on the plan's or insurer's behalf.

SEC. 3. Section 1374.721 of the Health and Safety Code is amended to read:

1374.721. (a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability

testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services before, after, or concurrent with, the provision of health care services to enrollees.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.

(i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.

(j) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) A health care service plan, and an entity acting on a plan's behalf, shall ensure compliance with all of the following:

(1) Utilization review determinations, including initial determinations and appeals, shall be made by a health care provider ~~practicing in the relevant clinical specialty with the same level of education, training, and experience in the relevant diagnosis or field of expertise, and holding the same applicable certification as the health care provider requesting the authorization.~~ *that has appropriate training and relevant experience in the clinical specialty and diagnosis. To the extent available, a health care provider conducting utilization review determinations shall complete training provided by formal education programs of nonprofit clinical specialty associations, pursuant to subdivisions (b) and (e).*

(2) The health care service plan, or an entity acting on the plan's behalf, shall maintain telephone access and any other direct communication access used for utilization review during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding patient issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity determination.

(3) An individual or health care provider performing utilization review shall disclose to the treating health care provider and the enrollee the name and credentials of the individual or health care provider performing utilization review, the health care service plan's basis for a denial, including a citation to the clinical

guidelines reviewed, and an analysis of why the enrollee did not meet the clinical criteria.

(4) This section does not preclude Section 1367.01.

(*l*) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

SEC. 4. Section 10144.52 of the Insurance Code is amended to read:

10144.52. (a) A disability insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a disability insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a disability insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a disability insurer from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified

in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a disability insurer purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the insurer shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every disability insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the disability insurer's staff, including any third parties contracted with the disability insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 10144.51. Valid,

evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 10144.5.

(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services before, after, or concurrent with, the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a disability insurance policy is covered as medically necessary for an insured.

(4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a disability insurer to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a disability insurance policy, including prescription drugs.

(h) This section applies to a disability insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(i) If the commissioner determines that a disability insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government

Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.

(j) A disability insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(k) A disability insurer, and an entity acting on an insurer's behalf, shall ensure compliance with all of the following:

(1) Utilization review determinations, including initial determinations and appeals, shall be made by a health care provider ~~practicing in the relevant clinical specialty with the same level of education, training, and experience in the relevant diagnosis or field of expertise, and holding the same applicable certification as the health care provider requesting the authorization.~~ *that has appropriate training and relevant experience in the clinical specialty and diagnosis. To the extent available, a health care provider conducting utilization review determinations shall complete training provided by formal education programs of nonprofit clinical specialty associations, pursuant to subdivisions (b) and (e).*

(2) The disability insurer, or an entity acting on the insurer's behalf, shall maintain telephone access and any other direct communication access used for utilization review during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding patient issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity determination.

(3) An individual or health care provider performing utilization review shall disclose to the treating health care provider and the insured the name and credentials of the individual or health care provider performing utilization review, the disability insurer's basis for a denial, including a citation to the clinical guidelines reviewed, and an analysis of why the insured did not meet the clinical criteria.

(4) This section does not preclude Section 10123.135.

(*l*) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

SEC. 5. 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.

O

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THIRD READING

Bill No: SB 999
Author: Cortese (D), et al.
Amended: 4/8/24
Vote: 21

SENATE HEALTH COMMITTEE: 9-1, 4/24/24
AYES: Roth, Glazer, Gonzalez, Hurtado, Limón, Menjivar, Rubio, Smallwood-Cuevas, Wiener
NOES: Grove
NO VOTE RECORDED: Nguyen

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/16/24
AYES: Caballero, Ashby, Becker, Bradford, Wahab
NOES: Jones, Seyarto

SUBJECT: Health coverage: mental health and substance use disorders

SOURCE: California Consortium of Addiction Programs and Professionals
The Kennedy Forum
The Steinberg Institute
Summit Estate Recovery Center
Santa Clara County Office of Education

DIGEST: This bill requires health plans and insurers that provide coverage for medically necessary treatment of mental health and substance use disorders to (1) ensure that utilization review determinations and appeals are determined by a health care provider that has appropriate training and relevant experience in the clinical specialty and diagnosis; (2) maintain telephone and other direct access during California business hours for a provider to request authorization and conduct peer-to-peer discussions; and, (3) disclose the name and credentials of the reviewer, the basis for a denial, including a citation to the clinical guidelines reviewed, and, an analysis of why the patient did not meet the clinical criteria.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers. [HSC §1340, et seq. and INS §106, et seq.]

2) Prohibits an individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying or modifying requests for authorization of health care services for an enrollee or insured for reasons of medical necessity, and requires the decision to be made and communicated as specified in the law in a timely fashion appropriate for the nature of the enrollee's or insured's condition, as specified. Requires insurers to maintain telephone access for providers to request authorization for health care services. Requires plans to provide the direct number or extension to allow the physician or health provider to easily contact the professional responsible for a denial, delay, or modification. [HSC 1367.01 and INS §10123.135]

3) Requires the plans and insurers that offer contracts and policies that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders to base any medical necessity determination or utilization review criteria used to determine medical necessity on current generally accepted standards of mental health and substance use disorder care. Requires the utilization review criteria and guidelines to be based on the most recent versions of treatment guidelines for the specialty; and, prohibits, for those decisions involving level of care placement or other patient care within this scope of care, from applying different, additional, conflicting, or more restrictive utilization review criteria, as specified. [HSC §1374.721 and INS §10144.52]

This bill:

1) Requires a health plan or disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with all of the following:

    a) Utilization review determinations, including requiring initial determinations and appeals, to be made by a health care provider that has appropriate training and relevant experience in the clinical specialty and diagnosis. Requires, to the extent available, a health care provider conducting

utilization review determinations to complete training provided by formal education programs of nonprofit clinical specialty associations, as specified;

b) Maintenance of telephone access and any other direct communication access used for utilization review during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding patient issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity determination; and,

c) Disclosure to the treating health care provider and the enrollee or insured: the name and credentials of the individual or health care provider performing utilization review; the health plan's or insurer's basis for a denial, including a citation to the clinical guidelines reviewed; and, an analysis of why the enrollee or insured did not meet the clinical criteria.

2) Adds that existing law, which describes general utilization review requirements, is not precluded by the sections of law that this bill amends specific to utilization review for mental health and substance use disorder services.

Comments

Author's statement. According to the author, this bill will ensure that Californians suffering from substance use disorders and addiction are able to receive timely treatment that is consistent with specific criteria developed by the American Society of Addiction Medicine (ASAM). While existing law does require health plans and disability insurers to comply with critical treatment and placement standards, inappropriate utilization review practices are still commonly used to avoid paying for care. This leaves insured substance use disorder patients unable to access treatment that they need to make full and lasting recoveries. By implementing the correct clinical and utilization review criteria for substance use disorder treatment, we have the opportunity to save lives by addressing the escalating rates of overdose deaths and suicides. Denials of medically necessary substance use treatment during our fentanyl and opioid epidemic could constitute a life-threatening failure of our health systems.

Mental health and substance use disorder utilization review. SB 855 (Wiener, Chapter 151, Statutes of 2020), among other provisions, creates utilization review requirements specific to mental health and substance use disorder treatment that include as criteria the appropriateness, level of care, service intensity, efficacy, or

efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit is covered as medically necessary for an enrollee or insured.

DMHC All Plan Letter. On January 5, 2021, DMHC issued guidance on SB 855 that requires, effective January 1, 2021, plans to apply criteria and guidelines for utilization review in the "most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty." DMHC compiled a list of criteria and organizations in Attachment A and requires plans to ensure proper use of Attachment A Criteria (and any other criteria required in the law approved for use by DMHC) by sponsoring formal education programs by the nonprofit clinical specialty associations, distributed and made available as described in the law. The guidance allows plans to develop these education programs separately or through a coordinated effort.

SB 855 regulations. Regulations promulgated by DMHC, effective April 1, 2024, require plans to cover the full range of levels of care pursuant to SB 855 and not limit benefits or coverage to short-term or acute treatment. These regulations include as basic health care services short-, intermediate-, and long-term services and levels of intensity of residential treatment services as well as ASAM residential levels of care. With regard to utilization review criteria, a health plan is responsible for ensuring compliance regardless of contracting and/or delegation arrangements. Plans are required to use clinical criteria developed by specified nonprofit professional associations, or successor organizations, including ASAM. Plans must include a description of the process for determining the criteria and guidelines that are consistent with generally accepted standards of care, as specified. For a contracted entity or delegate conducting utilization review on a plan's behalf, the plan must file specific information such as the name of the entity, a complete list of all the nonprofit professional association criteria the company will use, the policies and procedures, the plan's contract with the organization, and the plan's policies and procedures for overseeing the organization. The regulations also list specific instruments that, if used, will be in compliance with the law. For any delays, denials or modifications the plan must issue a written communication to the provider and enrollee that includes the condition, clinical specialty at issue, a list of the criteria or guidelines, as specified, a summary of reasons for deviating from criteria, and a summary of the clinical reasons for its decision providing full details of the plan or contracted entity's application of and/or scoring. CDI has not promulgated regulations at this time.

Behavioral health investigations. DMHC behavioral health investigations of full-service commercial health plans found issues with appointment availability and

timely access to care and utilization management violations. Specifically, there was inconsistent application of utilization management criteria, and delays in enrollee and provider notification. Plans were given an opportunity to develop corrective action plans and the violations have been referred for corrective and enforcement actions.

Related/Prior Legislation

SB 999 (Cortese, 2022), similar to this bill, would have required additional rules for utilization review related to reviewer qualifications and disclosures, and telephone and peer access during authorization requests. SB 999 was vetoed by the Governor, who stated:

> This bill would require health plans and health insurers that review coverage requests for mental health and substance use disorder treatment to employ reviewers having the same experience and credentials as the requesting provider in these cases.
>
> I share the author's goal of ensuring that patients are able to receive the behavioral health care they need, when they need it. Two years ago, I signed SB 855 (Wiener, Chapter 151, Statutes of 2020), a landmark update to California's mental health parity statutes. SB 855 and forthcoming regulations implementing the law seek to address the issues targeted by this bill by requiring the use of unbiased mental health and substance use disorder clinical standards in coverage reviews and mandating the appropriate training and oversight of staff performing those reviews. Implementation of SB 855 is underway, and the industry is in the process of adapting to California's stringent new requirements. As such, this bill is premature and unnecessary at this time.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee, DMHC estimates costs to be approximately $1,621,000 in 2024-25, $4,374,000 in 2025-26, $4,149,000 in 2026-27, $3,951,000 in 2027-28, and $3,955,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund). CDI estimates costs of $13,000 in 2025-26 for state administration (Insurance Fund).

SUPPORT: (Verified 4/30/24)

California Consortium of Addiction Programs and Professionals (co-source)
Santa Clara County Office of Education (co-source)
Summit Estate Recovery Center (co-source)
The Kennedy Forum (co-source)

The Steinberg Institute (co-source)
Addiction Therapeutic Services
Alum Rock Counseling Center
American Foundation for Suicide Prevention
Anaheim Lighthouse
Anaheim Family Chiropractic
Asian Americans for Community Involvement
AToN Center
Aubico Inc
Autism Speaks
Bill Wilson Center
Buckeye Recovery Network
California Alliance for State Advocacy
California Association of Alcohol and Drug Program Executives
California Association of Social Rehabilitation Agencies
California Commission on Aging
California Council of Community Behavioral Health Agencies
California County Superintendents
California Dental Association
California Federation of Teachers
California Hospital Association
California Life Sciences
California Medical Association
California Primary Care Association
California Psychological Association
California School-Based Health Alliance
California Teachers Association
Cambridge Healthcare Management Services, LLC
Capo by the Sea
CleanQuest, LLC
Clearly Clinical
CNV Detox
Community Social Model Advocates, Inc.
Covenant Hills Treatment Centers
Davis Healthcare Management Group
Design for Change
DIR/ Floortime Coalition of California
Dolorosa Operations, Inc.
Embodied Recovery
First Responder Wellness

First Responders Recovery Malibu
Greenhouse Therapy Center
Health Access California
Healthcare Consulting and Advocacy Group
Inseparable
Intervention 911
JMG Recovery, Harmony Place
Mental Health America of California
National Alliance on Mental Illness
National Union of Healthcare Workers
New Found Life Treatment Center
Opus Health
Orange County Recovery Collaboration
Recovery Advocacy Project
Rume Medical Group
San Diego County Dental Association
Santa Clara County Office of Education
Santa Clara County School Boards Association
Shatterproof
Sun Street Centers
Synthesis Recovery
The American Foundation for Suicide Prevention
The Council of Autism Service Providers
The Law Foundation of Silicon Valley
The Purpose of Recovery
The Recovery Advocacy Project
The Villa Center, Inc.
Valley Restoration Center
West Los Angeles Recovery
Young People in Recovery
2 individuals

OPPOSITION: (Verified 4/30/24)

American's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

ARGUMENTS IN SUPPORT: Proponents write that health plans and disability insurers are not complying with existing law relating to residential substance use disorder placement criteria and treatment and are using inappropriate utilization

review practices to avoid paying for care. It is unacceptable that insured individuals cannot access the critical substance use disorder and addiction recovery services they desperately need commensurate with the amount of time necessary to achieve clinical benchmarks and lasting recovery. By implementing the correct clinical and utilization review criteria for substance use disorder treatment, we can save lives by addressing the escalating rates of overdose deaths and suicides. Denials of necessary substance use treatment during our fentanyl and opioid epidemic could constitute a life-threatening failure of our health systems. The Council of Autism Service Providers writes that Applied Behavior Analysis (ABA) therapy is seen as the gold standard for treating individuals with autism spectrum disorder. ABA therapy is typically provided by Board Certified Behavior Analysts. However, many health plans utilize different providers to review ABA treatment plans submitted for authorization. A lack of experience and understanding by a reviewer who is not well versed in ABA or autism spectrum disorder can adversely impact decisions on care and lead to delays in treatment. Ensuring peer reviews occur between treating providers and utilization review decision makers with the same clinical expertise, certification, and/or license will increase access to medically necessary services and ensure standards of care are met. The California School Based Health Alliance writes that although federal and state law have established that health plans and insurers are required to cover medically necessary treatment for mental health and substance use disorders, treatments prescribed by patients' physicians or psychologists are regularly denied. These health plans employ staff without the appropriate medical expertise to conduct utilization reviews and in turn deny medically necessary care. Data from DMHC's annual IMR shows that 67.5% of denials are overturned when independent medical experts conduct a review.

ARGUMENTS IN OPPOSITION: America's Health Insurance Plans, the Association of California Life and Health Insurance Companies, and the California Association of Health Plans (opponents) write that this bill creates a new and complicated utilization management process for mental health services despite the presence of existing laws and regulations addressing this issue. Opponents indicate that existing law clearly specifies that no individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services based on medical necessity. Furthermore, with respect to utilization review, the newly approved DMHC regulations require plans, when there is a denial and/or modification, to include several specified items within any written communication including a list of all criteria or guidelines (e.g., CALOCUS for Mental Health

Disorders in Patients Under the Age of Eighteen) used, including any nonprofit criteria, criteria outside the scope of the nonprofit criteria or criteria that relate to advancements in technology or types of care not covered in the most recent versions of the nonprofit criteria. This along with the requirement that plans demonstrate, at the request of DMHC, that they are making determinations pursuant to the laws is intended to ensure not only that the plan is following the guidelines set forth in existing law, but also that the individual enrollee/insured is fully informed as to why a modification or denial was issued. Opponents say this along with another requirement is intended to ensure not only that the plan is following the guidelines set forth in law, but also that the individual enrollee/insured is fully informed as to why a modification or denial was issued.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
5/17/24 10:09:16

****** END ******

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(b)(4) - Review of Bills for Review and Consideration for Action Position Recommendation to the Board – SB 1120 (Becker) Health care coverage: utilization review

Background

At the May 10, 2024, Board meeting, members of the California Psychological Association requested the Board to review and consider SB 1120 for a possible position.

SB 1120 would require algorithms, artificial intelligence (AI), and other software tools used by or on behalf of a health care service plan or health insurer for the purpose of utilization review or utilization management functions for health care services to comply with specified requirements, including that they be fairly and equitably applied.

Action Requested

Staff Recommendation: Watch SB 1120.

Attachment #1: SB 1120 Bill Text
Attachment #2: SB 1120 – Senate Floor Analyses

AMENDED IN SENATE APRIL 15, 2024

AMENDED IN SENATE APRIL 1, 2024

SENATE BILL No. 1120

Introduced by Senator Becker

February 13, 2024

An act to amend Section 1367.01 of the Health and Safety Code, and to amend Section 10123.135 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1120, as amended, Becker. Health care coverage: utilization review.

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 the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law authorizes the Director of the Department of Managed Health Care

or the Insurance Commissioner to assess an administrative penalty to a health care service plan or health insurer, as applicable, for failure to comply with those requirements.

~~This bill would require a health care service plan or health insurer to ensure that a licensed physician supervises the use of artificial intelligence decisionmaking tools when those tools are used to inform decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees or insureds. The~~ *This* bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose 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.

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 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently

reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to the enrollee's 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 enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition,

not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible

for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

~~(6) A health care service plan shall ensure that a licensed physician supervises the use of artificial intelligence decisionmaking tools when those tools are used to inform decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees.~~

~~(7)~~

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed

to meet any other requirement of this section, the 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, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) (1) Use of algorithms or artificial intelligence by or on behalf of a health care service plan for the purpose of utilization review or utilization management functions shall comply with this section.

(2) Algorithms, artificial intelligence, and other software tools used by or on behalf of a health care service plan for the purpose of utilization review or utilization management functions for health care services shall comply with all of the following:

(A) Be based upon an enrollee's medical history and individual clinical circumstances as presented by the requesting provider and not supplant health care provider decisionmaking.

(B) Not directly or indirectly discriminate on the basis of race, color, religion, national origin, ancestry, age, sex, gender, gender identity, gender expression, sexual orientation, present or predicted disability, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(C) Be fairly and equitably applied.

(D) Be open to inspection and disclosed in the written policies and procedures required by subdivision (b).

(E) Be governed by policies with accountability for outcomes that are reviewed and revised for accuracy and reliability.

(F) Not allow data to be used beyond its intended and stated purpose.

(G) Be protected from risk that may directly or indirectly cause harm to the enrollee.

(3) Notwithstanding paragraphs (1) and (2), a denial, delay, or modification of health care services based on medical necessity shall be made by a licensed physician or other health care provider competent to evaluate the specific clinical issues involved in the health care services requested by the provider and with the same or similar specialty as the requesting provider, as provided in subdivision (e), by considering the requesting provider's recommendation and based on the enrollee's medical history and individual clinical circumstances.

(*l*) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(m) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(n) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 2. Section 10123.135 of the Insurance Code is amended to read:

10123.135. (a) Every disability insurer, or an entity with which it contracts for services that include utilization review or utilization management functions, that covers hospital, medical, or surgical expenses and that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole

or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A disability insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for insureds. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to subdivision (f). These policies and procedures, and a description of the process by which an insurer, or an entity with which an insurer contracts for services that include utilization review or utilization management functions, reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed by the insurer to insureds and providers upon request, and by the insurer to the public upon request.

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or the Osteopathic Initiative Act, or the insurer may employ a clinical director licensed in California whose scope of practice under California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to,

retrospectively, or concurrent with the provision of health care services to insureds, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

(d) If an insurer subject to this section, or individuals under contract to the insurer to review requests by providers, approve the provider's request pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) An individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may not deny or modify requests for authorization of health care services for an insured for reasons of medical necessity. The decision of the physician or other health care provider shall be communicated to the provider and the insured pursuant to subdivision (h).

(f) (1) An insurer shall disclose, or provide for the disclosure, to the commissioner and to network providers, the process the insurer, its contracting provider groups, or any entity with which it contracts for services that include utilization review or utilization management functions, uses to authorize, delay, modify, or deny health care services under the benefits provided by the insurance contract, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. An insurer shall also disclose those processes to policyholders or persons designated by a policyholder, or to any other person or organization, upon request.

(2) The criteria or guidelines used by an insurer, or an entity with which an insurer contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services, shall comply with all of the following:

(A) Be developed with involvement from actively practicing health care providers.

(B) Be consistent with sound clinical principles and processes.

(C) Be evaluated, and updated if necessary, at least annually.

(D) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the policyholder in that specified case.

(E) Be available to the public upon request. An insurer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An insurer may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph that are limited to copying and postage costs. The insurer may also make the criteria or guidelines available through electronic communication means.

(3) The disclosure required by subparagraph (E) of paragraph (2) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this insurer to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your insurance contract."

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, based in whole or in part on medical necessity, every insurer subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to insureds that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the insured's condition, not to exceed five business days from the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the insured's condition is such that the insured faces an imminent and serious threat to the insured's 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 insured's life or health or could jeopardize the insured's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the insured's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the insured in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the insured's treating provider has been notified of the insurer's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall be communicated to insureds in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the insurer's decision, a description

of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification or a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 and the regulations adopted thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, or because the insurer requires consultation by an expert reviewer, or because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The insurer shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

~~(6) An insurer shall ensure that a licensed physician supervises the use of artificial intelligence decisionmaking tools when those tools are used to inform decisions to approve, modify, or deny~~

~~requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds.~~

~~(7)~~

(6) If the commissioner determines that an insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the commissioner 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 an exclusive remedy for the commissioner. These penalties shall be paid to the Insurance Fund.

(i) Every insurer subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) (1) Use of algorithms or artificial intelligence by or on behalf of an insurer for the purpose of utilization review or utilization management functions shall comply with this section.

(2) Algorithms, artificial intelligence, and other software tools used by or on behalf of an insurer for the purpose of utilization review or utilization management functions for health care services shall comply with all of the following:

(A) Be based upon an insured's medical history and individual clinical circumstances as presented by the requesting provider and not supplant health care provider decisionmaking.

(B) Not directly or indirectly discriminate on the basis of race, color, religion, national origin, ancestry, age, sex, gender, gender identity, gender expression, sexual orientation, present or predicted disability, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(C) Be fairly and equitably applied.

(D) Be open to inspection and disclosed in the written policies and procedures required by subdivision (b).

(E) Be governed by policies with accountability for outcomes that are reviewed and revised for accuracy and reliability.

(F) Not allow data to be used beyond its intended and stated purpose.

(G) Be protected from risk that may directly or indirectly cause harm to the insured.

(3) Notwithstanding paragraphs (1) and (2), a denial, delay, or modification of health care services based on medical necessity shall be made by a licensed physician or other health care provider competent to evaluate the specific clinical issues involved in the health care services requested by the provider and with the same or similar specialty as the requesting provider, as provided in subdivision (e), by considering the requesting provider's recommendation and based on the insured's medical history and individual clinical circumstances.

(k) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 3. 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.

O

Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 1120
Author: Becker (D)
Amended: 4/15/24
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/10/24
AYES: Roth, Nguyen, Glazer, Gonzalez, Grove, Hurtado, Limón, Menjivar, Rubio, Smallwood-Cuevas, Wiener

SENATE APPROPRIATIONS COMMITTEE: 7-0, 5/16/24
AYES: Caballero, Jones, Ashby, Becker, Bradford, Seyarto, Wahab

SUBJECT: Health care coverage: utilization review

SOURCE: California Medical Association

DIGEST: Establishes requirements on health plans and insurers applicable to their use of Artificial Intelligence (AI) for utilization review decisions, including, that decisions be based upon an enrollee's medical history and individual clinical circumstances as presented by the requesting provider and not supplant health care provider decision making.

ANALYSIS:

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers. [HSC §1340, et seq., and INS §106, et seq.]

2) Establishes requirements on health plans and insurers relating to utilization review or utilization management functions that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers for the provision of

health care services to enrollees. These requirements also apply when a plan or insurer delegates these functions to medical groups or independent practice associations or to other contracting providers. [HSC §1367.01 and INS §10123.135]

3) Prohibits any individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by a provider, from denying or modifying requests for authorization of health care services for an enrollee or insured for reasons of medical necessity. Requires the decision to be communicated to the provider within 24 hours of the decision, and the enrollee (in writing) within two business days of the decision. In the case of concurrent review, prohibits discontinuance of care until the treating provider has been notified and has agreed to a care plan that is appropriate for the medical needs of the patient. [HSC §1367.01 and INS §10123.135]

This bill:

1) Requires the use of algorithms or AI by or on behalf of a health plan or insurer for the purpose of utilization review or utilization management functions to comply with the following:
   a) Be based upon an enrollee's or insurer's medical history and individual clinical circumstances as presented by the requesting provider and not supplant health care provider decision-making;
   b) Not directly or indirectly discriminate on the basis of race, color, religion, national origin, ancestry, age, sex, gender, gender identity, gender expression, sexual orientation, present or predicted disability, expected length of life, degree of medical dependency, quality of life, or other health conditions;
   c) Be fairly and equitably applied;
   d) Be open to inspection and disclosed in the written policies and procedures required in existing law;
   e) Be governed by policies with accountability for outcomes that are reviewed and revised for accuracy and reliability;
   f) Not allow data to be used beyond its intended and stated purpose; and,
   g)Be protected from risk that may directly or indirectly cause harm to the enrollee or insured.

2) Requires a denial, delay, or modification of health care services based on medical necessity to be made by a licensed physician or other health care provider competent to evaluate the specific clinical issues involved in the health

care services requested by the provider and with the same or similar specialty as the requesting provider, as provided in existing law, by considering the requesting provider's recommendation and based on the enrollee's medical history and individual clinical circumstances.

COMMENTS:

Author's statement. According to the author:

Recent reports of automated decision tools inaccurately denying provider requests to deliver care is worrisome. While AI has the potential to improve healthcare delivery, it must be supervised by trained medical professionals who understand the complexities of each patient's situation. Wrongful denial of insurance claims based on AI algorithms can lead to serious health consequences, and even death. This bill strikes a common sense balance that puts safeguards in place for automated decision tools without discouraging companies from using this new technology.

Background. The author's office provided articles describing health plan use of AI in review of prior authorization requests. One article describes a system where physicians "rubber stamped" decisions by a computer generated mechanism and were allegedly held to certain metrics. Another article describes a class action lawsuit where the company is accused of failing to fulfill its "statutory, common law, and contractual obligations to have a doctor determine individual coverage… in a thorough, fair, and objective manner…" According to a press release issued by the American Medical Association (AMA), the AMA has newly adopted policy that calls for health insurers utilizing AI technology to implement a thorough and fair process that is based on clinical criteria and includes reviews by physicians and other health care professionals with expertise for the service under review and no incentives to deny care. Additionally, some members of Congress have called upon the Center of Medicare and Medicaid Services (CMS) to monitor and evaluate Medicare Advantage (MA) plans use of AI/algorithmic tools by requiring the reporting of prior authorization data, comparison of AI generated guidance to coverage decisions, assessment of denials and data reviewed by third party appeals reviewers, assessment of adjustment of AI determinations to account for unanticipated patient conditions, attestations that coverage guidelines are not more restrictive than traditional Medicare, assessment of data and use of race and other factors, and, assessment of whether or not AI/algorithms are self-correcting. Another article describes recent CMS guidance that permits the use of algorithm or software to assist with coverage decisions as long as it complies with coverage rules.

Medicare Frequently Asked Questions (FAQ). In February of 2024, CMS issued a FAQ following the release of an April 5, 2023 final rule on MA coverage criteria, use of prior authorization, and review of utilization management tools. As it relates to AI or algorithms, FAQ #2 states that AI systems use machine- and human-based inputs to perceive real and virtual environments; abstract such perceptions into models through analysis in an automated manner; and use model inference to formulate options for information or action. An algorithm or software tool can be used to assist MA plans in making coverage determinations, but it is the responsibility of the MA organization to ensure that the algorithm or AI complies with rules for how coverage determinations by MA organizations are made. For example, compliance is required with the final rule for making a determination of medical necessity, including that the MA organization base the decision on the individual patient's circumstances. An algorithm that determines coverage based on a larger data set instead of the individual patient's medical history, the physician's recommendations, or clinical notes would not be compliant with the final rule.

MA organizations may only deny coverage for basic benefits based on criteria in the final rule or for other permissible bases, such as network limitations or failure to comply with prior authorization requirements. Therefore, the algorithm or software tool should only be used to adhere to the publicly posted coverage criteria. Because publicly posted coverage criteria are static and unchanging, AI cannot be used to shift the coverage criteria over time. Predictive algorithms or software tools cannot apply additional coverage criteria that have not been made public and adopted in compliance with the final rule.

CMS also expresses concerns that algorithms and many new AI technologies can exacerbate discrimination and bias, and reminds MA organizations of the nondiscrimination requirements of Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. MA organizations should, prior to implementing an algorithm or software tool, ensure that the tool is not perpetuating or exacerbating existing bias, or introducing new biases.

Trustworthy AI. The federal Health and Human Services Agency (HHS) has developed a "playbook" for AI development with the goal of maintaining public trust by using AI solutions that are "ethical, effective, and secure," according to the HHS Chief AI Officer. With regard to HHS agencies, principles have been established for trustworthy AI that "fosters public trust and confidence while protecting privacy, civil rights, civil liberties, and American values, consistent with applicable laws." The playbook describes AI as whether the solution or system:

a) Performs tasks under varying and unpredictable circumstances without significant human oversight, or can learn from experience and improvement performance when exposed to data sets;
b) Uses computer software, physical hardware, or other technology to solve tasks that require human-like perception, thinking, planning, learning, communication, or physical action;
c) Thinks or acts like a human, including the use of cognitive architecture or neural networks (e.g., developed to mimic the underlying mechanisms of the human mind);
d) Relies on a set of techniques, including machine learning, to approximate a cognitive task; and,
e) Is designed to act rationally by utilizing intelligent software or an embodied robot to achieve goals using perception, planning, reasoning, learning, communicating, decision-making, and action.

The HHS principles for use of trustworthy AI in government cover six areas: fair and impartial application; transparent and explainable data use; responsible and accountable governance and policies; robust and reliable outputs; safe and secure from risks; and, that privacy should be respected, data not used beyond its intended and stated use, and that it's use is approved by the data owner or steward.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

DMHC estimates costs of approximately $18,000 in 2024-25, $4,671,000 in 2025-26, $4,192,000 in 2026-27, $3,780,000 in 2027-28, $4,781,000 in 2028-29, and $4,779,000 in 2029-30 and annually thereafter for state administration (Managed Care Fund). CDI anticipates minor fiscal impacts (Insurance Fund).

SUPPORT: (Verified 5/1/24)

California Medical Association (Source)
Autism Business Association
Breathe California
California Chapter of American College of Cardiology
California Hospital Association
California Life Sciences
California Orthopedic Association
California Rheumatology Alliance
California State Council of Service Employees International Union
Consumer Attorneys of California

Oakland Privacy
Providence Medical Group and Clinical Network
Psychiatric Physicians Alliance of California
Spondylitis Association of America

OPPOSITION: (Verified 5/1/24)
America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

ARGUMENTS IN SUPPORT: The California Medical Association (sponsor) writes:

While AI tools can improve access to care and assist providers, they have also faced criticism for inaccuracies and biases. This bill addresses those issues by guaranteeing that a provider has final approval of utilization review decisions when AI is being used. Additionally, this bill includes safeguards to ensure AI, or algorithms used in utilization review do not discriminate against individuals based on their identity. As powerful as many AI tools are, they can be compromised when they rely on faulty, outdated, or biased data sources, leading to improper treatment recommendations. This bill adopts federal guidance requiring health plans to make certain that their AI technology is free from such problems. Without this bill, patients could have essential medical services denied by AI when being used for utilization review by health insurers. AI has been and will continue to be an essential tool in improving health care access and affordability for patients, but physicians must have oversight of critical utilization review decisions to allow for the best health outcomes for our communities. This bill provides essential guardrails to allow us to continue successfully integrating AI into our health care system.

Support if amended. The California Academy of Preventive Medicine requests amendments to ensure that no AI criteria or computerized algorithms tools shall be utilized in prior authorization without the approval of the medical director or clinical director.

ARGUMENTS IN OPPOSITION: The California Association of Health Plans, Association of California Life and Health Insurance Companies, and America's Health Insurance Plans writes:

With an oppose unless amended position. They are concerned that the bill includes narrow clinical peer review language that goes well beyond existing law. This bill

would substantially limit who is allowed to conduct utilization reviews by requiring the reviewing provider be within the same or similar specialty as the requesting provider. Current law already requires that all peer review must be done by a competent health professional within a timely manner. If the treating provider disagrees with the reviewing provider, current law already affords a process for the resolution of the dispute through independent medical review. They believe this provision is unnecessary and will only add more costs to the health care system, and request that the language outlined in Health and Safety Code 1367.07(k)(3) be removed from the bill.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
5/17/24 14:02:28

****** END ******

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(b)(5) - Review of Bills for Review and Consideration for Action Position Recommendation to the Board – SB 1451 (Ashby) Professions and vocations

Background

At the May 10, 2024, Board meeting, members of the California Psychological Association requested the Board to review and consider SB 1451 for a possible position.

SB 1451 would make various changes to the operations of programs governed by practice acts in the Business and Professions Code and various professions regulated by these programs, stemming from prior sunset review oversight efforts. This bill would also clarify that no person shall use the words “doctor” or “physician,” the letters or prefix Dr., the initials M.D. or D.O., or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed M.D. or D.O.

Action Requested

Staff Recommendation: The Legislative and Regulatory Affairs Committee review and take a Support-if Amended Position on SB 1451 to the full Board.

Attachment #1: SB 1451 Bill Text
Attachment #2: SB 1451 – Senate Floor Analyses
Attachment #3: SB 1451 - CPA Letter

AMENDED IN SENATE APRIL 17, 2024

SENATE BILL No. 1451

Introduced by Senator Ashby

February 16, 2024

An act to amend Sections 1926, *2054, 2837.101, 2837.103, 2837.104,* 2837.105, 3765, 7423, 8593, and 8593.1 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1451, as amended, Ashby. Professions and vocations.

(1) Existing law, the Dental Practice Act, establishes the Dental Hygiene Board of California to license and regulate dental hygienists. Existing law authorizes a registered dental hygienist in alternative practice to perform specified duties in dental health professional shortage areas, as certified by the Department of Health Care Access and Information, in accordance with specified guidelines.

This bill would authorize a registered dental hygienist in alternative practice with an existing practice in a dental health professional shortage area to continue to provide dental hygiene services if certification by the department is removed.

(2) Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensure and regulation of physicians and surgeons. Existing law makes it a misdemeanor for a person who is not licensed as a physician and surgeon under the act, except as specified, to use certain words, letters, and phrases or any other terms that imply that the person is authorized to practice medicine as a physician and surgeon.

This bill would add the initials "D.O." to the list of prohibited terms under that provision. The bill would also prohibit a person from using

the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that the person is a licensed "M.D." or "D.O.". By expanding the scope of a crime, this bill would impose a state-mandated local program.

~~(2)~~

(3) Existing law, the Nursing Practice Act, provides for the licensure and certification of nurse practitioners by the Board of Registered Nursing. Existing law requires the Office of Professional Examination Services in the Department of Consumer Affairs, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing specified functions, and requires the board and the office to assess the alignment of competencies tested in the national nurse practitioner certification examination with the occupational analysis.

This bill would make the provision requiring the assessment of the alignment of competencies inapplicable to a national nurse practitioner certification examination discontinued before January 1, 2017.

(4) Existing law establishes the Nurse Practitioner Advisory Committee to advise and give recommendations to the board on matters relating to Nurse Practitioners. Existing law requires the board, by regulation, to define minimum standards for transition to practice, as defined, and provides that clinical experience may include experience obtained before January 1, 2021, if the experience meets requirements established by the board.

This bill would specify that, for purposes of transition to practice, clinical experience shall not be limited to experience in a single category in which a nurse practitioner may practice, as specified, and would prohibit experience obtained before a person is certified as a nurse practitioner from being considered clinical experience for purposes of transition to practice requirements.

Existing law authorizes a nurse practitioner to perform specified functions without standardized procedures if the nurse practitioner satisfies certain requirements, including having completed a transition to practice in California of 3 full-time equivalent years of practice, or 4,600 hours.

This bill would deem a nurse practitioner who has been practicing as a nurse practitioner for 3 full-time equivalent years or 4,600 hours within the last 5 years, as of January 1, 2023, to have satisfied this

requirement. The bill would require proof of completion of a transition to practice to be provided to the board as an attestation from either a licensed physician and surgeon or a nurse practitioner. The bill would prohibit the board from requiring a nurse practitioner to tell a patient that the patient has a right to see a physician and surgeon, and would delete a provision requiring a nurse practitioner to use a certain phrase to inform Spanish language speakers that the nurse practitioner is not a physician and surgeon.

~~(3)~~

(5) Existing law, the Respiratory Care Practice Act, establishes the Respiratory Care Board of California to license and regulate the practice of respiratory care. Existing law authorizes a licensed vocational nurse who is employed by a home health agency to perform respiratory tasks and services identified by the board if, on or before January 1, 2025, the licensed vocational nurse has completed patient-specific training satisfactory to their employer, and, on and after January 1, 2025, the licensed vocational nurse has completed that training in accordance with guidelines promulgated by the Respiratory Care Board of California, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

This bill would extend those dates to January 1, 2028. The bill, on and after January 1, 2028, would also authorize a licensed vocational nurse to perform respiratory care services identified by the board while practicing in certain settings identified in the bill if the license vocational nurse has completed patient-specific training satisfactory to their employer and holds a current and valid certification of competency for each respiratory task to be performed, as specified.

~~(4)~~

(6) Existing law, the Barbering and Cosmetology Act, establishes the State Board of Barbering and Cosmetology to license and regulate barbering and cosmetology, and establishes a hairstylist application and examination fee of $50 or a fee determined by the board, not to exceed the reasonable cost of developing, purchasing, grading, and administering the examination.

This bill would instead require the hairstylist application and examination fee to be the actual cost to the board for developing, purchasing, grading, and administering the examination, and would establish that an initial licensee fee for a hairstylist shall be not more than $50.

~~(5)~~

(7) Existing law establishes the Structural Pest Control Board in the Department of Consumer Affairs to license and regulate structural pest control operators, structural pest control field representatives, and structural pest control applicators. Existing law requires those licensees, as a condition of license renewal, to submit proof to the board that they have informed themselves of the developments in the field of pest control by completing continuing education courses or equivalent activity approved by the board, or taking and completing an examination given by the board, as specified.

This bill would delete the authorization for a licenseholder to take and complete an examination given by the board to satisfy that requirement.

(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: ~~no~~ *yes*.

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

SECTION 1. Section 1926 of the Business and Professions Code is amended to read:

1926. In addition to practices authorized in Section 1925, a registered dental hygienist in alternative practice may perform the duties authorized pursuant to subdivision (a) of Section 1907, subdivision (a) of Section 1908, and subdivisions (a) and (b) of Section 1910 in the following settings:

(a) Residences of the homebound.

(b) Schools.

(c) Residential facilities and other institutions and medical settings that a residential facility patient has been transferred to for outpatient services.

(d) Dental health professional shortage areas, as certified by the Department of Health Care Access and Information in accordance with existing office guidelines. If the dental health professional shortage area certification is removed, a registered dental hygienist

in alternative practice with an existing practice in the area may continue to provide dental hygiene services.

(e) Dental offices.

SEC. 2. Section 2054 of the Business and Professions Code is amended to read:

2054. (a) Any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words "doctor" or "physician," the letters or prefix "Dr.," the initials ~~"M.D.,"~~ "*M.D.*" *or* "*D.O.*," or any other terms or letters indicating or implying that ~~he or she~~ *the person* is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that ~~he or she~~ *the person* is entitled to practice hereunder, or who represents or holds ~~himself or herself~~ *themselves* out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter, is guilty of a misdemeanor. *No person shall use the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed "M.D." or "D.O.".*

(b) Notwithstanding subdivision (a), any of the following persons may use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials ~~"M.D.":~~ *"M.D." or "D.O.":*

(1) A graduate of a medical *or an osteopathic medical* school approved or recognized by the *medical or osteopathic medical* board while enrolled in a postgraduate training program approved by the board.

(2) A graduate of a medical *or an osteopathic medical* school who does not have a certificate as a physician and surgeon under this chapter if ~~he or she~~ *the individual* meets all of the following requirements:

(A) If issued a license to practice medicine in any jurisdiction, has not had that license revoked or suspended by that jurisdiction.

(B) Does not otherwise hold ~~himself or herself~~ *themselves* out as a physician and surgeon entitled to practice medicine in this state except to the extent authorized by this chapter.

(C) Does not engage in any of the acts prohibited by Section 2060.

(3) A person authorized to practice medicine under Section 2111 or 2113 subject to the limitations set forth in those sections.

SEC. 3. Section 2837.101 of the Business and Professions Code is amended to read:

2837.101. For purposes of this article, the following terms have the following meanings:

(a) "Committee" means the Nurse Practitioner Advisory Committee.

(b) "Standardized procedures" has the same meaning as that term is defined in Section 2725.

(c) "Transition to practice" means additional clinical experience and mentorship provided to prepare a nurse practitioner to practice independently. "Transition to practice" includes, but is not limited to, managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism, and business management of a practice. The board shall, by regulation, define minimum standards for transition to practice. ~~Clinical experience may include experience obtained before January 1, 2021, if the experience meets the requirements established by the board.~~ *For purposes of the transition to practice:*

(1) Clinical experience shall not be limited to experience in a single category that a nurse practitioner may practice in pursuant to Section 2836.

(2) Clinical experience may include experience obtained before January 1, 2021, but clinical experience obtained before a person is certified by the board as a nurse practitioner shall not be included.

SEC. 4. Section 2837.103 of the Business and Professions Code is amended to read:

2837.103. (a) (1) Notwithstanding any other law, a nurse practitioner may perform the functions specified in subdivision (c) pursuant to that subdivision, in a setting or organization specified in paragraph (2) pursuant to that paragraph, if the nurse practitioner has successfully satisfied the following requirements:

(A) Passed a national nurse practitioner board certification examination and, if applicable, any supplemental examination

developed pursuant to paragraph (4) of subdivision (a) of Section 2837.105.

(B) Holds a certification as a nurse practitioner from a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the board.

(C) Provides documentation that educational training was consistent with standards established by the board pursuant to Section 2836 and any applicable regulations as they specifically relate to requirements for clinical practice hours. Online educational programs that do not include mandatory clinical hours shall not meet this requirement.

(D) Has completed a transition to practice in California *or another state* of a minimum of three full-time equivalent years of practice or 4600 hours. *A nurse practitioner who has been practicing as a nurse practitioner for a minimum of three full-time equivalent years or 4,600 hours within the last 5 years, as of January 1, 2023, may be deemed to have satisfied this requirement. For purposes of this subparagraph:*

(i) Proof of completion of a transition to practice shall be provided to the board, on a form prescribed by the board, as an attestation from either a licensed physician and surgeon, a certified nurse practitioner practicing pursuant to this section, or a certified nurse practitioner practicing pursuant to Section 2837.104.

(ii) A licensed physician and surgeon or a certified nurse practitioner who attests to the completion of a transition to practice is not required to specialize in the same category as the applicant pursuant to Section 2836.

(iii) A licensed physician and surgeon or a certified nurse practitioner practicing pursuant to this section or Section 2837.104 who attests to the completion of a transition to practice is not required to verify competence, clinical expertise, or any other standards related to the practice of the applicant and shall only attest to the completion of the transition to practice, as defined in Section 2837.101.

(iv) A licensed physician and surgeon or a certified nurse practitioner practicing pursuant to this section or Section 2837.104 who attests to the completion of a transition to practice shall not be liable for any civil damages and shall not be subject to an

administrative action, sanction, or penalty for attesting only to the completion of a transition to practice.

(2) A nurse practitioner who meets all of the requirements of paragraph (1) may practice, including, but not limited to, performing the functions authorized pursuant to subdivision (c), in one of the following settings or organizations in which one or more physicians and surgeons practice with the nurse practitioner without standardized procedures:

(A) A clinic, as defined in Section 1200 of the Health and Safety Code.

(B) A health facility, as defined in Section 1250 of the Health and Safety Code, except for the following:

(i) A correctional treatment center, as defined in paragraph (1) of subdivision (j) of Section 1250 of the Health and Safety Code.

(ii) A state hospital, as defined in Section 4100 of the Welfare and Institutions Code.

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

(D) A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

(E) A home health agency, as defined in Section 1727 of the Health and Safety Code.

(F) A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(3) In health care agencies that have governing bodies, as defined in Division 5 of Title 22 of the California Code of Regulations, including, but not limited to, Sections 70701 and 70703 of Title 22 of the California Code of Regulations, the following apply:

(A) A nurse practitioner shall adhere to all applicable bylaws.

(B) A nurse practitioner shall be eligible to serve on medical staff and hospital committees.

(C) A nurse practitioner shall be eligible to attend meetings of the department to which the nurse practitioner is assigned. A nurse practitioner shall not vote at department, division, or other meetings

unless the vote is regarding the determination of nurse practitioner privileges with the organization, peer review of nurse practitioner clinical practice, whether a licensee's employment is in the best interest of the communities served by a hospital pursuant to Section 2401, or the vote is otherwise allowed by the applicable bylaws.

(b) An entity described in subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner functioning pursuant to this section in a manner prohibited by Section 2400 or any other law.

(c) In addition to any other practices authorized by law, a nurse practitioner who meets the requirements of paragraph (1) of subdivision (a) may perform the following functions without standardized procedures in accordance with their education and training:

(1) Conduct an advanced assessment.

(2) (A) Order, perform, and interpret diagnostic procedures.

(B) For radiologic procedures, a nurse practitioner can order diagnostic procedures and utilize the findings or results in treating the patient. A nurse practitioner may perform or interpret clinical laboratory procedures that they are permitted to perform under Section 1206 and under the federal Clinical Laboratory Improvement Act (CLIA).

(3) Establish primary and differential diagnoses.

(4) Prescribe, order, administer, dispense, procure, and furnish therapeutic measures, including, but not limited to, the following:

(A) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.

(B) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.

(C) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.

(5) After performing a physical examination, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(6) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 (commencing with Section 1366) of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.

(d) A nurse practitioner shall ~~verbally~~ inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. ~~For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada."~~

(e) A nurse practitioner shall not be required to tell a patient the patient has a right to see a physician and surgeon.

~~(e)~~

(f) A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and the internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

~~(f)~~

(g) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the nurse practitioner.

~~(g)~~

(h) A nurse practitioner practicing under this section shall have professional liability insurance appropriate for the practice setting.

~~(h)~~

(i) Any health care setting operated by the Department of Corrections and Rehabilitation is exempt from this section.

SEC. 5. Section 2837.104 of the Business and Professions Code is amended to read:

2837.104. (a) Beginning January 1, 2023, notwithstanding any other law, the following apply to a nurse practitioner who holds an active certification issued by the board pursuant to subdivision (b):

(1) The nurse practitioner may perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision outside of the settings or organizations specified under subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 2837.103.

(2) Subject to subdivision (f) and any applicable conflict of interest policies of the bylaws, the nurse practitioner shall be eligible for membership of an organized medical staff.

(3) Subject to subdivision (f) and any applicable conflict of interest policies of the bylaws, a nurse practitioner member may vote at meetings of the department to which nurse practitioners are assigned.

(b) The board shall issue a certificate to perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision outside of the settings and organizations specified under subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 2837.103, if the nurse practitioner satisfies all of the following requirements:

(1) Meets all of the requirements specified in paragraph (1) of subdivision (a) of Section 2837.103.

(2) Holds a valid and active license as a registered nurse in California and a master's degree in nursing or in a clinical field related to nursing or a doctoral degree in nursing.

(3) Has practiced as a nurse practitioner in good standing for at least three years, not inclusive of the transition to practice required pursuant to subparagraph (D) of paragraph (1) of subdivision (a) of Section 2837.103. The board may, at its discretion, lower this requirement for a nurse practitioner holding a Doctorate of Nursing Practice degree (DNP) based on practice experience gained in the course of doctoral education experience.

(c) A nurse practitioner authorized to practice pursuant to this section shall comply with all of the following:

(1) The nurse practitioner, consistent with applicable standards of care, shall not practice beyond the scope of their clinical and professional education and training, including specific areas of concentration and shall only practice within the limits of their knowledge and experience and national certification.

(2) The nurse practitioner shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided. Physician consultation shall be obtained as specified in the individual protocols and under the following circumstances:

(A) Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

(B) Problem which is not resolving as anticipated after an ongoing evaluation and management of the situation.

(C) History, physical, or lab findings inconsistent with the clinical perspective.

(D) Upon request of patient.

(3) Nurse practitioner consultation with a physician and surgeon alone shall not create a physician-patient relationship. The nurse practitioner shall be solely responsible for the services they provide.

(4) The nurse practitioner shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers. The nurse practitioner shall have an identified referral plan specific to the practice area, that includes specific referral criteria. The referral plan shall address the following:

(A) Whenever situations arise which go beyond the competence, scope of practice, or experience of the nurse practitioner.

(B) Whenever patient conditions fail to respond or the patient is acutely decompensating in a manner that is not consistent with the progression of the disease and corresponding treatment plan.

(C) Any patient with a rare condition.

(D) Any patient conditions that do not fit the commonly accepted diagnostic pattern for a disease or disorder.

(E) All emergency situations after initial stabilizing care has been started.

(d) A nurse practitioner shall ~~verbally~~ inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. ~~For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada."~~

(e) A nurse practitioner shall not be required by the board to tell a patient that the patient has a right to see a physician and surgeon.

~~(e)~~

(f) A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

~~(f)~~

(g) A nurse practitioner practicing pursuant to this section shall maintain professional liability insurance appropriate for the practice setting.

~~(g)~~

(h) For purposes of this section, corporations and other artificial legal entities shall have no professional rights, privileges, or powers.

~~(h)~~

(i) Subdivision ~~(g)~~ *(h)* shall not apply to a nurse practitioner if either of the following apply:

(1) The certificate issued pursuant to this section is inactive, surrendered, revoked, or otherwise restricted by the board.

(2) The nurse practitioner is employed pursuant to the exemptions under Section 2401.

~~SEC. 2.~~

SEC. 6. Section 2837.105 of the Business and Professions Code is amended to read:

2837.105. (a) (1) The board shall request the department's Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision.

(2) The board, together with the Office of Professional Examination Services, shall assess the alignment of the competencies tested in the national nurse practitioner certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.103 with the occupational analysis performed according to paragraph (1). This paragraph shall not apply to a national nurse practitioner certification examination discontinued before January 1, 2017.

(3) The occupational analysis shall be completed by January 1, 2023.

(4) If the assessment performed according to paragraph (2) identifies additional competencies necessary to perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision that are not sufficiently validated by the national nurse practitioner board certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.103, the board shall identify and develop a supplemental exam that properly validates identified competencies.

(b) The examination process shall be regularly reviewed pursuant to Section 139.

~~SEC. 3.~~

SEC. 7. Section 3765 of the Business and Professions Code is amended to read:

3765. This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold themselves out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

(e) Temporary performance, by other health care personnel, students, or groups, of respiratory care services, as identified and authorized by the board, in the event of an epidemic, pandemic, public disaster, or emergency.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance, by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California who is employed by a home health agency licensed by the State Department of Public Health, of respiratory tasks and services identified by the board, if the licensed vocational nurse complies with the following:

(1) Before January 1, 2028, the licensed vocational nurse has completed patient-specific training satisfactory to their employer.

(2) On or after January 1, 2028, the licensed vocational nurse has completed patient-specific training by the employer in accordance with guidelines that shall be promulgated by the board no later than January 1, 2028, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(j) The performance of respiratory care services identified by the board by a licensed vocational nurse who satisfies the requirements in paragraph (1) in the settings listed in paragraph (2).

(1) (A) The licensed vocational nurse is licensed pursuant to Chapter 6.5 (commencing with Section 2840).

(B) The licensed vocational nurse has completed patient-specific training satisfactory to their employer.

(C) The licensed vocational nurse holds a current and valid certification of competency for each respiratory task to be performed from the California Association of Medical Product Suppliers, the California Society for Respiratory Care, or another organization identified by the board.

(2) A licensed vocational nurse may perform the respiratory care services identified by the board pursuant to this subdivision in the following settings:

(A) At a congregate living health facility licensed by the State Department of Public Health that is designated as six beds or fewer.

(B) At an intermediate care facility licensed by the State Department of Public Health that is designated as six beds or fewer.

(C) At an adult day health care center licensed by the State Department of Public Health.

(D) As an employee of a home health agency licensed by the State Department of Public Health or an individual nurse provider working in a residential home.

(E) At a pediatric day health and respite care facility licensed by the State Department of Public Health.

(F) At a small family home licensed by the Department of Social Services that is designated as six beds or fewer.

(G) As a private duty nurse as part of daily transportation and activities outside a patient’s residence or family respite for home- and community-based patients.

(3) This subdivision is operative on January 1, 2028.

(k) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

~~SEC. 4.~~

SEC. 8. Section 7423 of the Business and Professions Code is amended to read:

7423. The amounts of the fees required by this chapter relating to licenses for individual practitioners are as follows:

(a) (1) Cosmetologist application and examination fee shall be the actual cost to the board for developing, purchasing, grading, and administering the examination.

(2) A cosmetologist initial license fee shall not be more than fifty dollars ($50).

(b) (1) An esthetician application and examination fee shall be the actual cost to the board for developing, purchasing, grading, and administering the examination.

(2) An esthetician initial license fee shall not be more than forty dollars ($40).

(c) (1) A manicurist application and examination fee shall be the actual cost to the board for developing, purchasing, grading, and administering the examination.

(2) A manicurist initial license fee shall not be more than thirty-five dollars ($35).

(d) (1) A barber application and examination fee shall be the actual cost to the board for developing, purchasing, grading, and administering the examination.

(2) A barber initial license fee shall be not more than fifty dollars ($50).

(e) (1) An electrologist application and examination fee shall be the actual cost to the board for developing, purchasing, grading, and administering the examination.

(2) An electrologist initial license fee shall be not more than fifty dollars ($50).

(f) An apprentice application and license fee shall be not more than twenty-five dollars ($25).

(g) The license renewal fee for individual practitioner licenses that are subject to renewal shall be not more than fifty dollars ($50).

(h) A hairstylist application and examination fee shall be the actual cost to the board for developing, purchasing, grading, and administering the examination.

(i) A hairstylist's initial license fee shall be no more than fifty dollars ($50).

(j) Notwithstanding Section 163.5 the license renewal delinquency fee shall be 50 percent of the renewal fee in effect on the date of renewal.

~~SEC. 5.~~

SEC. 9. Section 8593 of the Business and Professions Code is amended to read:

8593. (a) The board shall require as a condition to the renewal of each operator's and field representative's license that the holder submit proof satisfactory to the board that they have informed themselves of developments in the field of pest control either by completion of courses of continuing education in pest control approved by the board or equivalent activity approved by the board.

(b) The board shall develop a correspondence course or courses with any educational institution or institutions as it deems appropriate. This course may be used to fulfill the requirements of this section. The institution may charge a reasonable fee for each course.

~~SEC. 6.~~

SEC. 10. Section 8593.1 of the Business and Professions Code is amended to read:

8593.1. The board shall require as a condition to the renewal of each applicator's license that the holder thereof submit proof satisfactory to the board that they have completed courses of continuing education in pesticide application and use approved by the board or equivalent activity approved by the board.

SEC. 11. 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.

O

Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 1451
Author: Ashby (D)
Amended: 4/17/24
Vote: 21

SENATE BUS., PROF. & ECON. DEV. COMMITTEE: 12-0, 4/22/24
AYES: Ashby, Nguyen, Alvarado-Gil, Archuleta, Becker, Dodd, Eggman, Glazer, Niello, Roth, Smallwood-Cuevas, Wilk
NO VOTE RECORDED: Menjivar

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SUBJECT: Professions and vocations

SOURCE: Author

DIGEST: This bill makes various changes to the operations of programs governed by practice acts in the Business and Professions Code and various professions regulated by these programs, stemming from prior sunset review oversight efforts.

ANALYSIS:

Existing law:

1) Provides for the licensure of registered dental hygienists in alternative practice (RDHAP), who must meet the same requirements as registered dental hygienists (RDHs) in addition to either meeting minimum experience and higher education requirements, or possessing a letter of acceptance into the employment utilization phase of the Health Workforce Pilot Project. Requires a RDHAP to provide the Dental Hygiene Board documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services. (Business and Professions Code (BPC) §§ 1922 and 1930)

2) Authorizes an RDHAP, in only limited settings including residences of the homebound; schools; residential facilities and other institutions; and, dental health professional shortage areas (DHPSA), as certified by the Department of Health Care Access and Information (HCAI) to perform specified, narrow services. (BPC § 1926)

3) Prohibits any person who does not have a valid, unrevoked, and unsuspended certificate as a physician and surgeon from the Medical Board of California (MBC) from using the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," or any other terms or letters indicating or implying that they are a physician and surgeon, with certain exceptions. (BPC § 2054)

4) Allows a person who has been issued a physician's and surgeon's certificate by the MBC to use the initials "M.D." (BPC § 2055)

5) Makes it unlawful for any healing arts licensee to publically communicate a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services in connection with the professional practice or business for which they are licensed. (BPC § 651)

6) Makes it unlawful for any person to make or disseminate any statement in the advertising of services, professional or otherwise, which is untrue or misleading. (BPC § 17500)

7) Authorizes an independently practicing nurse practitioner (NP) to perform specified functions in a defined healthcare setting if the NP has met specified requirements and authorizes a NP who meets these requirements to practice in an outpatient health facility, except for a correctional treatment center or a state hospital; a health facility including a general acute care hospital; a county hospital; a medical group practice, including a professional medical corporation, as specified, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that provide healthcare services; and a licensed hospice facility. (BPC §§ 2837.103, 2837.104)

8) Defines a transition to practice (TTP) for purposes of NP independent practice to mean "additional clinical experience and mentorship provided to prepare a NP to practice independently, and includes, but is not limited to, managing a panel of patients, working in a complex healthcare setting, interpersonal communication, interpersonal collaboration and team-based care,

professionalism and business management of a practice." (BPC § 2837.101(c))

9) Defines "respiratory care" as a health care profession performed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions. (BPC § 3702)

10) Specifies various activities that are not prohibited by the Respiratory Care Practice Act, including a licensed vocational nurse (LVN) employed by a home health agency who has met certain training requirements performing Respiratory Care Board (RCB)-specified respiratory services. (BPC § 3765 (i))

11) Specifies that in order to become a licensed hairstylist, an applicant must be at least 17, complete 10th grade (or the equivalent of public school 10th grade), is not subject to denial based on having been convicted of a crime within a certain time frame that is substantially related to the qualifications, functions, or duties of being a hairstylist, and has either completed a course in hairstyling from a Board of Barbering and Cosmetology (BBC)-approved school or practiced hairstyling, as defined, in another state for a specified period of time. (BPC § 7322)

This bill:

1) Specifies that if the DHPSA certification is removed, a RDHAP with an existing practice in the area may continue to provide dental hygiene services.

2) Clarifies that no person shall use the words "doctor" or "physician," the letters or prefix Dr., the initials M.D. or D.O., or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed M.D. or D.O.

3) Makes various changes to provisions in the Nursing Practice Act related to licensure of an NP practicing independently.

4) Clarifies that LVNs who have met specified requirements may perform specified respiratory care services as identified by the RCB in specified

settings and according to certain patient-specific training satisfactory to their employer.

5) Clarifies that BBC can only charge a hairstylist application and examination fee in an amount equal to BBC's actual costs for developing, purchasing, grading, and administering the examination. Limits a hairstylist's initial license to not more than $50.

6) Replaces gendered language in the Structural Pest Control Act and eliminates the option for Structural Pest Control Board (SPCB) licensees to take challenge examinations in lieu of completing continuing education requirements.

Background

1) *Registered Dental Hygienists in Alternative Practice.* As policymakers have explored opportunities to expand access to oral health care, it has continued to be argued that dental hygienists are underutilized and could play a larger role in delivering dental services to vulnerable communities. The issue of barriers to practice have been longstanding for RDHs, and particularly RDHAPs who are trained and authorized to provide unsupervised dental hygiene services in specified limited practice settings, settings that most likely result in a vulnerable and challenging patient populations - children, individuals with limited access to healthcare (and therefore likely with more advanced oral health conditions), and patients with compromised mobility or other health concerns that impede their ability to get dental care in more traditional settings. Currently, a RDHAP may establish a practice in a dental health professional shortage area, but once that shortage is deemed to no longer exist, the RDHAP must relocate his or her practice. Concerns remain that prohibiting a RDHAP from continuing to offer their narrow safe and effective services without supervision, as they can when a DHPSA designation is in place, once the designation is removed does not appear to benefit patients and the public. There is no change in the training, education, and skills the RDHAP receives and no adjustment to the fact that they still have to comply with scope of practice and standard of care laws – the only result of continued prohibition that these trained professionals serve patients once a designation is removed is further exacerbation of access to care challenges.

2) *Doctor Title Protection.* The Medical Practice Act currently prohibits any person from practicing or advertising as practicing medicine without a license. Statute specifically makes it a misdemeanor for any unlicensed person to use the words "doctor" or "physician," the letters or prefix "Dr.," the initials

"M.D.," or any other terms or letters indicating or implying that the person is a licensed physician and surgeon on any sign, business card, or letterhead, or, in an advertisement. To use these words, prefixes, or initials, a person's license must be valid, unrevoked, and unsuspended. The statute features three limited exceptions for individuals who are trained as physicians but not currently licensed in California.

General provisions governing health professional licensing boards make it unlawful for any healing arts licensee to publically communicate any false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of rendering professional services in connection with their licensed practice. Practitioners may advertise that they are certified or that they limit their practice to specific fields; however, the term "board certified" is reserved for physicians certified by an American Board of Medical Specialties member board. Additionally, Section 17500 of the Business and Professions Code makes it unlawful for any person to make any statement or advertisement with intent to perform services, professional or otherwise, that is untrue or misleading. While this code section covers a wide range of false advertisements by sellers of goods or services, its provisions would be applicable to health care licensees.

3) *Nurse Practitioners.* A NP is a registered nurse who has earned a postgraduate nursing degree, such as a Master's or Doctorate degree, and has obtained a certificate from a national certifying body or Board of Registered Nursing (BRN)-approved educational program. In 2020, the Legislature passed, and the Governor signed, AB 890 (Wood, Chapter 256, Statutes of 2020) into law which set education and experience requirements for an NP to be eligible to practice independent of physician supervision. While AB 890 provided the definition of a TTP, it also required that the BRN define the minimum standards of the TTP through regulations by January 1, 2023. The BRN regulations further expanding on the TTP included requirements more stringent than AB 890 and which in some cases, do not include references that sync with current NP certification and the training and clinical experience of a NP.

   While some categories have a corresponding physician specialty, such as pediatrics, a "women's health" NP may have clinical experiences with a wide range of physician specialists and BRN regulations could leave those individuals without a physician to attest to their completion of the TTP.

   The BRN regulations also narrowly define the TTP so that it must be completed in "direct patient care in the role of a [NP] in the category…in which the

applicant seeks certification as a NP…". The BRN regulations were adopted in 2022 and effective at the beginning of 2023.

4) *Respiratory Care Services.* SB 1436 (Roth, Chapter 624, Statutes of 2022) resolved a serious and long-standing consumer safety issue regarding the safe practice of respiratory care in health care facilities by allowing the RCB to identify the basic respiratory tasks and services that could be safely delivered by LVNs. There is currently no legal path for LVNs to provide respiratory care services beyond basic care. Patients receiving home and community-based services often require advanced respiratory care. Respiratory care services are not "skilled nursing services." Respiratory patients are often the most vulnerable of the home and community-based patient population with an overwhelming majority of those patients reliant upon Medi-Cal reimbursement.

5) *Barbering and Cosmetology Hairstylist License.* In 2021, SB 803 (Roth, Chapter 648, Statutes of 2021) continued the operations of the BBC until January 1, 2027 and made various technical changes, statutory improvements, and policy reforms to the Act based on the joint sunset review oversight of BBC by the Senate Business, Professions, and Economic Development Committee and Assembly Business and Professions Committee. SB 803 established a separate hairstylist license and outlined a specified practice of hairstyling that includes arranging, dressing, curling, cleansing, and shampooing, among other hair-specific beautification practices that utilize instruments or require chemical products to be applied.

6) *Structural Pest Control.* The Structural Pest Control Act requires that licensees fulfill continuing education (CE) requirements by completing industry-relevant courses to stay fluent with technology and accepted professional practices. Instead of completing CE courses, current law also provides an alternative option of taking and successfully completing an examination. Currently, BPC sections 8593 and 8593.1 require the SPCB offer examinations to its licensees to take in lieu of completing their CE requirements. On March 6, 2017, the United States Environmental Protection Agency (U.S. EPA) revised the federal rule for certification and recertification of applicators of restricted use pesticides under the Code of Federal Regulations Part 171 (40 CFR 171). This affects SPCB's Field Representative and Operator license types because the federal rule specifies that if recertification is based upon written examination, the State must ensure the examination evaluates whether the licensee demonstrates the level of competencies.

Comments

1) *Use of the term "Dr." and potential unintended consequences.* Various health professional licensee practice acts authorize use of the term "Doctor" or "Dr." under specified circumstances and limitations. For example, an acupuncturist can use the term in connection with the practice of acupuncture if they possess an earned doctorate degree in specific disciplines and the title is related to the authorized practice of an acupuncturist. An optometrist can use the title as a prefix but must us the word "optometrist" as a suffix and only if they hold an Opt. D or O.D. diploma. A physical therapist and an occupational therapist who has received a doctoral degree can use the term if they also specify they are a physical therapist or occupational therapist. A naturopathic doctor is authorized to use the designation "Dr." if they also further identify themselves as a naturopathic doctor so long as they do not use any term that would indicate the practice of medicine other than naturopathic medicine. In order to ensure that licensed healthcare professionals authorized to utilize the title "Doctor" or "Dr.", according to the specified requirements and limitations for the use of that term in various Business and Professions Code practice acts, are not in violation of the Medical Practice Act due to the changes in this bill, the Author is proposing to amend this bill moving forward to clarify that licensees whose practice act authorizes limited use of the title are not prevented from continuing to do so.

2) *RDHAP practice.* In order to ensure access to quality dental care for vulnerable patients, the Author is proposing to amend this bill moving forward to facilitate better connection and collaboration between RDHAPs who continue to operate a practice in a dental shortage area and dentists who can increase comprehensive care opportunities to those patients.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 5/6/24)

California Association for Nurse Practitioners
California Association of Alcohol and Drug Program Executives, Inc.
California Dental Hygienists' Association
California Dental Hygienists Association
California Nurses Association
Leading Age California

Little Lobbyists
Pediatric Day Health Care Coalition
Respiratory Care Board of California

OPPOSITION: (Verified 5/6/24)

California Dental Association
The California Naturopathic Doctors Association

ARGUMENTS IN SUPPORT: The California Association for Nurse Practitioners says that the BRN refusal to approve applications from NPs certified by legacy boards hinders the goals of AB 890 by blocking access to care, rather than increasing access to care.

Organizations in support of this bill state that California is the largest and most diverse state in the nation, yet we have a severe health care provider gap, particularly among primary care and behavioral health providers...NPs are critical to addressing these shortages – not only do they accept greater numbers of uninsured, Medi-Cal, and Medicare patients compared to physicians, but NPs are also more likely to work in rural and underserved communities. Additionally, to address the urgent health needs of our state in a sustainable and equitable manner, organizations in support of this bill say that we must ensure NPs are able to close the provider gap. By providing clarifying guidance surrounding legacy certifications, this bill will help streamline the application process and enable California's most experienced NPs to expand access to quality, affordable care.

According to the California Dental Hygienists' Association, "The legislature's goal is to increase access to oral healthcare in dental deserts. Therefore, it is essential amend the statute and allow APs to keep their practices open if the DHPSA designation is removed… This uncertainty in statute is impeding AP hygienists from investing in and opening dental hygiene practices in shortage areas. APs would be incentivized to invest in these shortage areas if the risk of losing their practice was removed.

The Respiratory Care Board of California notes that this bill "addresses the immediate need to ensure patients are not in jeopardy of having their lives severely disrupted by providing additional exemptions allowing LVNs with appropriate training to practice respiratory care in home and community-based settings where it is not feasible to employ a licensed RCP."

ARGUMENTS IN OPPOSITION: The California Dental Association opposes allowing RDHAPs to continue their independent brick-and-mortar practices

outside of a DHPSA designation and has suggested changes such as ensuring that 30% of an RDHAP's brick and mortar practice's patient base be in service of Medi-Cal Dental patients in the unlikely scenario a DHPSA designation was removed. "This requirement is consistent with dentists and physicians receiving student loan repayment and would ensure access to dental care for the state's most vulnerable populations."

Prepared by: Sarah Mason / B., P. & E.D. /
5/8/24 13:47:37

****** END ******

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May 23, 2024

Marisela Cervantes, EdD, MPA
Chair, Legislative and Regulatory Affairs Committee
California Board of Psychology
1625 North Market Blvd, Suite N-215
Sacramento, CA 95834

RE: Request for Addition on Upcoming Agenda: SB 1451 (Ashby) Professions and vocations

Dear Chair Cervantes:

The California Psychological Association (CPA), a non-profit association of licensed psychologists and others affiliated with delivering psychological services across California, respectfully requests the inclusion of SB 1451 (Ashby) on the upcoming June 14th Legislative and Regulatory Affairs Committee and for the Board to align with CPA's position. CPA's Board of Directors has adopted an oppose unless amended position, with requested language to affirmatively authorize psychologists with doctoral degrees to continue to utilize the term "doctor" and prefix "Dr.". Please find below the language in the bill that is concerning to our members and the rationale that CPA is opposing the bill.

We are particularly concerned with the addition of this language within SB 1451 in the April 17th amendments:

No person shall use the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon, physician, surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that person is a licensed "M.D." or "D.O.".

Psychologists are doctoral-level providers who work in myriad settings, including academic research, private psychology practice, K-12 schools, hospitals, state hospitals, the armed forces, court systems, prisons, business and industry and the VA. A doctoral-level psychologist holds a PhD, PsyD or EdD in psychology, pursuant to Business and Professions Code (BPC) Section 2914(b). The term "doctor" recognizes psychologists' extensive education and training as well as their positions in medical settings as mental health care providers, supervisors, and managers. Psychologists are also routinely referred to as "doctor" on the basis of their doctoral degrees. Psychologists do not represent themselves as physicians or MDs. The use of "doctor" by psychologists additionally differentiates them as a profession as doctoral-level provider from masters' level providers—this is a form of consumer protection.

California law already prohibits making false or deceptive statements. The American Psychological Association Ethics Code, incorporated into California statute as the standard of practice under BPC Section 2936, BPC 651, and CCR Title 16 Section 1397 prohibit false, fraudulent, misleading, or deceptive statements and advertising. Psychologists are not impersonating physicians in medical settings and this bill needs to affirmatively protect psychologists' right to refer to themselves as "doctor", reflecting the extensive education and training necessary to become a psychologist.

We are requesting inclusion of an amendment within the Psychology Practice Act at the end of BPC Code Section 2903, affirmatively allowing psychologists to continue, as they have done for decades in California, all 50 states, in the federal VA system, and around the world to use the term "doctor":

BPC Section 2903 (d) Notwithstanding Section 2054, individuals who possess an earned doctoral degree that meets the requirements of section 2914(b) may use the words "doctor" or the letters or prefix "Dr."

If this bill passes as written, we would like to acknowledge there will be workload considerations for the Board of Psychology to establish regulations, conduct investigations, and enforce the new provisions upon psychologists.

For these reasons, the California Psychological Association has an oppose unless amended position on SB 1451, and respectfully requests the Board of Psychology discuss it at your upcoming meeting. If you have any questions, please do not hesitate to reach out to Tyler Rinde at trinde@cpapsych.org or (916) 225-3861.

Sincerely,

Tyler Rinde
Director of Government Affairs

cc: Antonette Sorrick, Executive Officer, California Board of Psychology
Jonathan Burke, Assistant Executive Officer, California Board of Psychology
Troy Polk, Legislative and Regulatory Analyst, California Board of Psychology

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(1) – Bills Active Positions Taken by the Board – AB 1991 (Bonta) Licensees and Registrants Records

Background

On January 30, 2024, Assembly Bill (AB) 1991 was introduced by Assemblymember Bonta.

This bill would require certain boards that regulate healing arts licensees or registrants to collect workforce data from their respective licensees or registrants and would require that data to be required at the time of electronic license or registration renewal.

On March 11, 2024, AB 1991 was referred to the Assembly Committee on Business and Professions.

On April 12, 2024, AB 1991 was presented to the Legislative and Regulatory Affairs Committee and was advised that further information will be presented to the full Board at the May 10th meeting.

On April 16, 2024, AB 1991 was amended to prohibit certain boards from denying renewal if the workforce data was not provided, however, licensees and registrants could still be disciplined for failing to provide the data.

On April 18, 2024, AB 1991 was referred to the Committee on Appropriations.

On May 1, 2024, AB 1991 passed the Committee on Appropriations

On May 10, 2024, the Board adopted a Oppose position on AB 1991.

On May 13, 2024, AB 1991 was ordered to the Senate, and referred to the Committee on Rules.

Board Staff is continuing to monitor AB 1991.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: AB 1991 Bill Text
Attachment #2: AB 1991 – Assembly Floor Analysis

AMENDED IN ASSEMBLY APRIL 17, 2024

AMENDED IN ASSEMBLY MARCH 11, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 1991

Introduced by Assembly Member Bonta

January 30, 2024

An act to amend Section 502 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1991, as amended, Bonta. Licensee and registrant records.

Existing law establishes uniform requirements for the reporting and collection of workforce data from health care-related licensing boards. Existing law requires certain boards that regulate healing arts licensees or registrants to request specified workforce data from their respective licensees and registrants and requires the data to be requested at the time of electronic license or registration renewal, as specified. Existing law provides that a licensee or registrant is not required to provide the specified workforce data as a condition for license or registration renewal, and that those individuals who do not provide that data are not subject to discipline.

This bill would, instead, require certain boards that regulate healing arts licensees or registrants to collect workforce data from their respective licensees or registrants, and would require that data to be required at the time of electronic license or registration renewal, as specified. The bill would, instead, require a licensee or registrant to provide the specified workforce data as a condition for license or registration renewal and *would prohibit certain boards, notwithstanding*

that condition, from denying an application for license or registration renewal solely because the licensee or registrant failed to provide any of the workforce data. The bill would delete the provision that specifies that a licensee or registrant shall not be subject to discipline for not providing 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 502 of the Business and Professions Code is amended to read:

502. (a) Notwithstanding any other law, both of the following apply:

(1) The Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the Physician Assistant Board, and the Respiratory Care Board of California shall collect workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be collected at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(2) All other boards that are not listed in paragraph (1) that regulate healing arts licensees or registrants under this division shall collect workforce data from their respective licensees and registrants as specified in subdivision (b) for future workforce planning at least biennially. The data shall be required at the time of electronic license or registration renewal for those boards that utilize electronic renewals for licensees or registrants.

(b) In conformance with specifications under subdivision (d), the workforce data collected or required by each board about its licensees and registrants shall include, at a minimum, all of the following information:

(1) Anticipated year of retirement.

(2) Area of practice or specialty.

(3) City, county, and ZIP Code of practice.

(4) Date of birth.

(5) Educational background and the highest level attained at time of licensure or registration.

(6) Gender or gender identity.

(7) Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.

(8) Languages spoken.

(9) National Provider Identifier.

(10) Race or ethnicity.

(11) Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.

(12) Work hours.

(13) Sexual orientation.

(14) Disability status.

(c) Each board shall maintain the confidentiality of the information it receives from licensees and registrants under this section and shall only release information in an aggregate form that cannot be used to identify an individual other than as specified in subdivision (e).

(d) The Department of Consumer Affairs, in consultation with the Department of Health Care Access and Information, shall specify for each board subject to this section the specific information and data that will be collected or requested pursuant to subdivision (b). The Department of Consumer Affairs' identification and specification of this information and data shall be exempt until June 30, 2023, from the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) Each board, or the Department of Consumer Affairs on its behalf, shall, beginning on July 1, 2022, and quarterly thereafter, provide the individual licensee and registrant data it collects pursuant to this section to the Department of Health Care Access and Information in a manner directed by the Department of Health Care Access and Information, including license or registration number and associated license or registration information. The Department of Health Care Access and Information shall maintain the confidentiality of the licensee and registrant information it receives and shall only release information in an aggregate form that cannot be used to identify an individual.

(f) *(1)* A licensee or registrant shall be required to provide the information listed in subdivision (b) as a condition for license or registration renewal.

(2) Notwithstanding paragraph (1), a board described in paragraph (2) of subdivision (a) shall not deny an application for license or registration renewal solely because the licensee or registrant failed to provide any of the information listed in subdivision (b).

(g) This section does not alter or affect mandatory reporting requirements for licensees or registrants established pursuant to this division, including, but not limited to, Sections 1715.5, 1902.2, 2425.3, and 2455.2.

O

ASSEMBLY THIRD READING
AB 1991 (Bonta)
As Amended April 17, 2024
Majority vote

SUMMARY

Requires all healing arts boards under the Department of Consumer Affairs (DCA) to collect specified workforce data from their licensees and registrants at least biennially as a requirement of license or registration renewal, and requires that information to be subsequently provided to the Department of Health Care Access and Information (HCAI).

Major Provisions

1) Provides that healing arts boards under the DCA that are not already required to collect workforce data from their licensees and registrants shall be required to collect that workforce data for future workforce planning at least biennially.

2) Requires a licensee or registrant to provide the workforce data information as a condition for license or registration renewal.

3) Prohibits healing arts boards from denying an application for license or registration renewal solely because the licensee or registrant failed to provide any of the required workforce data.

COMMENTS

California has long faced significant gaps and inequities in its health care workforce. There has historically been a persistent shortage of accessible health professionals overall, which disproportionately impacts communities with concentrated populations of immigrant families and people of color. A recent study found that between 2010 and 2019, the number of primary care physicians in proportion to population remained largely unchanged nationally. Meanwhile, counties with a higher proportion of minorities saw a decline during that period.

Compounding these issues of access is a significant lack of diversity among health care practitioners, with several minority groups remaining persistently underrepresented within the healing arts. A recent study of data from the American Community Survey and the Integrated Postsecondary Education Data System found that Black, Hispanic, and Native American people are nationally represented across 10 different health professions. As a result, minorities seeking to enter these professions face significant systemic obstacles, and patients who are representative of minority groups or immigrant communities often do not have access to practitioners who possess the cultural or linguistic competence to provide them with appropriate care.

Research cited by the California Health Care Foundation in its 2021 report found that while 39% of Californians identified as Latino/x in 2019, only 14% of medical school matriculants and 6% of active patient care physicians in California were Latino/x. A 2018 study published by the Latino Policy & Politics Initiative at the University of California, Los Angeles found that while nearly 44% of the California population speaks a language other than English at home, many of the most commonly spoken languages are underrepresented by the physician workforce. While the physician community has worked with the Medical Board of California to improve linguistic competency among providers, these efforts have yet to resolve systemic challenges with addressing language barriers in California.

Another issue resulting from underrepresentation in the health professions relates to implicit bias. According to the Stanford Encyclopedia of Philosophy, "implicit bias" can be described as "a term of art referring to relatively unconscious and relatively automatic features of prejudiced judgment and social behavior." In her 2019 book *Biased: Uncovering the Hidden Prejudice That Shapes What We See, Think, and Do*, Dr. Jennifer L. Eberhardt explains that "implicit bias is not a new way of calling someone a racist. In fact, you don't have to be a racist at all to be influenced by it. Implicit bias is a kind of distorting lens that's a product of both the architecture of our brain and the disparities in our society." Dr. Eberhardt goes on to describe how "bias is not limited to one domain of life. It is not limited to one profession, one race, or one country. It is also not limited to one stereotypic association."

In December 2015, the American Journal of Public Health published a systematic review titled *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*. The review concluded that "most health care providers appear to have implicit bias in terms of positive attitudes toward whites and negative attitudes toward people of color." Additional published studies suggest that implicit bias in regards to gender, sexual orientation and identity, and other characteristics has resulted in inconsistent diagnoses and courses of treatment being provided to patients based on their respective demographic. These trends take into account not only the characteristics of the person being treated, but those of the licensed professional in correlation to that patient.

The results of implicit bias can have serious consequences in the provision of health care. For example, one frequently cited statistic is that Black women have average maternal mortality rates that are three-to-four times higher than white women. While much of the research and action relating to implicit bias has been focused on the area of law enforcement and police procedure, there has been a growing call to also address the presence of implicit bias in the healing arts professions through additional awareness and training. In 2019, the Legislature enacted AB 241 (Kamlager-Dove) to require continuing education courses for physicians and surgeons, nurses, and physician assistants to include the understanding of implicit bias and the promotion of bias-reducing strategies. While implementation of these requirements has undoubtedly had at least some impact on improving health care outcomes for minority patients, education and training is not a substitute for increasing diversity and representation among providers.

In February 2024, the Assembly Committee on Health held an informational hearing focused on Diversity in California's Health Care Workforce. This hearing included perspectives from various stakeholders and public health researchers, along with policymakers who provided updates on the state's efforts to increase diversity. The background paper for the hearing[1] cited research published in December 2022 by the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University in a report titled "The Race and Ethnicity of the California Health Care Workforce," which demonstrated that "a health workforce that reflects the racial and ethnic diversity of the population can improve access to, quality of, and outcomes of care." As explained in the Health Committee's background paper, underrepresentation in the health care workforce both "contributes to health disparities" and "limits access to high-paying, meaningful professions for underrepresented minorities."

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[1] https://ahea.assembly.ca.gov/media/1665

California has attempted to resolve these longstanding issues of representation and access through a number of different approaches. The Legislature has previously enacted and funded loan repayment programs, such as the Dental Corps Loan Repayment Program of 2002, which provided grants to qualifying dentists who agreed to work for at least three years in a clinic or dental practice located in a dentally unserved area, or in which at least 50% of patients are from a dentally underserved population. The Health Professions Career Opportunity Program within HCAI similarly supports initiatives designed to enhance diversity and representation in the health professions by awarding grant funding through competitive programs.

As discussed in the Health Committee's background paper, it is often challenging to evaluate the long-term impacts of these programs, as "HCAI does not currently collect longitudinal data that could demonstrate which of these programs are more effective." During sunset review oversight hearings on healing arts boards that were held jointly in 2024 by the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development, committee members expressed frustration that there was not sufficient data to confirm whether any particular strategy to improve access has been successful. This is in large part due to a lack of consistent data from healing arts licensees to inform policymakers about how many practitioners of particular specialties are providing services in any given area of the state, or about the demographic makeup of those practitioners.

The California Health Workforce Research and Data Center, previously established in 2007 as the Healthcare Workforce Clearinghouse under the prior Office of Statewide Health Planning and Development, serves as California's central source for collection, analysis, and reporting of information on the healthcare workforce employment and educational data trends for the state. As part of its statutory duties, HCAI is mandated to prepare an annual report to the Legislature that accomplishes the following three goals: (1) identifying education and employment trends in the health care professions (2) reporting on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas; and (3) recommending state policy needed to address issues of workforce shortage and distribution.

In 2014, the Legislature enacted AB 2102, authored by Assembly Member Phil Ting and co-sponsored by the California Pan-Ethnic Health Network and the Latino Coalition for a Healthy California. The bill required four specified healing arts boards—the Board of Registered Nursing, the Physician Assistant Board, the Respiratory Care Board of California, and the Board of Vocational Nursing and Psychiatric Technicians—to collect and report specific demographic data related to its licensees. Specifically, AB 2102 mandated that the four boards collect the following data from licensees: (1) location of practice, including city, county, and zip Code; (2) race or ethnicity; (3) gender; (4) languages spoken; (5) educational background and (6) classification of primary practice site, such as clinic, hospital, managed care organization, or private practice. In order to implement AB 2102, the DCA and HCAI established an interagency agreement to facilitate the specified data collection and exchange.

Assembly Member Ting subsequently introduced AB 2704 in 2020, which sought to replace the distinct data collection requirements for the four healing arts boards with a single statute requiring data collection for all healing arts boards. The bill was not set for a hearing in this committee. The next year, Assembly Member Ting reintroduced the bill as AB 1236, adding sexual orientation and disability status to the list of required data points. This bill passed this committee but the author ultimately decided to hold the bill on the Assembly floor.

Instead, language was included in the omnibus health trailer bill as part of the Budget Act of 2021 consolidating the existing workforce data collection requirements for the four healing arts boards into one section with an expanded list of data points. However, the trailer bill did not require this data to be collected by any additional boards under the DCA; instead, it provided that all other healing arts boards *request* the information. The trailer bill also expressly provided that licensees could not be required to provide the information as a condition for license renewal, and that they could not be disciplined for failing to provide the information.

This bill would amend the consolidated data collection law enacted through the trailer bill to require all healing arts boards to collect the workforce data and report it to HCAI. The author cites recommendations in a 2019 report by the California Future Health Workforce Commission, which included among its goals an objective to "expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers." The author believes that providing HCAI with workforce data for all healing arts licensees will allow legislators and policymakers to more effectively evaluate the success of efforts to improve representation and diversity in the state's health care professions.

According to the Author
"California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. There are 16 health care professional oversight boards that "request" workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended. This information will provide HCAI with data necessary to assess whether or not loan repayment programs intended to increase the diversity of the health workforce, and to encourage providers to serve in underserved areas, are working as intended."

Arguments in Support
The *California Pan-Ethnic Health Network* supports this bill, writing: "HCAI administers several Loan Repayment Programs that offer financial support to health professionals who agree to provide direct patient care in medically underserved areas. However, California has recently faced major shortages of health workers, not producing enough new workers to meet future needs, and the current health workforce does not match the state's diversity. Reports have also found that Hispanic and Black workers are very underrepresented in the existing health workforce in California. [This bill] would help support workforce supply and diversity problems to help improve the impacts on health access, quality, and equity in our most underserved communities."

The *Latino Coalition for a Healthy California* also supports this bill, writing: "We urge you to support [this bill], as California faces major shortages of health workers, isn't producing enough new workers to meet future needs, and the current health workforce does not match the diversity of the state. These workforce supply and diversity problems have a major impact on health access, quality, and equity. Specifically, there are 16 health care professional oversight boards that 'request' workforce data but do not require workforce data to be reported as condition as licensure. Without accurate information about the makeup of California's health workforce, it is difficult to assess whether or not programs designed to improve diversity and increase access to care in underserved areas are working as intended."

Arguments in Opposition
None on file.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations, minor and absorbable costs to the DCA and HCAI.

VOTES

ASM BUSINESS AND PROFESSIONS: 17-0-1
YES: Berman, Flora, Alanis, Bains, Juan Carrillo, Chen, Dixon, Grayson, Irwin, Jackson, Ward, Lowenthal, McKinnor, Stephanie Nguyen, Pellerin, Soria, Zbur
ABS, ABST OR NV: Sanchez

ASM APPROPRIATIONS: 14-0-1
YES: Wicks, Sanchez, Arambula, Bryan, Calderon, Wendy Carrillo, Dixon, Mike Fong, Grayson, Haney, Hart, Pellerin, Ta, Villapudua
ABS, ABST OR NV: Jim Patterson

UPDATED

VERSION: April 17, 2024

CONSULTANT: Robert Sumner / B. & P. / (916) 319-3301 FN: 0002832

California Board of PSYCHOLOGY

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(2) – Bill with Active Position Taken by the Board - AB 2051 (Bonta) Psychology interjurisdictional compact

Background

On February 2, 2024, Assembly Bill (AB) 2051 was introduced by Assemblymember Bonta.

This bill would make California a compact state under the Psychology Interjurisdictional Compact (PSYPACT), to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines.

On March 1, 2024, AB 2051 was presented to the Board. The Board adopted an Oppose position.

On March 15, 2024, an Oppose Letter was submitted to the members of the Assembly Business and Professions Committee, as well as the author's office.

On April 16, 2024, AB 2051 was heard in the Assembly Committee on Business and Professions, and board staff provided in-person testimony in opposition.

On April 17, 2024, AB 2051 was amended to include that the compact would be operative only if the Board has voted in favor of joining the compact.

On April 18, 2024, AB 2051 was referred to the Committee on Appropriations and was ordered to the Suspense file. Board staff submitted a Oppose Position Letter to the Committee Members.

On May 16, 2024, AB 2051 passed the Committee on Appropriations.

On May 20, 2024, AB 2051 was amended to include that any person who is authorized by the compact to practice in CA as an employee or contractor of another state is prohibited unless they are licensed by the Board.

On May 21, 2024, Board Staff submitted a Floor Alert in Opposition to all Assembly Members.

Board Staff is continuing to monitor AB 2051.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: AB 2051 Bill Text
Attachment #2: AB 2051 – Assembly Floor Analysis
Attachment #3: AB 2051 Floor Alert - Oppose

AMENDED IN ASSEMBLY MAY 20, 2024

AMENDED IN ASSEMBLY APRIL 17, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 2051

Introduced by Assembly Member Bonta

February 1, 2024

An act to amend Section 2903 of, to add Section 2948.5 to, and to add Article 11 (commencing with Section 2999.110) to Chapter 6.6 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2051, as amended, Bonta. Psychology interjurisdictional compact.

Existing law, the Psychology Licensing Law, establishes the Board of Psychology to license and regulate the practice of psychology. Existing law, except as specified, prohibits persons without a license under existing law from practicing psychology or representing themselves to be a psychologist in this state. Existing law requires an applicant for licensure as a psychologist to possess specified degrees, have engaged in supervised professional experience, pass an examination, and complete particular coursework or provide evidence of training.

This bill would provide that the Psychology Interjurisdictional Compact is approved and ratified, and would provide that the compact is an interstate compact that is intended to regulate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries. *The bill would prohibit a person who is authorized by the compact to practice psychology in this state*

from engaging in the practice of psychology as an employee or contractor of a state or local government entity if the person does not have a license granted by the board, as prescribed.

Under this bill, the compact would require this state, as a compact state, to recognize the right of a psychologist, licensed in a compact state in conformance with the compact, to practice telepsychology in other compact states in which the psychologist is not licensed, as provided in the compact. Under the bill, the compact would also require this state to recognize the right of a psychologist, licensed in a compact state in conformance with the compact, to practice temporarily in other compact states in which the psychologist is not licensed, as provided in the compact. Under the bill, the compact would require the board to appoint a commissioner to the Psychology Interjurisdictional Compact Commission, a joint body with powers and responsibilities as established by the compact, including rulemaking authority, as prescribed. Under the bill, a person without a license granted under existing state law, but holding a privilege to practice under the compact, would not be prohibited from engaging in the practice of psychology or representing themselves to be a psychologist.

This bill would provide that the board is required to comply with the requirements of the compact and to adopt regulations as necessary to implement the compact. The bill would specify that those requirements on the board and the compact shall not become operative until the Director of Consumer Affairs certifies that a majority of the board has voted in favor of joining the compact, and would require the director to notify the Secretary of State and the Legislative Counsel Bureau of the date of that certification.

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 2903 of the Business and Professions Code is amended to read:

2903. (a) No person may engage in the practice of psychology, or represent themselves to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter, including, but not limited to, holding a privilege to practice under the Psychology Interjurisdictional Compact (PSYPACT)

adopted pursuant to Article 11 (commencing with Section 2999.110).

(b) The practice of psychology is defined as rendering or offering to render to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.

(c) The application of these principles and methods includes, but is not restricted to, assessment, diagnosis, prevention, treatment, and intervention to increase effective functioning of individuals, groups, and organizations.

(d) "Psychotherapy," within the meaning of this chapter, means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes, and behaviors that are emotionally, intellectually, or socially ineffectual or maladaptive.

SEC. 2. Section 2948.5 is added to the Business and Professions Code, to read:

2948.5. (a) The board shall comply with the requirements of the Psychology Interjurisdictional Compact (PSYPACT) adopted pursuant to Article 11 (commencing with Section 2999.110) and shall adopt regulations necessary to implement the requirements of the compact.

(b) Neither this section nor Article 11 (commencing with Section 2999.110) shall become operative until the Director of Consumer Affairs certifies that a majority of the board has voted in favor of joining the compact during a regular meeting. The director shall notify the Secretary of State and the Legislative Counsel Bureau of the date of that certification.

SEC. 3. Article 11 (commencing with Section 2999.110) is added to Chapter 6.6 of Division 2 of the Business and Professions Code, to read:

Article 11. Psychology Interjurisdictional Compact (PSYPACT)

2999.110. Psychology Interjurisdictional Compact (PSYPACT) as set forth in Section 2999.111 is hereby ratified and approved.

2999.111. The provisions of the Psychology Interjurisdictional Compact (PSYPACT) between the State of California and other states that are parties to the compact are as follows:

ARTICLE I. PURPOSE

Whereas, states license psychologists, in order to protect the public through verification of education, training and experience and ensure accountability for professional practice; and

Whereas, this Compact is intended to regulate the day to day practice of telepsychology (i.e. the provision of psychological services using telecommunication technologies) by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for 30 days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority;

Whereas, this Compact is intended to authorize State Psychology Regulatory Authorities to afford legal recognition, in a manner consistent with the terms of the Compact, to psychologists licensed in another state;

Whereas, this Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety;

Whereas, this Compact does not apply when a psychologist is licensed in both the Home and Receiving States; and

Whereas, this Compact does not apply to permanent in-person, face-to-face practice, it does allow for authorization of temporary psychological practice.

Consistent with these principles, this Compact is designed to achieve the following purposes and objectives:

1. Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology;

2. Enhance the states' ability to protect the public's health and safety, especially client/patient safety;

3. Encourage the cooperation of Compact States in the areas of psychology licensure and regulation;

4. Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions and disciplinary history;

5. Promote compliance with the laws governing psychological practice in each Compact State; and

6. Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

ARTICLE II. DEFINITIONS

A. "Adverse Action" means: Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

B. "Association of State and Provincial Psychology Boards (ASPPB)" means: the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

C. "Authority to Practice Interjurisdictional Telepsychology" means: a licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

D. "Bylaws" means: those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to Article X for its governance, or for directing and controlling its actions and conduct.

E. "Client/Patient" means: the recipient of psychological services, whether psychological services are delivered in the context of healthcare, corporate, supervision, and/or consulting services.

F. "Commissioner" means: the voting representative appointed by each State Psychology Regulatory Authority pursuant to Article X.

G. "Compact State" means: a state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to Article XIII, Section C or been terminated pursuant to Article XII, Section B.

H. “Coordinated Licensure Information System” also referred to as “Coordinated Database” means: an integrated process for collecting, storing, and sharing information on psychologists’ licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

I. “Confidentiality” means: the principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

J. “Day” means: any part of a day in which psychological work is performed.

K. “Distant State” means: the Compact State where a psychologist is physically present (not through the use of telecommunications technologies), to provide temporary in-person, face-to-face psychological services.

L. “E.Passport” means: a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

M. “Executive Board” means: a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

N. “Home State” means: a Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

O. “Identity History Summary” means: a summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

P. “In-Person, Face-to-Face” means: interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

Q. “Interjurisdictional Practice Certificate (IPC)” means: a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily, and verification of one’s qualifications for such practice.

R. “License” means: authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

S. “Non-Compact State” means: any State which is not at the time a Compact State.

T. “Psychologist” means: an individual licensed for the independent practice of psychology.

U. “Psychology Interjurisdictional Compact Commission” also referred to as “Commission” means: the national administration of which all Compact States are members.

V. “Receiving State” means: a Compact State where the client/patient is physically located when the telepsychological services are delivered.

W. “Rule” means: a written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to Article XI of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal or suspension of an existing rule.

X. “Significant Investigatory Information” means:

1. investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

2. investigative information that indicates that the psychologist represents an immediate threat to public health and safety

regardless of whether the psychologist has been notified and/or had an opportunity to respond.

Y. "State" means: a state, commonwealth, territory, or possession of the United States, the District of Columbia.

Z. "State Psychology Regulatory Authority" means: the Board, office or other agency with the legislative mandate to license and regulate the practice of psychology.

AA. "Telepsychology" means: the provision of psychological services using telecommunication technologies.

BB. "Temporary Authorization to Practice" means: a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

CC. "Temporary In-Person, Face-to-Face Practice" means: where a psychologist is physically present (not through the use of telecommunications technologies), in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

ARTICLE III. HOME STATE LICENSURE

A. The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

B. A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

C. Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

D. Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

E. A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

1. Currently requires the psychologist to hold an active E.Passport;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation FBI, or other designee with similar authority, no later than ten years after activation of the Compact; and

5. Complies with the Bylaws and Rules of the Commission.

F. A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

1. Currently requires the psychologist to hold an active IPC;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation FBI, or other designee with similar authority, no later than ten years after activation of the Compact; and

5. Complies with the Bylaws and Rules of the Commission.

ARTICLE IV. COMPACT PRIVILEGE TO PRACTICE TELEPSYCHOLOGY

A. Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

B. To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, OR authorized by Provincial Statute or Royal Charter to grant doctoral degrees; OR

b. A foreign college or university deemed to be equivalent to 1 (a) above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; AND

2. Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full- time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master’s degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

3. Possess a current, full and unrestricted license to practice psychology in a Home State which is a Compact State;

4. Have no history of adverse action that violate the Rules of the Commission;

5. Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

6. Possess a current, active E.Passport;

7. Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology; criminal background; and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

D. A psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice.

A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State, is restricted, suspended or otherwise limited, the E.Passport shall be revoked and therefore the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

ARTICLE V. COMPACT TEMPORARY AUTHORIZATION TO PRACTICE

A. Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with

Article III, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

B. To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, OR authorized by Provincial Statute or Royal Charter to grant doctoral degrees; OR

b. A foreign college or university deemed to be equivalent to 1 (a) above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; AND

2. Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full- time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

3. Possess a current, full and unrestricted license to practice psychology in a Home State which is a Compact State;

4. No history of adverse action that violate the Rules of the Commission;

5. No criminal record history that violates the Rules of the Commission;

6. Possess a current, active IPC;

7. Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

D. A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State, is restricted, suspended or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

ARTICLE VI. CONDITIONS OF TELEPSYCHOLOGY PRACTICE IN A RECEIVING STATE

A. A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in

the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

1. The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State;

2. Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

ARTICLE VII. ADVERSE ACTIONS

A. A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

B. A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

C. If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

1. All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

2. In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

3. Other actions may be imposed as determined by the Rules promulgated by the Commission.

D. A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a

licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

E. A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

F. Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

G. No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection C, above.

ARTICLE VIII. ADDITIONAL AUTHORITIES INVESTED IN A COMPACT STATE'S PSYCHOLOGY REGULATORY AUTHORITY

A. In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

1. Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses, and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage and other fees required by

the service statutes of the state where the witnesses and/or evidence are located; and

2. Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

3. During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

ARTICLE IX. COORDINATED LICENSURE INFORMATION SYSTEM

A. The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists individuals to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

B. Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against a psychologist's license;

5. An indicator that a psychologist's Authority to Practice Interjurisdictional

Telepsychology and/or Temporary Authorization to Practice is revoked;

6. Non-confidential information related to alternative program participation information;

7. Any denial of application for licensure, and the reasons for such denial; and

8. Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

C. The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

D. Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

E. Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

ARTICLE X. ESTABLISHMENT OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION

A. The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

1. The Commission is a body politic and an instrumentality of the Compact States.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall

appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State;

OR

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

2. Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

3. Each Commissioner shall be entitled to one (1) vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

4. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

5. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article XI.

6. The Commission may convene in a closed, non-public meeting if the Commission must discuss:

a. Non-compliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the

Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

7. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. for the establishment and meetings of other committees; and

b. governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals

of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

8. The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compact States;

9. The Commission shall maintain its financial records in accordance with the Bylaws; and

10. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

D. The Commission shall have the following powers:

1. The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rule shall have the force and effect of law and shall be binding in all Compact States;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compact State;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property real, personal or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees comprised of Members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

E. The Executive Board

The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

1. The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission;

b. One ex-officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

2. The ex-officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

3. The Commission may remove any member of the Executive Board as provided in Bylaws.

4. The Executive Board shall meet at least annually.

5. The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, fees paid by Compact States such as annual dues, and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

F. Financing of the Commission

1. The Commission shall pay, or provide for the payment of the reasonable expenses of its establishment, organization and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services.

3. The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified Immunity, Defense, and Indemnification

1. The members, officers, Executive Director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, Executive Director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person’s intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of

Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE XI. RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission; and

2. On the website of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons who submit comments independently of each other;

2. A governmental subdivision or agency; or

3. A duly appointed person in an association that has having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section

shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Compact State funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule.

A challenge shall be made in writing, and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

ARTICLE XII. OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

A. Oversight

1. The Executive, Legislative and Judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact’s purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of

process to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States, and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

4. A Compact State which has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

5. The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney’s fees.

C. Dispute Resolution

1. Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the commission.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

ARTICLE XIII. DATE OF IMPLEMENTATION OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENTS

A. The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

1. A Compact State's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

E. This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

ARTICLE XIV. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States

2999.112. No person authorized to practice in this state by the Authority to Practice Interjurisdictional Telepsychology or the Temporary Authorization to Practice under the Psychology Interjurisdictional Compact (PSYPACT) shall engage in the practice of psychology as an employee or contractor of a state or local government entity without a license granted by the board under Article 3 (commencing with Section 2940).

O

ASSEMBLY THIRD READING
AB 2051 (Bonta)
As Amended April 17, 2024
Majority vote

SUMMARY

Codifies, subject to approval by the Board of Psychology (Board or BOP), the Psychology Interjurisdictional Compact (PSYPACT) to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines for licensees who have authorization.

Major Provisions

1) Codify the entirety of the PSYPACT, including provisions that do all of the following:

   i) Require compact states to adhere to specified requirements for a psychologist's home state license to authorize them to practice telepsychology or temporarily practice psychology in-person in another compact state:

   ii) Set forth requirements for a psychologist who is licensed in a compact state to practice telepsychology or temporarily practice psychology in-person in other compact states in which the psychologist is not licensed, and requires compact states to recognize the rights of psychologists who meet those requirements.

   iii) Provide that the PSYPACT shall come into effect on the date of which the PSYPACT is enacted into law by seven member states.

   iv) Specify that an out-of-state psychologist practicing telepsychology or psychology in-person temporarily as authorized under the PSYPACT is subject to the scope of practice in the state in which the psychologist is providing psychological services.

   v) Require a psychologist's E.Passport or Interjurisdictional Practice Certificate (IPC) to be revoked if the psychologist's license is restricted, suspended, or otherwise limited in their home state or if their Authority to Practice Interjurisdictional Telepsychology (APIT) or Temporary Authorization to Practice (TAP) is restricted, suspended, or otherwise limited.

   vi) Authorize a compact state to take adverse action on an out-of-state psychologist's APIT and/or TAP in that state.

   vii) Require state licensing authorities to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee in another compact state as it would if such conduct had occurred in its own state. Additionally requires state licensing authorities to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by an out-of-state psychologist as it would if such conduct had occurred by a licensee within their own state.

   viii) Authorize state licensing authorities to issue subpoenas for hearings and investigations that require the attendance and testimony of witnesses and the production

of evidence, as well as issue cease and desist and/or injunctive relief orders to revoke an out-of-state psychologist's APIT and/or TAP.

ix) Provide that the Commission must develop and maintain a Coordinate Licensure Information System and reporting system containing licensure and disciplinary action information on all psychologists to whom the Compact is applicable.

x) Require compact states to provide specified information about licensees.

xi) Provide for the establishment of a joint public agency known as the Psychology Interjurisdictional Compact Commission, consisting of one voting representative appointed by each compact state.

xii) Authorize the Commission to, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct, as specified.

xiii) Authorize the Commission to levy on and collect an annual assessment from each Compact state or impose fees on other parties to cover the cost of the Commission's operations and activities, and its staff.

xiv) Require the Executive, Legislative, and Judicial branches of state government in each compact state to enforce the compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent.

xv) Requires the Board to comply with the requirements of the PSYPACT.

xvi) Prohibits a person from engaging in the practice of psychology without a license from the BOP or a privilege to practice under the PSYPACT.

2) Conditions the enactment of PSYPACT on the Director of Consumer Affairs certifying that a majority of the Board has voted in favor of joining the compact during a regular meeting.

COMMENTS

Board of Psychology. The BOP is the state licensing entity responsible for licensing and regulating psychologists in California. Its mission is to "protect consumers of psychological services by licensing psychologists, regulating the practice of psychology, and supporting the evolution of the profession." The BOP has authority to take disciplinary action against licensees who violate the Psychology Licensing Law, the laws and regulations governing the practice of psychology in California. At its disposal are an escalating scale of penalties ranging from citations and fines to formal disciplinary action to suspend or revoke a license. The Board is self-funded through license, application, and examination fees, and receives no General Fund revenue.

Applicants for a Psychologist license must have a qualifying doctorate degree from a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education, complete a minimum of 3,000 hours of supervised professional experience, half of which must be accrued post-doctorally, and pass both a national examination and a California law and ethics examination. Licensees are also required to complete more than 36 hours of continuing professional development every two years as a

condition of license renewal. During the Board's 2021 Sunset Review, the Board reported that in Fiscal Year (FY) 2018/19 (the most recent FY for which data was provided), there were 18,719 actively licensed psychologists in California. At the time, the BOP reported that based on data as of August 29, 2019, it took about 25 days to review initial applications for a psychologist license and notify the applicant of application deficiencies or next steps.

Interstate Licensing Compacts. An interstate licensing compact represents a legally binding agreement between multiple states to facilitate cross-state practice for licensed professionals without requiring them to obtain full licensure in each participating state. To participate in such a compact, a state must adopt model statutory language provided by a compact organization. Typically, a practitioner must already hold a license in their home state before seeking authorization to practice in a compact member state. California currently does not participate in any licensing compacts related to the healing arts professions.

The Psychology Interjurisdictional Compact. The PSYPACT is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries. To date, 41 states have joined the PSYPACT. Each state may appoint one voting member to sit on the PSYPACT Commission, the governing body of the PSYPACT. The PSYPACT Commission is responsible for establishing the bylaws, rules, and regulations that govern the interstate practice of psychology. The PSYPACT Commission is also responsible for granting psychologists the authority to practice psychology in every Compact. To be eligible for an APIT or for a TAP, psychologists must be licensed in a PSYPACT state, have an unrestricted license with no history of disciplinary action taken against their license, and obtain an E.Passport or IPC from the ASPPB. Psychologists must also pay application and renewal fees. Psychologists are subject to the laws and regulations in the state in which they are practicing telepsychology or temporary in-person psychological services. A psychologist's APIT or TAP may be revoked by a PSYPACT state if found to have violated the laws and regulations governing the practice of psychology in that state. Forty-two states have joined the PSYPACT and a handful of others are considering joining.

The author's office report that there are approximately 11,000 psychologists who participate in the PSYPACT. That number has the potential to double—to the benefit of other PSYPACT states—if California were to join. This bill would enact the PSYPACT, subject to the Board's approval, thereby allowing out-of-state psychologists to provide telepsychology to Californians and temporarily provide services in-person in this state. According to the author and sponsors of this bill, California's membership in the PSYPACT will help address the shortage of behavioral health providers affecting the state. A workforce needs study by the Steinberg Institute, one of the co-sponsors of this measure, found that California needs to add more than 370,000 behavioral health professionals, including more than 16,000 psychologists, specifically, by 2030 to meet need.

According to the Author
"Mental illness affects nearly one in six Californians, yet according to a 2018 poll, 57% of Californians surveyed reported that they have been unable to access needed mental health services. On top of the existing shortage of mental health professionals, California faces an 11% decline in psychologists in the next four years due to retirement. We must act now to increase patient access to psychological services. By joining the Psychology Interjurisdictional Compact (PSYPACT), Californians will gain access to more psychologists. Moreover, through PSYPACT, Californians who relocate temporarily, move, or frequently travel out of state, like

college students, can seamlessly continue their care with their provider using telehealth, ensuring uninterrupted access to mental health services across the lifespan."

Arguments in Support
As co-sponsors of this bill, the *Steinberg Institute* and *Mental Health America of California* write in support:

> Occupational licensure compacts are one way that we can address the behavioral health workforce shortage and get Californians the care they need now. Through licensure compacts, states establish and agree upon uniform standards that enable multi-state practice. There are currently 15 Occupational Licensure Compacts recognized by the National Center for Interstate Compacts. Occupational licensure compacts are one way that we can address the behavioral health workforce shortage and get Californians the care they need now. Through licensure compacts, states establish and agree upon uniform standards that enable multi-state practice. There are currently 15 Occupational Licensure Compacts recognized by the National Center for Interstate Compacts. PSYPACT, the occupational licensure compact for psychologists, was created by the Association of State and Provincial Psychology Boards (ASSPB) in 2014. To date, 40 states have enacted PSYPACT legislation, joining the compact. By providing a means for psychologists to practice across state lines, PSYPACT increases access to care and allows for continuity of care when patients or providers relocate or travel. Because all compact states enact the same model legislation, PSYPACT promotes cooperation between states and provides a means for telepsychology regulation and consumer protection. California can't afford not to join PSYPACT. We must use all tools at our disposal to address our behavioral health workforce shortage and ensure clients have continuity of care.

Arguments in Opposition
The *Board of Psychology* raises in its opposition letter numerous concerns related to consumer protection, need for the bill, cost and workload, and equity, and writes, in part, the following:

> The Board has concerns with [this bill], including the promulgation of rules and laws by PSYPACT's Commission which would have the force of law in California. This delegation of substantial authority to a non-governmental entity located in another jurisdiction and dominated in large part by smaller states many of which do not share some of the contemporary core values of California is problematic. It vests in this nongovernmental entity the authority to promulgate regulations that would affect the Board, California licensees, and California consumers. For instance, many of the nonresident psychologists who practice telehealth with California consumers will not be from jurisdictions that share the same requirements for continuing professional development in social justice and diversity, equity, and inclusion like California licensees, thereby subjecting California consumers to potential harm. Further, some of the states in which out of state practitioners reside still allow practices such as conversion therapy for LGBTQ+ children and adolescents or mandatory counseling for women seeking to terminate an unwanted pregnancy.

FISCAL COMMENTS

According to the Assembly Appropriations Committee, the Board estimates ongoing annual costs of $191,000 to $216,000 (Psychology Fund). The funds to support this bill's requirements would come primarily from license fees.

The Board estimated costs as follows: the Board receives approximately 940 complaints annually for a licensee population of 23,537 (4% of licensees). There are 70,965 licensed professionals in the Compact. If 25% of those licensees were to provide services in California, and the Board were to receive complaints about 4% of those licenses per year, the Board would receive an additional 710 complaints per year. Based on the Board's current average review time of three hours per complaint, the Board assumes an increase in workload of approximately 2,130 hours. The Board could not absorb this workload and would require about $166,000 to hire one analyst to support the likely additional workload resulting from this bill.

Additionally, the Board would require funds to support cases referred to the Attorney General (AG). Estimating five to ten new cases to the AG at approximately $5,000 per case, the Board will require an additional $25,000 to $50,000 for AG expenses.

VOTES

ASM BUSINESS AND PROFESSIONS: 17-0-1
YES: Berman, Flora, Alanis, Bains, Juan Carrillo, Chen, Dixon, Grayson, Jackson, Ward, Lowenthal, McKinnor, Stephanie Nguyen, Pellerin, Sanchez, Soria, Zbur
ABS, ABST OR NV: Irwin

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Sanchez, Arambula, Bryan, Calderon, Wendy Carrillo, Dixon, Mike Fong, Grayson, Haney, Hart, Jim Patterson, Pellerin, Ta, Villapudua

UPDATED

VERSION: April 17, 2024

CONSULTANT: Kaitlin Curry / B. & P. / (916) 319-3301 FN: 0003043

California Board of PSYCHOLOGY

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FLOOR ALERT

RE: AB 2051 (Bonta) – Psychology Interjurisdictional Compact – Oppose

The Board of Psychology has adopted an **Oppose** position on AB 2051 (Bonta). This bill would make California a compact state under the Psychology Interjurisdictional Compact (PSYPACT), to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state lines for licensees who have authorization.

The Board has concerns with AB 2051, including the promulgation of rules and laws by PSYPACT's Commission which would have the force of law in California. This delegation of substantial authority to a non-governmental entity located in another jurisdiction and dominated in large part by smaller states many of which do not share some of the contemporary core values of California is problematic. It vests in this nongovernmental entity the authority to promulgate regulations that would affect the Board, California licensees, and California consumers. For instance, many of the nonresident psychologists who practice telehealth with California consumers will not be from jurisdictions that share the same requirements for continuing professional development in social justice and diversity, equity, and inclusion like California licensees, thereby subjecting California consumers to potential harm. Further, some of the states in which out of state practitioners reside still allow practices such as conversion therapy for LGBTQ+ children and adolescents or mandatory counseling for women seeking to terminate an unwanted pregnancy.

Another serious concern with this bill is the requirement that psychologists must graduate from an American Psychological Association (APA) accredited program to obtain the E. Passport and gain authorization to provide services in a compact state. The APA accreditation requirement conflicts with Business and Professions Code 2914, which does not require the completion of an APA accredited program for licensure and otherwise authorizes the Board to make the final determination. Current law under 2914 allows for flexibility for approval outside of APA accreditation. Approval of this bill would constrict this flexibility.

The exclusion of licensees due to the APA accreditation requirement would have a negative impact on historically underrepresented groups, as graduates of regionally accredited programs have a more significant representation of historically underrepresented groups and devote much of their training providing services to those groups. This is a particular concern due to its inequity, variable impact on California consumers, and the exclusion of a substantial proportion of our licensees. Further, it may impact the viability of graduate programs that contribute to a broader theoretical and philosophical diversity in the delivery of psychological services. Stakeholders have also expressed their grave concerns about the negative impact of this requirement.

Although no accusation of intentionality is being made, the overall impact of the scheme is likely to result in the elevation of historically elite graduate programs over other

graduate programs with more diverse student populations, thereby resulting in structural discrimination against historically underrepresented groups.

The fiscal impact of joining the compact will be equally problematic. There is no funding for California to become a Compact State, as all fees are paid to the Association of State and Provincial Psychology Boards (ASPPB) and the Commission. However, the Board will be taking on substantial additional duties which will likely require the hiring of an additional staff member to discharge the responsibilities of a compact state without a concomitant source of funding. Although a substantial percentage of our licensees will not be eligible to participate in PSYPACT, their licensing fees will be going to support the additional services necessary for participation in the pact, further enhancing the injustice to graduates of programs at regionally accredited universities. In fact, California will have to pay the Commission each year for its participation.

Lastly, AB 2051 will increase the Boards enforcement workload. The Board would require additional staff to support the additional workload, since out of state licensees who hold an E. Passport could potentially provide psychological services to California consumers, thus increasing the number of complaints the Enforcement Division would receive. The additional workload to the Board and its staff, could create delays in providing existing services, given there is no provision for revenue sharing for the tasks that would be required for participation in PSYPACT.

The bill is also unnecessary as current California law does permit the delivery of telepsychology within the state and to clients in other jurisdictions. Our regulations allow for telehealth practice with clients outside of California; however, the laws and regulations of the jurisdiction where the client is located may determine whether it is permissible. The Board will investigate any complaint made against a California licensee as to the legality of that interjurisdictional practice and the services rendered regardless of where the services were delivered or received. The regulations also permit licensees of other jurisdictions to temporarily provide services to Californians.

If you have any questions or concerns, please feel free to contact Troy Polk, Legislative and Regulatory Analyst at (916) 574-8154.

cc: Assembly Member Bonta

California Board of PSYCHOLOGY

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(3) – Bill with Active Positions Taken by the Board AB 2270 (Maienschein) Healing Arts: continuing education: menopausal mental and physical health

Background

On February 8, 2024, AB 2270 was introduced by Assembly Member Maienschein.

Existing law, the Psychology Licensing Law, establishes the Board of Psychology and sets forth its powers and duties relating to the licensure and regulation of psychologists, and establishes continuing education requirements.

AB 2270 would allow medical providers including psychologists to have the option to take a course in menopausal mental and physical health as part of the continuing education or professional development requirements.

On February 26, 2024, AB 2270 was referred to the Assembly Committee on Business and Professions.

On April 1, 2024, the bill was amended by the Business and Professions Committee which removed the term “physical health” from the course requirement and added “within the scope of their practice to BPC 2914.4”.

On April 10, AB 2270 was amended to require the Board to consider including a course in menopausal mental or physical health for continuing professional development.

On April 12, 2024. AB 2270 was presented to the Legislative and Regulatory Affairs Committee for possible position recommendation.

On May 2, 2024, AB 2270 passed the Committee on Appropriations and was ordered to the Senate.

On May 10, 2024, the Board adopted a Support position on AB 2270. Board Staff submitted a Support Position Letter to the members of the Rules Committee.

On May 15, 2024, AB 2270 was referred to the Committee on Business, Professions and Economic Development.

Board Staff is continuing to monitor AB 2270.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: AB 2270 Bill Text
Attachment #2: AB 2270 – Assembly Appropriations Analysis
Attachment #3: AB 2270 – Support Position Letter – Senate Committee on Rules

AMENDED IN ASSEMBLY APRIL 10, 2024

AMENDED IN ASSEMBLY APRIL 1, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 2270

Introduced by Assembly Member Maienschein
(Coauthor: Assembly Member Bains)

February 8, 2024

An act to ~~add Sections 2191.3, 2811.7, 2914.4, 3524.6, 4980.56, 4989.35, 4996.29, and 4999.77 to~~ *amend Sections 2191, 2811.5, 3524.5, 4980.54, 4989.34, 4996.22, and 4999.76 of, and to add Section 2914.4 to,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2270, as amended, Maienschein. Healing arts: continuing education: menopausal mental or physical health.

Existing law, the Medical Practice Act, establishes the Medical Board of California and sets forth its powers and duties relating to the licensure and regulation of physicians and ~~surgeons.~~ *surgeons, including osteopathic physicians and surgeons.* Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing and sets forth its powers and duties relating to the licensure and regulation of the practice of nursing. Existing law, the Psychology Licensing Law, establishes the Board of Psychology and sets forth its powers and duties relating to the licensure and regulation of psychologists. Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Board and sets forth its powers and duties relating to the licensure and regulation of physician assistants.

Existing law, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, the Licensed Professional Clinical Counselor Act, and the Educational Psychologist Practice Act, provides for the licensure and regulation of the practices of marriage and family therapy, clinical social work, professional clinical counseling, and education psychology, respectively, by the Board of Behavioral Sciences.

Existing law establishes continuing education requirements for all of these various healing arts practitioners.

This bill would require ~~licensees under these provisions to have the option of taking coursework on menopausal mental or physical health within the scope of their practice to satisfy continuing education and professional development requirements.~~ *the above-specified boards, in determining their continuing education requirements, to consider including a course in menopausal mental or physical health.*

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 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human sexuality, defined as the study of a human being as a sexual being and how ~~he or she functions~~ *they function* with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The board shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The board shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The board shall encourage every physician and surgeon to take nutrition as part of ~~his or her~~ *their* continuing education, particularly a physician and surgeon involved in primary care.

(e) The board shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the board shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the board shall consider including a course in the special care needs of ~~drug addicted~~ *drug-addicted* infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the board shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the board shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its continuing education requirements, the board shall give its highest priority to considering a course on pain management and the risks of addiction associated with the use of Schedule II drugs.

(k) In determining its continuing education requirements, the board shall consider including a course in geriatric care for emergency room physicians and surgeons.

(l) In determining its continuing education requirements, the board shall consider including a course in menopausal mental or physical health.

SEC. 2. Section 2811.5 of the Business and Professions Code is amended to read:

2811.5. (a) Each person renewing their license under Section 2811 shall submit proof satisfactory to the board that, during the preceding two-year period, they have been informed of the developments in the registered nurse field or in any special area of practice engaged in by the licensee, occurring since the last renewal thereof, either by pursuing a course or courses of continuing education in the registered nurse field or relevant to the practice of the licensee, and approved by the board, or by other means deemed equivalent by the board.

(b) Notwithstanding Section 10231.5 of the Government Code, the board, in compliance with Section 9795 of the Government Code, shall do the following:

(1) By January 1, 2019, deliver a report to the appropriate legislative policy committees detailing a comprehensive plan for approving and disapproving continuing education opportunities.

(2) By January 1, 2020, report to the appropriate legislative committees on its progress implementing this plan.

(c) For purposes of this section, the board shall, by regulation, establish standards for continuing education. The standards shall be established in a manner to ensure that a variety of alternative forms of continuing education are available to licensees, including, but not limited to, online, academic studies, in-service education, institutes, seminars, lectures, conferences, workshops, extension studies, and home study programs. The standards shall take cognizance of specialized areas of practice, and content shall be relevant to the practice of nursing and shall be related to the scientific knowledge or technical skills required for the practice of nursing or be related to direct or indirect patient or client care. The continuing education standards established by the board shall not exceed 30 hours of direct participation in a course or courses approved by the board, or its equivalent in the units of measure adopted by the board.

(d) The board shall audit continuing education providers at least once every five years to ensure adherence to regulatory

requirements, and shall withhold or rescind approval from any provider that is in violation of the regulatory requirements.

(e) The board shall encourage continuing education in spousal or partner abuse detection and treatment. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(f) In establishing standards for continuing education, the board shall consider including a course in the special care needs of individuals and their families, including, but not limited to, all of the following:

(1) Pain and symptom management, including palliative care.

(2) The psychosocial dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(g) In establishing standards for continuing education, the board shall consider including a course in menopausal mental or physical health.

~~(g)~~

(h) This section shall not apply to licensees during the first two years immediately following their initial licensure in California or any other governmental jurisdiction, except that, beginning January 1, 2023, those licensees shall complete one hour of direct participation in an implicit bias course offered by a continuing education provider approved by the board that meets all the same requirements outlined in paragraph (1) of subdivision (f) of Section 2786, including, but not limited to, the identification of the licensees previous or current unconscious biases and misinformation and corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.

~~(h)~~

(i) The board may, in accordance with the intent of this section, make exceptions from continuing education requirements for licensees residing in another state or country, or for reasons of health, military service, or other good cause.

SEC. 3. Section 2914.4 is added to the Business and Professions Code, to read:

2914.4. In determining its continuing professional development, the board shall consider including a course in menopausal mental or physical health.

SEC. 4. Section 3524.5 of the Business and Professions Code is amended to read:

3524.5. (a) The board may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The board shall not require more than 50 hours of continuing education every two years. The board shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the board, as evidence of compliance with continuing education requirements.

(b) (1) The board shall adopt regulations to require that, on and after January 1, 2022, all continuing education courses for licensees under this chapter contain curriculum that includes the understanding of implicit bias.

(2) Beginning January 1, 2023, continuing education providers shall ensure compliance with paragraph (1).

(3) Beginning January 1, 2023, the board shall audit continuing education providers at least once every five years to ensure adherence to regulatory requirements, and shall withhold or rescind approval from any provider that is in violation of the regulatory requirements.

(c) Notwithstanding the provisions of subdivision (b), a continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of physician assistants.

(d) In order to satisfy the requirements of subdivision (a), continuing education courses shall address at least one or a combination of the following:

(1) Examples of how implicit bias affects perceptions and treatment decisions of physician assistants, leading to disparities in health outcomes.

(2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

(e) In determining its continuing education requirements, the board shall consider including a course in menopausal mental or physical health.

SEC. 5. Section 4980.54 of the Business and Professions Code is amended to read:

4980.54. (a) The Legislature recognizes that the education and experience requirements in this chapter constitute only minimal requirements to ensure that an applicant is prepared and qualified to take the licensure examinations as specified in subdivision (d) of Section 4980.40 and, if an applicant passes those examinations, to begin practice.

(b) In order to continuously improve the competence of licensed and registered marriage and family therapists and as a model for all psychotherapeutic professions, the Legislature encourages all licensees and registrants to regularly engage in continuing education related to the profession or scope of practice as defined in this chapter.

(c) (1) Except as provided in subdivision ~~(e),~~ *(f),* the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of marriage and family therapy in the preceding two years, as determined by the board.

(2) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education on the subject of California law and ethics during the preceding year.

(d) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(e) In determining its continuing education requirements, the board shall consider including a course in menopausal mental or physical health.

~~(e)~~

(f) The board may establish exceptions from the continuing education requirements of this section for good cause, as defined by the board.

~~(f)~~

(g) The continuing education shall be obtained from one of the following sources:

(1) An accredited school or state-approved school that meets the requirements set forth in Section 4980.36 or 4980.37. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

~~(g)~~

(h) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision ~~(f),~~ *(g),* shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

~~(h)~~

(i) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of marriage and family therapy.

(2) Aspects of the discipline of marriage and family therapy in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy.

~~(i)~~

(j) A system of continuing education for licensed marriage and family therapists shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

~~(j)~~

(k) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 6. Section 4989.34 of the Business and Professions Code is amended to read:

4989.34. (a) To renew a license, a licensee shall certify to the board, on a form prescribed by the board, completion in the preceding two years of not less than 36 hours of approved continuing education in, or relevant to, educational psychology.

(b) (1) The continuing education shall be obtained from either an accredited university or a continuing education provider as specified by the board by regulation.

(2) The board shall establish, by regulation, a procedure identifying acceptable providers of continuing education courses, and all providers of continuing education shall comply with procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(c) In determining its continuing education requirements, the board shall consider including a course in menopausal mental or physical health.

~~(c)~~

(d) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of educational psychology.

(2) Aspects of the discipline of educational psychology in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of educational psychology.

~~(d)~~

(e) The board may audit the records of a licensee to verify completion of the continuing education requirement. A licensee shall maintain records of the completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon its request.

~~(e)~~

(f) The board may establish exceptions from the continuing education requirements of this section for good cause, as determined by the board.

~~(f)~~

(g) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 7. Section 4996.22 of the Business and Professions Code is amended to read:

4996.22. (a) (1) Except as provided in subdivision ~~(c)~~, *(d)*, the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of social work in the preceding two years, as determined by the board.

(2) The board shall not renew any license of an applicant who began graduate study before January 1, 2004, pursuant to this chapter unless the applicant certifies to the board that during the applicant's first renewal period after the operative date of this section, the applicant completed a continuing education course in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. On and after January 1, 2005, the course shall consist of not less than seven hours of training. Equivalent courses in spousal or partner abuse assessment, detection, and intervention strategies taken before the operative date of this section or proof of equivalent teaching or practice experience may be submitted to the board and at its discretion, may be accepted in satisfaction of this requirement. Continuing education courses taken pursuant to this paragraph shall be applied to the 36 hours of approved continuing education required under paragraph (1).

(3) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education in the subject of California law and ethics during the preceding year.

(b) In determining its continuing education requirements, the board shall consider including a course in menopausal mental or physical health.

~~(b)~~

(c) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education

requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

~~(c)~~

(d) The board may establish exceptions from the continuing education requirement of this section for good cause as defined by the board.

~~(d)~~

(e) The continuing education shall be obtained from one of the following sources:

(1) An accredited school of social work, as defined in Section 4991.2, or 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. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) 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 a school, college, or university that is approved by the Bureau for Private Postsecondary Education.

(3) Another continuing education provider, as specified by the board by regulation.

~~(e)~~

(f) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision ~~(d),~~ *(e),* shall adhere to the procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

~~(f)~~

(g) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding, or the practice, of social work.

(2) Aspects of the social work discipline in which significant recent developments have occurred.

(3) Aspects of other related disciplines that enhance the understanding, or the practice, of social work.

~~(g)~~

(h) A system of continuing education for licensed clinical social workers shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

~~(h)~~

(i) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

~~(i)~~

(j) The board may adopt regulations as necessary to implement this section.

SEC. 8. Section 4999.76 of the Business and Professions Code is amended to read:

4999.76. (a) (1) Except as provided in subdivision ~~(c),~~ *(d),* the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of professional clinical counseling in the preceding two years, as determined by the board.

(2) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education in the subject of California law and ethics during the preceding year.

(b) In determining its continuing education requirements, the board shall consider including a course in menopausal mental or physical health.

~~(b)~~

(c) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completed continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

~~(c)~~

(d) The board may establish exceptions from the continuing education requirement of this section for good cause, as defined by the board.

~~(d)~~

(e) The continuing education shall be obtained from one of the following sources:

(1) A school, college, or university that is accredited or approved, as defined in Section 4999.12. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers as specified by the board by regulation.

~~(e)~~

(f) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision ~~(d)~~, *(e),* shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

~~(f)~~

(g) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of professional clinical counseling.

(2) Significant recent developments in the discipline of professional clinical counseling.

(3) Aspects of other disciplines that enhance the understanding or the practice of professional clinical counseling.

~~(g)~~

(h) A system of continuing education for licensed professional clinical counselors shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

~~(h)~~

(i) The continuing education requirements of this section shall fully comply with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

~~SECTION 1. Section 2191.3 is added to the Business and Professions Code, to read:~~

~~2191.3. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental or physical health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 2. Section 2811.7 is added to the Business and Professions Code, to read:~~

~~2811.7. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental or physical health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 3. Section 2914.4 is added to the Business and Professions Code, to read:~~

~~2914.4. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 4. Section 3524.6 is added to the Business and Professions Code, to read:~~

~~3524.6. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental or physical health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 5. Section 4980.56 is added to the Business and Professions Code, to read:~~

~~4980.56. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 6. Section 4989.35 is added to the Business and Professions Code, to read:~~

~~4989.35. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 7. Section 4996.29 is added to the Business and Professions Code, to read:~~

~~4996.29. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental~~

~~health within the scope of their practice to satisfy continuing education requirements.~~

~~SEC. 8. Section 4999.77 is added to the Business and Professions Code, to read:~~

~~4999.77. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on menopausal mental health within the scope of their practice to satisfy continuing education requirements.~~

O

Date of Hearing: April 24, 2024

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 2270 (Maienschein) – As Amended April 10, 2024

Policy Committee: Business and Professions Vote: 18 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the Medical Board of California (MBC), the Osteopathic Medical Board of California (OMBC), the Board of Registered Nursing (BRN), the Physician Assistants Board (PAB), the Board of Psychology (BOP), and the Board of Behavioral Sciences (BSS) to consider, in determining CE requirements, a course on menopausal mental or physical health to satisfy continuing education (CE) requirements.

FISCAL EFFECT:

No significant state costs.

COMMENTS:

1) **Purpose.** According to the author:

> It is imperative to address the misconceptions and lack of understanding surrounding menopause. It is crucial for both women experiencing menopause and healthcare professionals to comprehend the perimenopause transition, as it affects almost every woman. Lack of knowledge perpetuates anxiety and delays in care, potentially impacting the health-related quality of life. This bill aims to add an educational course on menopausal mental and physical health for healthcare providers, including physicians, nurses, psychologists, and others, to improve patient care during this significant life transition.

2) **Background.** Menopause, which marks the end of a woman's fertility, is a natural part of aging for women. Menopause is diagnosed after 12 consecutive months without a menstrual cycle. During perimenopause, the transitional time around menopause, decreases in estrogen and progesterone cause menstrual periods to cease, typically over many years in a person's 40s or 50s. Symptoms include hot flashes, sleep disturbances, and emotional changes, and may be managed by hormone therapy, prescription medications, and lifestyle changes. Symptoms may improve during postmenopause, but risks of adverse health conditions including osteoporosis and heart disease are elevated.

   A survey of postgraduates in family medicine, internal medicine, and obstetrics and gynecology residency programs across the U.S. revealed knowledge gaps concerning

hormone therapy and menopause management strategies. Notably, 20% of respondents reported a lack of menopause lectures during residency and just 7% felt adequately prepared to manage menopausal patients. The authors of the study emphasized the need to invest in "the education of future clinicians to ensure evidence-based, comprehensive menopause management for the increasing population of midlife women."

3) **Related Legislation.**

a) AB 2581 (Maienschein) requires the same boards referenced in this bill to consider, in determining CE requirements, coursework on maternal mental health. AB 2581 is pending in this committee.

b) AB 3119 (Low) requires MBC to consider requiring licensed physicians to take a continuing education CE course on long COVID. AB 3119 is pending in this committee.

4) **Prior Legislation.**

a) AB 845 (Maienschein), Chapter 220, Statutes of 2019, requires MBC to consider including a course in maternal mental health in CE requirements for physicians.

b) AB 1791 (Waldron), Chapter 122, Statutes of 2018, requires MBC to consider including among CE requirements for physicians a course relating to the integration of HIV/AIDS pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medication maintenance and counseling in primary care settings.

c) AB 1340 (Maienschein), Chapter 759, Statutes of 2017, requires MBC to consider including among CE requirement for physicians a course integrating mental and physical health care in primary care settings.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

California Board of PSYCHOLOGY

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May 15, 2024

The Honorable Mike McGuire
Chair, Senate Committee on Rules
State Capitol, Room 400
Sacramento, CA 95814

RE: **AB 2270 – Healing Arts: continuing education: menopausal mental or physical health - SUPPORT**

Dear Senator McGuire:

The Board of Psychology (Board) protects consumers of psychological services by licensing psychologists, and associated professionals, regulating the practice of psychology, and supporting the ethical evolution of the profession.

The Board is in **SUPPORT** of AB 2270. This bill would add Business and Professions Code 2914.4 to allow the Board to consider including a course in menopausal mental or physical health when determining the continuing professional development, which is required for licensure renewal. By considering a course in the topic of menopausal mental or physical health, the Board believes this will grant licensees the option to gain further education, training, and experience in treating clients and improve client care.

The Board asks for your support of AB 2270 when it is heard in the Senate Committee on Rules. If you have any questions or concerns, please feel free to contact the Board's Executive Officer, Antonette Sorrick, at (916) 574-8938 or Antonette.Sorrick@dca.ca.gov. Thank you.

Sincerely,

Lea Tate, PsyD
President, Board of Psychology

cc: Senator Shannon Grove (Vice Chair)
Members of the Senate Committee on Rules
Assembly Member Brian Maienschein
Chinook Shin Consultant, Senate Committee Assistant
Kayla Williams, Senate Republican Caucus

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(4) – Bills with Active Positions Taken by the Board AB 2581 (Maienschein) Healing arts: continuing education: maternal mental health

Background

On February 14, 2024, AB 2581 was introduced by Assembly Member Maienschein.

AB 2581 would allow medical providers including psychologists to have the option to take coursework in maternal mental health to satisfy continuing education or professional development requirements.

On March 4, 2024, AB 2581 was referred to the Assembly Committee on Business and Professions.

On April 10, AB 2581 was amended to require the Board to consider including a course in maternal mental health for continuing professional development.

On April 11, 2024, AB 2581 passed the Committee on Business and Professions and was referred to Committee on Appropriations.

On April 12, 2024, AB 2581 was presented to the Legislative and Regulatory Affairs Committee for a possible position recommendation.

On May 2, 2024, AB 2270 passed the Committee on Appropriations and was ordered to the Senate.

On May 10, 2024, the Board adopted a Support position on AB 2581. Board Staff submitted a Support Position Letter to the members of the Rules Committee.

On May 15, 2024, AB 2581 was referred to the Committee on Business, Professions and Economic Development.

Board Staff is continuing to monitor AB 2581.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: AB 2581 Bill Text
Attachment #2: AB 2581 – Assembly Appropriations Analysis
Attachment #3: AB 2581 – Support Position Letter-Senate Committee on Rules

AMENDED IN ASSEMBLY APRIL 10, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 2581

Introduced by Assembly Member Maienschein
(Coauthor: Assembly Member Bains)

February 14, 2024

An act to ~~add Sections 2191.3, 2811.7, 2914.4, 3524.6, 4980.56, 4989.35, 4996.29, and 4999.77 to~~ *amend Sections 2811.5, 3524.5, 4980.54, 4989.34, 4996.22, and 4999.76 of, and to add Section 2914.4 to,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2581, as amended, Maienschein. Healing arts: continuing education: maternal mental health.

Existing law, the ~~Medical Practice Act, establishes the Medical Board of California and sets forth its powers and duties relating to the licensure and regulation of physicians and surgeons. Existing law, the~~ Nursing Practice Act, establishes the Board of Registered Nursing and sets forth its powers and duties relating to the licensure and regulation of the practice of nursing. Existing law, the Psychology Licensing Law, establishes the Board of Psychology and sets forth its powers and duties relating to the licensure and regulation of psychologists. Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Board and sets forth its powers and duties relating to the licensure and regulation of physician assistants.

Existing law, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, the Licensed Professional Clinical Counselor Act, and the Educational Psychologist Practice Act, provides for the licensure and regulation of the practices of marriage and family

therapy, clinical social work, professional clinical counseling, and education psychology, respectively, by the Board of Behavioral Sciences.

Existing law establishes continuing education requirements for all of these various healing arts practitioners.

This bill would require ~~licensees under these provisions to have the option of taking coursework on maternal mental health to satisfy continuing education and professional development requirements.~~ *the above-specified boards, in determining their continuing education requirements, to consider including a course in maternal mental health.*

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 2811.5 of the Business and Professions Code is amended to read:

2811.5. (a) Each person renewing their license under Section 2811 shall submit proof satisfactory to the board that, during the preceding two-year period, they have been informed of the developments in the registered nurse field or in any special area of practice engaged in by the licensee, occurring since the last renewal thereof, either by pursuing a course or courses of continuing education in the registered nurse field or relevant to the practice of the licensee, and approved by the board, or by other means deemed equivalent by the board.

(b) Notwithstanding Section 10231.5 of the Government Code, the board, in compliance with Section 9795 of the Government Code, shall do the following:

(1) By January 1, 2019, deliver a report to the appropriate legislative policy committees detailing a comprehensive plan for approving and disapproving continuing education opportunities.

(2) By January 1, 2020, report to the appropriate legislative committees on its progress implementing this plan.

(c) For purposes of this section, the board shall, by regulation, establish standards for continuing education. The standards shall be established in a manner to ensure that a variety of alternative forms of continuing education are available to licensees, including, but not limited to, online, academic studies, in-service education, institutes, seminars, lectures, conferences, workshops, extension

studies, and home study programs. The standards shall take cognizance of specialized areas of practice, and content shall be relevant to the practice of nursing and shall be related to the scientific knowledge or technical skills required for the practice of nursing or be related to direct or indirect patient or client care. The continuing education standards established by the board shall not exceed 30 hours of direct participation in a course or courses approved by the board, or its equivalent in the units of measure adopted by the board.

(d) The board shall audit continuing education providers at least once every five years to ensure adherence to regulatory requirements, and shall withhold or rescind approval from any provider that is in violation of the regulatory requirements.

(e) The board shall encourage continuing education in spousal or partner abuse detection and treatment. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(f) In establishing standards for continuing education, the board shall consider including a course in the special care needs of individuals and their families, including, but not limited to, all of the following:

(1) Pain and symptom management, including palliative care.

(2) The psychosocial dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(g) In establishing standards for continuing education, the board shall consider including a course in maternal mental health.

~~(g)~~

(h) This section shall not apply to licensees during the first two years immediately following their initial licensure in California or any other governmental jurisdiction, except that, beginning January 1, 2023, those licensees shall complete one hour of direct participation in an implicit bias course offered by a continuing education provider approved by the board that meets all the same requirements outlined in paragraph (1) of subdivision (f) of Section 2786, including, but not limited to, the identification of the licensees previous or current unconscious biases and misinformation and corrective measures to decrease implicit bias

at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.

~~(h)~~

(i) The board may, in accordance with the intent of this section, make exceptions from continuing education requirements for licensees residing in another state or country, or for reasons of health, military service, or other good cause.

SEC. 2. Section 2914.4 is added to the Business and Professions Code, to read:

2914.4. In determining its continuing professional development, the board shall consider including a course in maternal mental health.

SEC. 3. Section 3524.5 of the Business and Professions Code is amended to read:

3524.5. (a) The board may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The board shall not require more than 50 hours of continuing education every two years. The board shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the board, as evidence of compliance with continuing education requirements.

(b) (1) The board shall adopt regulations to require that, on and after January 1, 2022, all continuing education courses for licensees under this chapter contain curriculum that includes the understanding of implicit bias.

(2) Beginning January 1, 2023, continuing education providers shall ensure compliance with paragraph (1).

(3) Beginning January 1, 2023, the board shall audit continuing education providers at least once every five years to ensure adherence to regulatory requirements, and shall withhold or rescind approval from any provider that is in violation of the regulatory requirements.

(c) Notwithstanding the provisions of subdivision (b), a continuing education course dedicated solely to research or other issues that does not include a direct patient care component is not required to contain curriculum that includes implicit bias in the practice of physician assistants.

(d) In order to satisfy the requirements of subdivision (a), continuing education courses shall address at least one or a combination of the following:

(1) Examples of how implicit bias affects perceptions and treatment decisions of physician assistants, leading to disparities in health outcomes.

(2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

(e) In determining its continuing education requirements, the board shall consider including a course in maternal mental health.

SEC. 4. Section 4980.54 of the Business and Professions Code is amended to read:

4980.54. (a) The Legislature recognizes that the education and experience requirements in this chapter constitute only minimal requirements to ensure that an applicant is prepared and qualified to take the licensure examinations as specified in subdivision (d) of Section 4980.40 and, if an applicant passes those examinations, to begin practice.

(b) In order to continuously improve the competence of licensed and registered marriage and family therapists and as a model for all psychotherapeutic professions, the Legislature encourages all licensees and registrants to regularly engage in continuing education related to the profession or scope of practice as defined in this chapter.

(c) (1) Except as provided in subdivision ~~(e),~~ *(f),* the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of marriage and family therapy in the preceding two years, as determined by the board.

(2) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education on the subject of California law and ethics during the preceding year.

(d) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(e) In determining its continuing education requirements, the board shall consider including a course in maternal mental health.

~~(e)~~

(f) The board may establish exceptions from the continuing education requirements of this section for good cause, as defined by the board.

~~(f)~~

(g) The continuing education shall be obtained from one of the following sources:

(1) An accredited school or state-approved school that meets the requirements set forth in Section 4980.36 or 4980.37. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

~~(g)~~

(h) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision ~~(f)~~, *(g)*, shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

~~(h)~~

(i) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of marriage and family therapy.

(2) Aspects of the discipline of marriage and family therapy in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy.

~~(i)~~

(j) A system of continuing education for licensed marriage and family therapists shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

~~(j)~~

(k) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 5. Section 4989.34 of the Business and Professions Code is amended to read:

4989.34. (a) To renew a license, a licensee shall certify to the board, on a form prescribed by the board, completion in the preceding two years of not less than 36 hours of approved continuing education in, or relevant to, educational psychology.

(b) (1) The continuing education shall be obtained from either an accredited university or a continuing education provider as specified by the board by regulation.

(2) The board shall establish, by regulation, a procedure identifying acceptable providers of continuing education courses, and all providers of continuing education shall comply with procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(c) In determining its continuing education requirements, the board shall consider including a course in maternal mental health.

~~(c)~~

(d) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of educational psychology.

(2) Aspects of the discipline of educational psychology in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of educational psychology.

~~(d)~~

(e) The board may audit the records of a licensee to verify completion of the continuing education requirement. A licensee shall maintain records of the completion of required continuing

education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon its request.

~~(e)~~

(f) The board may establish exceptions from the continuing education requirements of this section for good cause, as determined by the board.

~~(f)~~

(g) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 6. Section 4996.22 of the Business and Professions Code is amended to read:

4996.22. (a) (1) Except as provided in subdivision ~~(c),~~ *(d),* the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of social work in the preceding two years, as determined by the board.

(2) The board shall not renew any license of an applicant who began graduate study before January 1, 2004, pursuant to this chapter unless the applicant certifies to the board that during the applicant's first renewal period after the operative date of this section, the applicant completed a continuing education course in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. On and after January 1, 2005, the course shall consist of not less than seven hours of training. Equivalent courses in spousal or partner abuse assessment, detection, and intervention strategies taken before the operative date of this section or proof of equivalent teaching or practice experience may be submitted to the board and at its discretion, may be accepted in satisfaction of this requirement. Continuing education courses taken pursuant to this paragraph shall be applied to the 36 hours of approved continuing education required under paragraph (1).

(3) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have

completed not less than three hours of continuing education in the subject of California law and ethics during the preceding year.

(b) in determining its continuing education requirements, the board shall consider including a course in maternal mental health.

~~(b)~~

(c) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

~~(c)~~

(d) The board may establish exceptions from the continuing education requirement of this section for good cause as defined by the board.

~~(d)~~

(e) The continuing education shall be obtained from one of the following sources:

(1) An accredited school of social work, as defined in Section 4991.2, or 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. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) 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 a school, college, or university that is approved by the Bureau for Private Postsecondary Education.

(3) Another continuing education provider, as specified by the board by regulation.

~~(e)~~

(f) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision ~~(d),~~ *(e),* shall adhere to the procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

~~(f)~~

(g) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding, or the practice, of social work.

(2) Aspects of the social work discipline in which significant recent developments have occurred.

(3) Aspects of other related disciplines that enhance the understanding, or the practice, of social work.

~~(g)~~

(h) A system of continuing education for licensed clinical social workers shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

~~(h)~~

(i) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

~~(i)~~

(j) The board may adopt regulations as necessary to implement this section.

SEC. 7. Section 4999.76 of the Business and Professions Code is amended to read:

4999.76. (a) (1) Except as provided in subdivision ~~(c),~~ *(d),* the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that the applicant has completed not less than 36 hours of approved continuing education in or relevant to the field of professional clinical counseling in the preceding two years, as determined by the board.

(2) The board shall not renew any registration pursuant to this chapter unless the registrant certifies under penalty of perjury to the board, and on a form prescribed by the board, that they have completed not less than three hours of continuing education in the subject of California law and ethics during the preceding year.

(b) In determining its continuing education requirements, the board shall consider including a course in maternal mental health.

~~(b)~~

(c) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education

requirement. Applicants shall maintain records of completed continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

~~(c)~~

(d) The board may establish exceptions from the continuing education requirement of this section for good cause, as defined by the board.

~~(d)~~

(e) The continuing education shall be obtained from one of the following sources:

(1) A school, college, or university that is accredited or approved, as defined in Section 4999.12. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers as specified by the board by regulation.

~~(e)~~

(f) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision ~~(d)~~, *(e)*, shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

~~(f)~~

(g) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of professional clinical counseling.

(2) Significant recent developments in the discipline of professional clinical counseling.

(3) Aspects of other disciplines that enhance the understanding or the practice of professional clinical counseling.

~~(g)~~

(h) A system of continuing education for licensed professional clinical counselors shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

~~(h)~~

(i) The continuing education requirements of this section shall fully comply with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

~~SECTION 1. Section 2191.3 is added to the Business and Professions Code, to read:~~

~~2191.3. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

~~SEC. 2. Section 2811.7 is added to the Business and Professions Code, to read:~~

~~2811.7. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

~~SEC. 3. Section 2914.4 is added to the Business and Professions Code, to read:~~

~~2914.4. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mentalhealth to satisfy continuing education requirements.~~

~~SEC. 4. Section 3524.6 is added to the Business and Professions Code, to read:~~

~~3524.6. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

~~SEC. 5. Section 4980.56 is added to the Business and Professions Code, to read:~~

~~4980.56. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

~~SEC. 6. Section 4989.35 is added to the Business and Professions Code, to read:~~

~~4989.35. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

~~SEC. 7. Section 4996.29 is added to the Business and Professions Code, to read:~~

~~4996.29. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

~~SEC. 8. Section 4999.77 is added to the Business and Professions Code, to read:~~

~~4999.77. Notwithstanding any law to the contrary, a licensee shall have the option of taking coursework on maternal mental health to satisfy continuing education requirements.~~

O

Date of Hearing: April 24, 2024

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 2581 (Maienschein) – As Amended April 10, 2024

Policy Committee: Business and Professions Vote: 18 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the following healing arts licensing boards to consider, in determining requirements for continuing education (CE) for licensees, a course in maternal mental health (MMH): Medical Board of California (MBC), Board of Registered Nursing (BRN), Physician Assistant Board (PAB), Board of Psychology (BOP), and the Board of Behavioral Sciences (BBS).

FISCAL EFFECT:

Minor and absorbable costs.

COMMENTS:

1) **Purpose.** According to the author:

> In 2019, maternal mental health conditions became the primary cause of pregnancy-related deaths. Training perinatal nurses and providers in maternal mental health is crucial for effective patient support. Understanding women's health factors and addressing pregnancy risks is essential across healthcare disciplines. This bill expands education to include maternal mental health courses for various medical professionals, enhancing their ability to treat patients effectively.

2) **Maternal Mental Health.** According to the Maternal Mental Health Leadership Alliance (MMHLA), 20% of pregnant people are affected by mental health conditions, ranging from the "baby blues" to more serious conditions, such as depression, substance use disorder, post-traumatic stress disorders, bipolar disorder, and psychosis. Of those experiencing MMH conditions, 75% go untreated, increasing the likelihood of poor prenatal care, abusing substances, and experiencing physical, emotional, or sexual abuse. Suicide and overdose are the leading cause of maternal death in the first year following pregnancy. Babies born to parents with untreated MMH conditions have a higher risk of preterm birth, low birth weight, excessive crying, developmental delays, and adverse childhood experiences. The risk of stillbirth is also greater. MMHLA reports untreated MMH conditions cost an estimated $14 billion in the U.S. annually.

3) **Related Legislation.**

a) AB 2270 (Maienschein) requires the Medical Board of California (MBC), the Osteopathic Medical Board of California (OMBC), BRN, PAB, BOP, and BBS to consider, in determining CE requirements, a course on menopausal mental or physical health to satisfy CE requirements.

b) AB 3119 (Low) requires MBC to consider requiring licensed physicians to take a continuing education CE course on long COVID. AB 3119 is pending in this committee.

4) **Prior Legislation.**

a) AB 845 (Maienschein), Chapter 220, Statutes of 2019, requires MBC to consider including a course in maternal mental health in CE requirements for physicians.

b) AB 1340 (Maienschein), Chapter 759, Statutes of 2017, requires MBC to consider including among CE requirement for physicians a course integrating mental and physical health care in primary care settings.

Analysis Prepared by: Allegra Kim / APPR. / (916) 319-2081

California Board of PSYCHOLOGY

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May 15, 2024

The Honorable Mike McGuire
Chair, Senate Committee on Rules
State Capitol, Room 400
Sacramento, CA 95814

RE: **AB 2581 – Healing Arts: continuing education: maternal mental health - SUPPORT**

Dear Senator McGuire:

The Board of Psychology (Board) protects consumers of psychological services by licensing psychologists, and associated professionals, regulating the practice of psychology, and supporting the ethical evolution of the profession.

The Board is in **SUPPORT** of AB 2581. This bill would add Business and Professions Code 2914.4 to allow the Board to consider including a course in maternal mental health when determining the continuing professional development, which is required for licensure renewal. By considering a course in the topic of maternal mental health, the Board believes this will grant licensees the option to be further experienced in treating clients during pregnancy and postpartum and improve client care.

The Board asks for your support of AB 2581 when it is heard in the Senate Committee on Rules. If you have any questions or concerns, please feel free to contact the Board's Executive Officer, Antonette Sorrick, at (916) 574-8938 or Antonette.Sorrick@dca.ca.gov. Thank you.

Sincerely,

Lea Tate, PsyD
President, Board of Psychology

cc: Senator Shannon Grove (Vice Chair)
Members of the Senate Committee on Rules
Assembly Member Brian Maienschein
Chinook Shin Consultant, Senate Committee Assistant
Kayla Williams, Senate Republican Caucus

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(5) – Bills with Active Positions Taken by the Board AB 2703 (Aguiar-Curry) Federally qualified health centers and rural health clinics: psychological associates

Background

On February 14, 2024, AB 2703 was introduced by Assembly Member Aguiar-Curry. The bill is co-sponsored by The California Psychological Association (CPA) and the Primary Care Association.

Existing law does not specifically allow Federally Qualifies Health Centers (FQHC) and Rural Health Centers (RHC) to be reimbursed for services provided by psychological associates. CPA provides that the current law limits training opportunities and limits the access to mental and behavioral health services to patients at FQHCs and RHCs.

AB 2703 would amend the current law to allow psychological associates to perform services in FQHCs and RHCs and allow the centers to be reimbursed for the services.

On March 4, 2024, AB 2703 was referred to the Assembly Committee on Health.

On April 3, 2024, AB 2703 passed the committee on Health, and was referred to the committee on Appropriations.

On April 12, 2024, AB 2703 was presented the Legislative and Regulatory Affairs Committee for possible position recommendation.

On May 10, 2024, the Board adopted a Support position on AB 2703.

On May 15, 2024, Board Staff submitted a Support Position Letter to Appropriations Committee Members.

On May 16, 2024, AB 2703 passed the Appropriations Committee.

On May 20, 2024, Board Staff submitted a Floor Alert in Support to all Assembly Members.

Board Staff is continuing to monitor AB 2703.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: AB 2703 Bill Text
Attachment #2: AB 2703 – Assembly Floor Analysis
Attachment #3: AB 2703 – Assembly Floor Alert - Support

ASSEMBLY BILL No. 2703

Introduced by Assembly Member Aguiar-Curry

February 14, 2024

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 2703, as introduced, Aguiar-Curry. Federally qualified health centers and rural health clinics: psychological associates.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law requires the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit.

This bill would add a psychological associate to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to

supervision by a licensed psychologist as required by the Board of Psychology.

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 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section ~~413) of Subchapter B of Chapter 4~~ *413.1)* of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised

PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease

in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist.

(4) (A) (i) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(ii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only

synchronous interaction, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) Subject to subparagraphs (C) and (D), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

(iv) (I) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction.

(II) Notwithstanding subclause (I), the department may provide for exceptions to the prohibition established by subclause (I), including, but not limited to, the exceptions described in sub-subclauses (ia) and (ib), which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(ia) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(ib) Notwithstanding the prohibition in subclause (I) and subject to subparagraphs (C) and (D), an FQHC or RHC may establish a new patient relationship using an audio-only synchronous

interaction when the patient requests an audio-only modality or attests they do not have access to video, and when established in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

(v) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) The department may provide specific exceptions to the requirement specified in clause (i), based on an FQHC's or RHC's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iv) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(D) This paragraph shall be operative on January 1, 2023, or on the operative date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later. This paragraph shall not be construed to limit coverage of, and reimbursement for, covered telehealth services provided before the operative date of this paragraph.

(E) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this paragraph by means of all-county letters, plan letters, provider

manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(5) For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs

or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined ~~by paragraph (2) of~~ *in* subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) This subdivision does not preclude or otherwise limit the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be

adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(*l*) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include

a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring

during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC

provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the

PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) The department shall seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an

encounter between an FQHC or RHC patient and ~~an associate clinical social worker~~ *a psychological associate, associate clinical social worker,* or associate marriage and family therapist when all of the following conditions are met:

(1) The ~~associate clinical social worker or the~~ *psychological associate, associate clinical social worker, or* associate marriage and family therapist is supervised by the licensed behavioral health practitioner, as required by the Board of ~~Behavioral Sciences.~~ *Psychology or the Board of Behavioral Sciences, as applicable. For purposes of this subdivision, in the case of a psychological associate, "licensed behavioral health practitioner" shall be a licensed psychologist.*

(2) The visit is billed under the supervising licensed behavioral health practitioner of the FQHC or RHC.

(3) The FQHC or RHC is otherwise authorized to bill for services provided by the supervising licensed behavioral health practitioner as a separate visit.

(o) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(p) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(q) The department shall implement this section only to the extent that federal financial participation is available.

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions (*l*) and (m) by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting,

or making specific the provisions of subdivisions (*l*) and (m), including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

O

ASSEMBLY THIRD READING
AB 2703 (Aguiar-Curry)
As Introduced February 14, 2024
Majority vote

SUMMARY

Permits federally qualified health centers (FQHCs) and rural health clinics (RHCs) (health centers) to bill Medi-Cal for a visit provided by a psychological associate, subject to supervision and billing requirements consistent with current law and practice, and makes minor technical changes to correct code references.

COMMENTS

1) *FQHCs and RHCs.* FQHCs and RHCs are federally designated health centers that receive federal grant funding under Section 330 of the federal Public Health Service Act. These health centers are core providers in the Medi-Cal program as well as serving as a health care safety net within communities. Health centers are required to provide primary care services regardless of ability to pay.

2) *Prospective Payment System (PPS).* Federal grants provide grants to health centers to fund uncompensated care, and federal law established the PPS rate methodology to ensure state Medicaid agencies compensate health centers for the full cost of care for Medicaid patients. States also may implement an alternative payment method that pays the same or more than the federal PPS.

   A PPS rate is a per-visit rate calculated separately for each health center. Although calculation of a PPS rate is highly technical, it can be generally thought of as an average per-visit cost, derived by dividing costs for Medi-Cal-reimbursable services by Medi-Cal billable visits. A PPS rate is also adjusted annually by an economic inflator, the Medicare Economic Index. Each health center has a specific Medi-Cal PPS rate for each patient encounter, irrespective of the reason for the visit. Importantly, clinics can only bill the PPS rate when the encounter with a patient is with one of a specified list of providers. This bill would add psychological associates to this list of "billable providers," if a health center met specified criteria.

3) *Behavioral Health Services at FQHCs and RHCs.* In recent years, health centers have greatly expanded the provision of mental health services at their sites. Federal law allows, but does not require, health centers to offer behavioral health services, including mental health and substance use disorder services.

4) *Behavioral Health Trainees in FQHCs and RHCs.* During the COVID-19 Public Health Emergency (PHE), the state pursued a large number of flexibilities to enhance the accessibility of health care. One such temporary flexibility added the services of associate clinical social workers (ACSWs) and associate marriage and family therapists (AMFTs) at health centers as billable visits. SB 966 (Limón), Chapter 607, Statutes of 2022, continues this flexibility after the expiration of the PHE. Pursuant to that legislation and as implemented by State Plan Amendment 22-014, health centers can now permanently bill and receive the PPS rate for an encounter with an ACSW or AMFT.

Similar to ACSWs and AMFTs, psychological associates are behavioral health professional trainees. Psychological associates and licensed psychologists are regulated by the Board of Psychology (Board). Psychological associates have a master's or doctorate degree or are admitted into a specified doctoral program.

Licensed behavioral health practitioners must supervise and assume professional liability for services furnished by the unlicensed practitioners; for psychological associates, the supervising practitioner is a licensed psychologist.

According to the Author
California's mental health crisis is compounded by a shortage of mental health professionals. Health centers, in particular, need more behavioral health professionals. The author indicates this bill will expand access to such services for safety net patients at health centers by allowing Medi-Cal to reimburse health centers for services provided by psychological associates. The author notes that this bill will also help bring more culturally competent psychologists into the workforce in two ways, namely, it will create more training opportunities and it will expose psychological associates to community-based healthcare, making them more likely to continue working in that setting once they are licensed. This bill is cosponsored by California Primary Care Association Advocates, the advocacy organization representing health centers, and the California Psychological Association.

Arguments in Support
Cosponsors jointly write in support of this bill, indicating this effort follows up on the success of SB 966, which enjoyed bipartisan support and has expanded the behavioral health workforce at health centers. Cosponsors note this bill will similarly expand training opportunities and opportunities to hire psychologists, as psychological associates who gain experience in clinics may be motivated to work in this setting after they become licensed.

Arguments in Opposition
There is no known opposition.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

Cost pressure to DHCS of an unknown amount, possibly in the hundreds of thousands to millions of dollars to reimburse health centers for services provided by psychological associates (General Fund, federal funds). DHCS would also incur minor additional costs to pursue a state plan amendment.

According to the Legislative Analyst's Office, the General Fund faces a structural deficit in the tens of billions of dollars over the next several fiscal years.

VOTES

ASM HEALTH: 15-0-1
YES: Bonta, Waldron, Aguiar-Curry, Arambula, Wendy Carrillo, Flora, Haney, Jones-Sawyer, Maienschein, Joe Patterson, Rodriguez, Sanchez, Santiago, Schiavo, Weber

ABS, ABST OR NV: McCarty

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Sanchez, Arambula, Bryan, Calderon, Wendy Carrillo, Dixon, Mike Fong, Grayson, Haney, Hart, Jim Patterson, Pellerin, Ta, Villapudua

UPDATED

VERSION: February 14, 2024

CONSULTANT: Lisa Murawski / HEALTH / (916) 319-2097 FN: 0003178

California Board of PSYCHOLOGY

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FLOOR ALERT

RE: AB 2703 (Aguiar-Curry) – Federally qualified health centers and rural health clinics: psychological associates – Support

The Board of Psychology (Board) protects consumers of psychological services by licensing psychologists and associated professionals, regulating the practice of psychology, and supporting the ethical evolution of the profession.

The Board adopted a **Support** position on AB 2703 (Aguiar-Curry). This bill would allow registered psychological associates to provide services in federally qualified health centers (FQHCs) and rural health clinics (RHCs) and allow the centers to bill Medi-Cal for a visit provided by a psychological associate. By allowing registered psychological associates to perform services under direct supervision of a licensed psychologist in these centers, the Board believes this will increase access to client care and increase training opportunities for registered psychological associates.

If you have any questions or concerns, please feel free to contact Troy Polk, Legislative and Regulatory Analyst at (916) 574-8154.

cc: Assembly Member Aguiar-Curry

California Board of PSYCHOLOGY

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(6) – Bills with Active Positions Taken by the Board SB 1012 (Wiener) The Regulated Psychedelic-assisted Therapy Act and the Regulated Psychedelic Substances Control Act

Background

On February 5, 2024, SB 1012 was introduced by Senator Wiener.

SB 1012 would enact the Regulated Psychedelic-assisted Therapy Act, which would establish the Board of Regulated Psychedelic Facilitators in the Department of Consumer Affairs to license and regulate psychedelic-assisted therapy facilitators, as defined. The bill would require the board to be appointed, as specified, by April 1, 2025.

The new Board would be required to establish education, training, and other qualifications and requirements for obtaining a license as a regulated psychedelic-assisted therapy facilitator and would establish conditions of licensure. The bill would require the board to establish license fees for the reasonable regulatory costs to the board to administer the act. The bill would require the board to begin accepting license applications by April 1, 2026.

On February 14, 2024, SB 1012 was referred to the Senate Committees on Business, Professions and Economic Development and Public Safety.

On April 12, 2024, SB 1012 was presented to the Legislative and Regulatory Affairs Committee for possible position recommendation. The Committee expressed concerns regarding the language, and how the Board, licensees and the profession would apply to the new registration category and the practice of psychedelic-assisted therapy.

On April 16, 2024, SB 1012 passed the Committee on Business, Professions and Economic Development.

On May 10, 2024, the Board adopted an Oppose Position on SB 1012.

On May 15, 2024, Board Staff submitted an Oppose Position Letter to the Members of the Appropriations Committee.

On May 16, 2024, SB 1012 was held in the Appropriations Committee, and failed to pass the committee and will not be progressing through the legislative process.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: SB 1012 Bill Text
Attachment #2: SB 1012 – Senate Appropriations Analysis
Attachment #3: SB 1012 – Oppose Letter – Senate Appropriations Committee

AMENDED IN SENATE MARCH 20, 2024

SENATE BILL No. 1012

Introduced by Senator Wiener
(Principal coauthors: Assembly Members Lowenthal and Waldron)
(Coauthors: Senators Becker, Bradford, Dodd, and Skinner)
(Coauthors: Assembly Members Bryan, Haney, Jackson, Kalra, Lee, Rendon, and Wilson)

February 5, 2024

An act to amend ~~Section 101~~ *Sections 101 and 729* of, to add Chapter 7.1 (commencing with Section 3200) to Division 2 of, and to add Division 11 (commencing with Section 27000) to, the Business and Professions Code, to add Section 1550.6 to the Civil Code, and to amend Sections 11350, 11351, 11352, ~~11364,~~ 11364.7, 11377, 11378, 11379, 11390, and 11391 of the Health and Safety Code, relating to ~~regulated psychedelic substances.~~ *controlled substances.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1012, as amended, Wiener. The Regulated ~~Psychedelic-assisted Therapy Act and the Regulated Psychedelic Substances Control~~ *Psychedelic Facilitators Act and the Regulated Psychedelic-Assisted Therapy* Act.

(1) Existing law provides for the regulation of various professions and vocations by boards established under the jurisdiction of the Department of Consumer ~~Affairs.~~ *Affairs in the Business, Consumer Services, and Housing Agency.* Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 schedules, and places the greatest restrictions and penalties on the use of those substances placed in Schedule I. Existing law classifies dimethyltryptamine, mescaline, 3,4-methylenedioxymethamphetamine

(MDMA), ibogaine, psilocybin, and psilocyn as Schedule I substances, and prohibits various actions related to those substances, including their sale, possession, transportation, manufacture, or cultivation.

(2) This bill would enact the Regulated ~~Psychedelic-assisted Therapy~~ *Psychedelic Facilitators* Act, which would establish the Board of Regulated Psychedelic Facilitators in the Department of Consumer Affairs to license and regulate ~~psychedelic-assisted therapy~~ *psychedelic* facilitators, as defined. The bill would require the board to be appointed, as specified, by April 1, 2025. The bill would require the board to establish ~~education,~~ *educational,* training, and other qualifications and requirements for obtaining a license as a regulated ~~psychedelic-assisted therapy~~ *psychedelic* facilitator and would establish conditions of licensure. The bill would require the board to establish ~~license~~ fees for the reasonable regulatory costs to the board to administer the act. The bill would require the board to begin accepting license applications by April 1, 2026. The bill would make a license subject to renewal every 2 years. The bill would create the Regulated ~~Psychedelic-assisted Therapy~~ *Psychedelic Facilitators* Fund in the State Treasury, would require all funds received pursuant to the act to be credited to the fund, and would make moneys in the fund available to the board for the act's purposes upon appropriation by the Legislature. The bill would require the board, ~~in consultation~~ *consistent* with *recommendations made by* the Regulated Psychedelic Substances Advisory Committee, which would be created by the bill, to adopt regulations, on or before January 1, 2026, governing the safe provision of regulated ~~psychedelic-assisted therapy,~~ *psychedelic facilitation,* including regulations governing the scope of practice for regulated ~~psychedelic-assisted therapy~~ *psychedelic* facilitators and recordkeeping requirements, provided the recordkeeping does not result in the disclosure of personally identifiable information of participants. The bill would require the board to determine which schools and programs meet the requirements of the act and to adopt regulations governing the requirements and process for approving schools and programs related to the provision of ~~regulated psychedelic-assisted therapy.~~ *psychedelic facilitation training.* The bill would authorize the board to charge a reasonable fee for the inspection or approval of schools or programs. The bill would make a violation of the act a misdemeanor and subject a licenseholder's license to ~~suspension for 3 years and a $1,000 fine.~~ *suspension or revocation.* The bill would make a violation of specified acts subject to discipline *or denial of a license* by the board in accordance with specified procedures.

By creating a new crime, the bill would impose a state-mandated local program. The bill would make specified practices unfair business practices, including a person without a license holding themselves out as a ~~licensed psychedelic-assisted therapy~~ *regulated psychedelic* facilitator. The bill would ~~prohibit a local government from enacting or enforcing an ordinance that conflicts with the act.~~ *authorize a local government to reasonably regulate the time, place, and manner of regulated psychedelic facilitation within its boundaries.*

(3) This bill would enact the Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* Act to establish a comprehensive system to control and regulate the ~~cultivation,~~ *production,* distribution, transportation, storage, processing, manufacturing, testing, quality control, and sale of regulated psychedelic substances for use in conjunction with ~~regulated psychedelic-assisted therapy.~~ *psychedelic facilitation, as defined, the provision of psychedelic facilitation, the approval of locations where regulated psychedelic facilitation may take place, and the collection and publication of data on the implementation and outcomes of the act.* The bill would define "regulated psychedelic substances" to include dimethyltryptamine; mescaline; 3,4-methylenedioxymethamphetamine (MDMA); psilocybin; psilocyn; and spores or mycelium capable of producing mushrooms that contain psilocybin or psilocyn. The bill would establish the Division of Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy, to be under the supervision and control of a director appointed by the Governor,* in the Business, Consumer Services, and Housing Agency to administer and enforce the act. The bill would require the division to ~~adopt emergency regulations and to take other actions~~ *take specified actions* to carry out its duties under the act, including conducting investigations and employing peace officers. *The bill would grant to specified personnel the authority of peace officers while engaged in investigating the laws administered by the division or commencing criminal prosecution arising from investigations, as specified.* The bill would require the division, no later than April 1, 2025, to convene a Regulated Psychedelic Substances ~~Advisory Committee~~ *Expert Oversight Committee, to be appointed by the Governor,* to advise the division and the Board of Regulated Psychedelic Facilitators on the development of standards and regulations that include best practices and guidelines that protect public health and safety. The bill would require the ~~advisory~~ *oversight* committee, commencing on January 1, 2026, to publish an annual public report that includes, among

other things, the ~~advisory~~ *oversight* committee's recommendations to the division *and the board* and whether those recommendations were implemented. The bill would require the division to adopt ~~regulations~~ *regulations, consistent with the recommendations of the oversight committee,* for the administration and enforcement of laws regulating regulated psychedelic substances and services, including regulations ~~that, among other things,~~ *that* establish categories of licensure and ~~registration, establish requirements governing the safe provision of regulated psychedelic substances to participants, and that establish requirements governing the licensing and operation of psychedelic therapy centers and approved locations, as defined.~~ *registration.* The bill would require the division, no later than April 1, 2026, to begin to accept and process applications for licensure. *The bill would authorize the division to collect fees in connection with activities it regulates.* The bill would create the Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* Fund within the State Treasury, and would allocate the funds, upon appropriation by the Legislature, to the division for the purposes of implementing, administering, and enforcing the act. The bill would also create the ~~Regulated~~ Psychedelic Substances *Public* Education and Harm Reduction Fund, to be available to the Office of Community Partnerships and Strategic Communications, upon appropriation by the Legislature, to award grants for public education and harm reduction relating to psychedelic substances. The bill would authorize the division to accept moneys from private sources to supplement state funds, which may be appropriated by the Legislature to the fund. The bill would make a violation of the act a ~~misdemeanor and subject to a fine of up to $1,000 and forfeiture of a license granted under the act for 3 years.~~ *misdemeanor.* By creating a new crime, the bill would impose a state-mandated local program. The bill would require the division to work with state and local enforcement agencies to implement, administer, and enforce the division's rules and regulations.

(4) Existing law provides that a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor who engages in specified sexual conduct with a patient or client or certain former patients or clients is guilty of sexual exploitation and prescribes specified criminal penalties for acts of sexual exploitation.

This bill would make those provisions applicable to registered psychedelic facilitators. By expanding the scope of a crime, the bill would impose a state-mandated local program.

~~(4)~~

(5) This bill would declare that it is the public policy of the people of the State of California that contracts related to the operation of licenses under the *Regulated Psychedelic Facilitators Act and the* Regulated ~~Psychedelic-assisted~~ *Psychedelic-Assisted* Therapy Act ~~and the Regulated Psychedelic Substances Control Act~~ shall be enforceable.

~~(5)~~

(6) This bill would make conforming changes to the California Uniform Controlled Substances Act.

(7) This bill would state that its provisions are severable.

~~(6)This~~

(8) This bill would include findings that changes proposed by this bill address a matter of statewide concern rather than a municipal affair and, therefore, apply to all cities, including charter cities.

~~(7) This bill would state that its provisions are severable.~~

(9) 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.

~~(8)~~

(10) 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.

~~(9) 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: yes.

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

SECTION 1. (a) (1) California's current approach to mental health has failed to fulfill its promise. Californians deserve more

tools to address mental health issues, including approaches such as regulated psychedelic-assisted therapy, that are grounded in treatment, recovery, health, and wellness rather than criminalization, stigma, suffering, and punishment.

(2) Californians are experiencing problematic mental health issues, ~~including~~ *including,* but not limited to, suicidality, addiction, depression, and anxiety.

(3) An extensive and growing body of research is advancing to support the efficacy of regulated psychedelic substances combined with therapy as treatment for depression, anxiety, substance use disorders, end-of-life distress, other conditions, and overall human wellness.

(4) Psychedelic substances are powerful agents that have known contraindications for certain populations ~~and,~~ *or,* when used with certain other substances, ~~and~~ can trigger a variety of adverse effects. Thus, the use of psychedelic substances must be accompanied by a strong public education campaign, guardrails for safe access and use in a supervised environment by trained facilitators, harm reduction initiatives, and training for first responders and multiresponders.

(5) If accompanied by strong public education, guardrails, and safety standards, Californians can promote health and healing by providing regulated access to psychedelic-assisted therapy through a ~~humane, cost-effective,~~ *cost-effective* and responsible approach.

(6) Oregon voters enacted Measure 109 in November 2020 and Colorado voters enacted Proposition 122 in November 2022 to establish regulated systems of delivering one or more regulated psychedelic substances in conjunction with therapeutic services.

(b) The intent of the Legislature in enacting this act is as follows:

~~(1) Establish a regulated program to allow safe access to regulated psychedelic-assisted therapy for adults 21 years of age and older under the supervision of a licensed psychedelic-assisted therapy facilitator.~~

~~(2) To house the regulatory program within the California Business, Consumer Services, and Housing Agency and to authorize that agency to oversee and regulate manufacture, testing, quality control, transport, and safety of regulated psychedelic substances.~~

~~(3) To create and establish a professional licensing board for psychedelic-assisted therapy facilitators to govern the qualifications~~

~~for education, training, experience, licensure, professional practice, standards of care, appropriate locations for the provision of psychedelic-assisted therapy, ethics, and discipline for psychedelic-assisted therapy facilitators.~~

~~(4) To create an advisory committee housed within the California Business, Consumer Services, and Housing Agency to advise and make recommendations to the agency, the professional licensing board, and other involved agencies and departments on the adoption of rules and the implementation of this act.~~

(1) To create a Psychedelic Substances Public Education and Harm Reduction Fund within the Office of Community Partnerships and Strategic Communications that may receive public and private dollars to provide grants to public and private entities to develop and advance education and harm reduction curricula, public education campaigns, trainings, and information for the public related to the use of psychedelic substances, including an internet website, screening tool, and information about contraindications and adverse effects and education and training for first responders and multiresponders including law enforcement, emergency medical services, social services, and fire services.

(2) To establish a Division of Regulated Psychedelic-Assisted Therapy within the Business, Consumer Services, and Housing Agency.

(3) To establish an expert oversight committee comprised of subject matter experts appointed by the Governor to advise all aspects of the regulatory program, including advising the division, the professional licensing board, and all other involved agencies and departments on the adoption of rules and the implementation of this act.

(4) To authorize the division, under the guidance of the expert oversight committee, (A) to establish a program to allow for regulated access to psychedelic facilitation for adults 21 years of age and older under the supervision of a licensed psychedelic facilitator, (B) to oversee and regulate manufacture, testing, quality control, transport, and safety of regulated psychedelic substances for this purpose, and (C) to approve appropriate locations for the provision of psychedelic facilitation.

(5) Within the Department of Consumer Affairs, and under the guidance of the expert oversight committee, to establish a professional licensing board for psychedelic facilitators to govern

the qualifications for education, training, experience, licensure, professional practice, standards of care, ethics, and discipline for psychedelic facilitators.

(6) To authorize the division, under the guidance of the expert oversight committee, to collect data and to publish deidentified and aggregate data, while strictly protecting the confidentiality of program participants.

~~(5)~~

(7) To ensure that the ~~psychedelic-assisted therapy~~ *psychedelic facilitation* available under the regulated program be accessible, equitable, affordable, and safe for adults 21 years of age and older for whom ~~psychedelic-assisted therapy~~ *psychedelic facilitation* is potentially beneficial.

~~(6) Respect~~

(8) To respect and support indigenous cultures, traditions, and uses of psychedelic substances and not affect rights or undermine any protected status, or practice under other laws related to indigenous uses of psychedelic substances, or affect churches operating pursuant to the Religious Freedom Restoration Act of 1993.

~~(7) To create a fund that may receive both public and private dollars to provide grants to public and private entities to develop and advance education and harm reduction curricula, public education campaigns, trainings, and information for the public related to the use of psychedelic substances, including an internet website, screening tool, and information about contraindications and adverse effects and education and training for first responders and multiresponders including law enforcement, emergency medical services, social services, and fire services.~~

~~(8)~~

(9) Not affect or limit any rights or activities protected under any other ~~local, state,~~ *state* or federal law to expand upon any rights or activities protected by this act.

SEC. 2. Section 101 of the Business and Professions Code is amended to read:

101. The department is comprised of the following:

(a) The Dental Board of California.

(b) The Medical Board of California.

(c) The California State Board of Optometry.

(d) The California State Board of Pharmacy.

(e) The Veterinary Medical Board.
(f) The California Board of Accountancy.
(g) The California Architects Board.
(h) The State Board of Barbering and Cosmetology.
(i) The Board for Professional Engineers, Land Surveyors, and Geologists.
(j) The Contractors State License Board.
(k) The Bureau for Private Postsecondary Education.
(*l*) The Bureau of Household Goods and Services.
(m) The Board of Registered Nursing.
(n) The Board of Behavioral Sciences.
(o) The State Athletic Commission.
(p) The Cemetery and Funeral Bureau.
(q) The Bureau of Security and Investigative Services.
(r) The Court Reporters Board of California.
(s) The Board of Vocational Nursing and Psychiatric Technicians.
(t) The Landscape Architects Technical Committee.
(u) The Division of Investigation.
(v) The Bureau of Automotive Repair.
(w) The Respiratory Care Board of California.
(x) The Acupuncture Board.
(y) The Board of Psychology.
(z) The Podiatric Medical Board of California.
(aa) The Physical Therapy Board of California.
(ab) The Arbitration Review Program.
(ac) The Physician Assistant Board.
(ad) The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.
(ae) The California Board of Occupational Therapy.
(af) The Osteopathic Medical Board of California.
(ag) The California Board of Naturopathic Medicine.
(ah) The Dental Hygiene Board of California.
(ai) The Professional Fiduciaries Bureau.
(aj) The State Board of Chiropractic Examiners.
(ak) The Bureau of Real Estate Appraisers.
(a*l*) The Structural Pest Control Board.
(am) The Board of Regulated Psychedelic Facilitators.
(an) Any other boards, offices, or officers subject to its jurisdiction by law.

SEC. 3. Section 729 of the Business and Professions Code is amended to read:

729. (a) Any physician and surgeon, psychotherapist, alcohol and drug abuse ~~counselor~~ *counselor, psychedelic facilitator,* or any person holding ~~himself or herself~~ *themselves* out to be a physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse counselor, *or psychedelic facilitator,* who engages in an act of sexual intercourse, sodomy, oral copulation, or sexual contact with a patient or client, or with a former patient or client when the relationship was terminated primarily for the purpose of engaging in those acts, unless the physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor~~ *counselor, or regulated psychedelic facilitator* has referred the patient or client to an independent and objective physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor~~ *counselor, or regulated psychedelic facilitator* recommended by a third-party physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor~~ *counselor, or regulated psychedelic facilitator* for treatment, is guilty of sexual exploitation by a physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor.~~ *counselor, or regulated psychedelic facilitator.*

(b) Sexual exploitation by a physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor~~ *counselor, or regulated psychedelic facilitator* is a public offense:

(1) An act in violation of subdivision (a) shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(2) Multiple acts in violation of subdivision (a) with a single victim, when the offender has no prior conviction for sexual exploitation, shall be punishable by imprisonment in a county jail for a period of not more than six months, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(3) An act or acts in violation of subdivision (a) with two or more victims shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one

year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(4) Two or more acts in violation of subdivision (a) with a single victim, when the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000); or the act or acts shall be punishable by imprisonment in a county jail for a period of not more than one year, or a fine not exceeding one thousand dollars ($1,000), or by both that imprisonment and fine.

(5) An act or acts in violation of subdivision (a) with two or more victims, and the offender has at least one prior conviction for sexual exploitation, shall be punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of 16 months, two years, or three years, and a fine not exceeding ten thousand dollars ($10,000).

For purposes of subdivision (a), in no instance shall consent of the patient or client be a defense. However, physicians and surgeons shall not be guilty of sexual exploitation for touching any intimate part of a patient or client unless the touching is outside the scope of medical examination and treatment, or the touching is done for sexual gratification.

(c) For purposes of this section:

(1) "Psychotherapist" has the same meaning as defined in Section 728.

(2) "Alcohol and drug abuse counselor" means an individual who holds ~~himself or herself~~ *themselves* out to be an alcohol or drug abuse professional or paraprofessional.

(3) "Sexual contact" means sexual intercourse or the touching of an intimate part of a patient for the purpose of sexual arousal, gratification, or abuse.

(4) "Intimate part" and "touching" have the same meanings as defined in Section 243.4 of the Penal Code.

(5) "Regulated psychedelic facilitator" has the same meaning as defined in Section 27002.

(d) In the investigation and prosecution of a violation of this section, no person shall seek to obtain disclosure of any confidential files of other patients, clients, or former patients or

clients of the physician and surgeon, psychotherapist, or alcohol and drug abuse counselor.

(e) This section does not apply to sexual contact between a physician and surgeon and ~~his or her~~ *their* spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to ~~his or her~~ *their* spouse or person in an equivalent domestic relationship.

(f) If a physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor~~ *counselor, or psychedelic facilitator* in a professional partnership or similar group has sexual contact with a patient in violation of this section, another physician and surgeon, psychotherapist, ~~or~~ alcohol and drug abuse ~~counselor~~ *counselor, or psychedelic facilitator* in the partnership or group shall not be subject to action under this section solely because of the occurrence of that sexual contact.

~~SEC. 3.~~

SEC. 4. Chapter 7.1 (commencing with Section 3200) is added to Division 2 of the Business and Professions Code, to read:

CHAPTER 7.1. REGULATED PSYCHEDELIC ~~THERAPY~~FACILITATORS

~~Article 1. General Provisions~~

~~3200. (a) This act shall be known as the Regulated Psychedelic-assisted Therapy Act.~~

~~(b) The intent of the Legislature in acting this act is as follows:~~

~~(1) Establish a regulated program to allow safe access to psychedelic-assisted therapy for adults 21 years of age and older under the supervision of a licensed facilitator.~~

~~(2) To create and establish a professional licensing board for psychedelic-assisted therapy facilitators to govern the qualifications for education, training, experience, licensure, professional practice, standards of care, ethics, and discipline for psychedelic-assisted therapy facilitators.~~

~~(3) Ensure that regulated psychedelic-assisted therapy is available, equitable, and affordable for all adults 21 years of age~~

~~and older for whom regulated psychedelic-assisted therapy is appropriate and potentially beneficial.~~

~~(4) Respect indigenous cultures, traditions, and uses of psychedelic substances and not affect rights or undermine any protected status, or practice under other laws related to indigenous uses of psychedelic substances, or affect churches operating pursuant to the Religious Freedom Restoration Act of 1993.~~

~~(5) Provide education and harm reduction information for the public related to the use of regulated psychedelic substances, including information about contraindications and adverse effects and training for first responders and multiresponders, including law enforcement, emergency medical services, social services, and fire services.~~

~~(6) Not affect or limit any rights or activities protected under any other local, state, or federal law to expand upon any rights or activities protected by this act.~~

~~3201. The Board of Regulated Psychedelic Facilitators is hereby created within the Department of Consumer Affairs to carry out the responsibilities and duties set forth in this chapter.~~

~~3202. Unless otherwise specified, the following definitions apply for purposes of this chapter:~~

~~(a) "Administration session" means a session conducted at a regulated psychedelic-assisted therapy establishment or other approved location during which a participant consumes and experiences the effects of a regulated psychedelic substance under the supervision of a regulated psychedelic-assisted therapy facilitator.~~

~~(b) "Adverse event" or "adverse reaction" means any adverse reaction during or after the psychedelic experience requiring psychiatric, medical, or psychological care.~~

~~(c) "Approved location" means a location approved by the board for the provision of regulated psychedelic-assisted therapy or a clinic, center, or other premises approved by the State Department of Public Health for the provision of regulated psychedelic-assisted therapy.~~

~~(d) "Approved school" means a school or educational program approved by the board that meets minimum standards for training and curriculum in regulated psychedelic-assisted therapy facilitation and related subjects established by the board and that has not been otherwise unapproved by the board.~~

~~(e) "Board" means the Board of Regulated Psychedelic Facilitators.~~

~~(f) "Compensation" means a payment, loan, advance, donation, contribution, deposit, gift of money, or anything of value.~~

~~(g) "Followup session" means a meeting between a participant and a regulated psychedelic-assisted therapy facilitator that occurs within 12 to 36 hours after the completion of an administration session or sooner, if warranted, to assess well-being, screen for adverse reactions and, if needed, make referrals to needed care, additional psychosocial support, or other interventions.~~

~~(h) "Integration session" means counseling provided by the regulated psychedelic-assisted facilitator or other personnel trained in postpsychedelic support that is intended to help the participant ground themselves and feel oriented, better understand their psychedelic experience, and apply insights from their experience to healthy behavioral change in their daily life.~~

~~(i) "License" means a valid license issued by the board pursuant to this chapter.~~

~~(j) "Participant" means an individual who is 21 years of age or older and who received regulated psychedelic-assisted therapy performed by and under the supervision of a regulated psychedelic-assisted therapy facilitator.~~

~~(k) "Preparation session" means a session conducted between the participant and the facilitator before the administration of the regulated psychedelic substance. More than one preparation session may be indicated to provide participants adequate education and instruction, to develop sufficient rapport between participant and facilitator before psychedelic substance administration, and to revisit informed consent and safety planning. The initial preparation session shall include review of the safety screen and considerations for exclusion; presentation and discussion of detailed information about the psychedelic substance, including its potential risks and benefits; presentation and discussion of the therapeutic process, including administration session parameters; obtaining informed consent; safety planning; and other information as the board may determine. If three months or more have passed since the last psychedelic administration session conducted by a given participant with a given facilitator, this will be considered a new course of care, and another initial preparation session must be conducted.~~

~~(*l*) "Regulated psychedelic substances" has the same meaning as in subdivision (i) of Section 27002.~~

~~(m) "Regulated psychedelic-assisted therapy" means services provided pursuant to this chapter by a regulated psychedelic-assisted therapy facilitator or other authorized person to a participant before, during, and after the participant's consumption of a regulated psychedelic substance, that includes all of the following:~~

~~(1) A safety screen.~~

~~(2) One or more preparation sessions.~~

~~(3) An administration session.~~

~~(4) One or more followup sessions.~~

~~(n) "Regulated psychedelic-assisted therapy establishment" or "establishment" means an approved location where regulated psychedelic-assisted therapy is performed for compensation.~~

~~(o) "Regulated psychedelic-assisted therapy facilitator" means a person licensed by the board who satisfies the requirements set forth in Section 3220.~~

~~(p) "Safety screen" means a screening for medical conditions, mental health conditions, family history, contraindications, and pharmacological interactions that must be provided to every participant before an administration session.~~

~~(q) "Set" means the mindset of an individual, including the individual's history, personality, and intentions going into psychedelic-assisted therapy.~~

~~(r) "Setting" means the physical and social environment in which the psychedelic-assisted therapy experience occurs.~~

~~(s) "Sole provider" means a regulated psychedelic-assisted therapy business where the owner owns 100 percent of the business and is the only person who provides regulated psychedelic-assisted therapy for compensation for that business pursuant to a valid and active license issued in accordance with this chapter.~~

~~Article 2. Administration~~

~~3210. Protection of the public shall be the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.~~

~~3211. (a) The board shall consist of nine members. Seven members shall be appointed by the Governor, one public member shall be appointed by the Senate Committee on Rules, and one public member shall be appointed by the Speaker of the Assembly. Members of the board shall include five members who have experience facilitating psychedelic-assisted therapy and four public members. At least one member shall have experience as a facilitator as part of a United States Food and Drug Administration-approved clinical trial; at least one member shall have experience in training and supervising facilitators; at least one member shall be a licensed physician or licensed nurse practitioner; at least one member shall have experience providing care health care to veterans; and at least one member shall be a licensed marriage and family therapist or a licensed clinical social worker.~~

~~(b) A member of the board shall be appointed for a four-year term. A person shall not serve as a member of the board for more than two consecutive terms. A member shall hold office until the appointment and qualification of the member's successor, or until one year from the expiration of the term for which the member was appointed, whichever first occurs. Any vacancy shall be filled by appointment by the appointing authority which originally appointed the member whose position has become vacant.~~

~~(c) A public member of the board shall be a resident of this state for at least one year preceding the public member's appointment.~~

~~(d) A person shall not be appointed as a public member if the person or the person's immediate family owns an economic interest in a college, school, or institution engaged in regulated psychedelic-assisted therapy education. "Immediate family" means the public member's spouse, domestic partner, parent, child, or child's spouse or domestic partner.~~

~~(e) Each member of the board shall receive a per diem and expenses as provided in Section 103.~~

~~(f) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in the executive officer by this chapter.~~

~~(g) Each appointing authority has power to remove from office at any time any member of the board appointed by that authority pursuant to Section 106.~~

~~3213. (a) The board may take any reasonable actions necessary to carry out the responsibilities and duties set forth in this chapter, including, but not limited to, hiring staff, entering into contracts, and developing policies, procedures, rules, and bylaws to implement this chapter.~~

~~(b) The board may require background checks for employees, contractors, volunteers, and board members as a condition of their employment, formation of a contractual relationship, or participation in board activities.~~

~~(c) The board shall establish educational, training, examination, practicum, and supervision requirements, different tiers of licensing, scope of practice, and qualifications for regulated psychedelic-assisted therapy facilitators that protect participant safety, eliminate abuse, and reduce harm, and establish procedures to collect and report data to better inform use and increase equitable access to services.~~

~~(d) The board shall issue requirements for psychedelic-assisted therapy for both individuals and groups, including those that include veterans.~~

~~(e) The board shall issue a license to an individual applicant who satisfies the requirements of this chapter for that license.~~

~~(f) The board shall determine whether the information provided to the board in relation to the licensure of an applicant is true and accurate and meets the requirements of this chapter. If the board has any reason to question whether the information provided is true or accurate, or meets the requirements of this chapter, the board may make any investigation it deems necessary to establish that the information received is accurate and satisfies the criteria established by this chapter. The applicant has the burden to prove that they are entitled to licensure.~~

~~(g) The board shall establish fees for the reasonable regulatory costs to the board in administering this chapter. Initial license and renewal fees shall be in an amount sufficient, but shall not exceed the amount necessary, to support the functions of the board in the administration of this chapter. The renewal fee shall be reassessed biennially by the board.~~

~~(h) The meetings of the board shall be subject to the rules of the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code). The board may adopt additional policies~~

and procedures that provide greater transparency to licenseholders and the public than required by the Bagley-Keene Open Meeting Act.

(i) The board shall have the authority to, and shall collect available and relevant information and data necessary to, perform its functions and duties under this act, but must not disclose the identity of any participant or publicly disclose any information that could disclose the identity of a participant.

3214. (a) The board shall be appointed by April 1, 2025. The board shall adopt the regulations set forth in subdivision (b) on or before January 1, 2026, and begin accepting license applications by April 1, 2026.

(b) The board, in consultation with the Regulated Psychedelic Substances Advisory Committee established pursuant to Section 27018 and in compliance with the Regulated Psychedelic Substances Control Act (Division 11 (commencing with Section 27000)) and any regulations adopted pursuant to that act, shall adopt regulations governing the safe provision of regulated psychedelic-assisted therapy by regulated psychedelic-assisted therapy facilitators that include, at a minimum, the following:

(1) Requirements for holding and verifying completion of medical and mental health screenings, including a safety screening, at least one preparation session, an administration session, and at least one followup session and one integration session.

(2) Health and safety warnings required to be provided to participants before regulated psychedelic-assisted therapy begins.

(3) Educational materials required to be provided to participants before regulated psychedelic-assisted therapy begins.

(4) A medical, mental health, and contraindications safety screen that a participant must complete prior to an administration session.

(5) The informed consent form that each regulated psychedelic-assisted therapy facilitator and participant must sign before providing or receiving regulated psychedelic-assisted therapy verifying that the participant was provided accurate and complete health information in accordance with board rules, was informed of identified risk factors and contraindications, and provided informed consent to receive regulated psychedelic-assisted therapy. The form shall also include agreements that the participant and facilitator make about how the session will be conducted and safety measures that will be followed

~~to ensure the participant remains safe for the duration of the session.~~

~~(6) Proper supervision during the administration session and safe transportation for the participant when the session is complete.~~

~~(7) Rules to prevent exploitation or abuse during the administration session.~~

~~(8) Requirements for group administration sessions where one or more regulated psychedelic-assisted therapy facilitators provide regulated psychedelic-assisted therapy to more than one participant as part of the same administration session.~~

~~(9) Conditions under which the session must take place, including what should not be present, such as weapons of any sort, mirrors, intense physical stimuli, or triggering or polarizing objects, art, or signs.~~

~~(10) Requirements for postsession integration.~~

~~(11) The restrictions on advertising and marketing regulated psychedelic-assisted therapy and substances, including prohibition on any claims of beneficial health or medical use.~~

~~(12) Insurance requirements to the extent the policies are commercially available and not cost prohibitive.~~

~~(13) Age verification procedures to ensure that a participant is 21 years of age or older.~~

~~(14) The scope of practice for regulated psychedelic-assisted therapy facilitators.~~

~~(15) The qualifications, education, and training requirements that regulated psychedelic-assisted therapy facilitators must meet before providing regulated psychedelic-assisted therapy, that shall satisfy all of the following:~~

~~(A) Be tiered depending on the prior education, experience, or training of the facilitator or the complexity of the conditions or the background of the participant.~~

~~(B) Include education and training on participant safety, contraindications, mental health, mental state, physical health, physical state, social and cultural considerations, physical environment, screening, preparation, administration, integration, ethics, facilitation skills, and compliance with new regulations and laws.~~

~~(C) Allow for limited waivers of education and training requirements based on an applicant's prior experience, training, or skill, including, but not limited to, with regulated psychedelic~~

~~substances, including credit for prior training and experience when that training or experience otherwise meets the standards set by the board.~~

~~(D) Include practicum requirements with a practicum supervisor.~~

~~(E) Do not require a professional license or professional degree other than a regulated psychedelic-assisted therapy facilitator license granted pursuant to this chapter for the first tier of licensing established pursuant to paragraph (1).~~

~~(16) Procedures and policies that allow for compensation for regulated psychedelic-assisted therapy.~~

~~(17) Procedures and policies that allow for the provision of regulated psychedelic-assisted therapy to more than one participant at a time in group administration sessions.~~

~~(18) Oversight and supervision requirements for regulated psychedelic-assisted therapy facilitators, including professional responsibility standards and continuing education requirements, including limited hours within a regulated psychedelic-assisted therapy facilitator support network with peer support.~~

~~(19) A complaint, review, and disciplinary process for regulated psychedelic-assisted therapy facilitators who engage in misconduct.~~

~~(20) Recordkeeping, privacy, and confidentiality requirements for regulated psychedelic-assisted therapy facilitators, provided the recordkeeping does not result in the disclosure to the public or any governmental agency of personally identifiable information of participants.~~

~~(21) Deidentified data collection and reporting requirements for psychedelic-assisted therapy facilitators and participants pertaining to the implementation and outcomes of this act, to comprehensively measure its success, safety, quality, impact on individuals' well-being and public health, including adverse events experienced during, immediately after, or after the passage of time with information about substance, dosage, and other contextual information.~~

~~(22) Requirements for the safe and secure handling and assurance of quality control of regulated psychedelic substances by regulated psychedelic-assisted therapy facilitators.~~

~~3214.5. The Regulated Psychedelic-assisted Therapy Advisory Committee established pursuant to Section 27018 shall advise the board on the development of standards and regulations pursuant to this chapter, including best practices and guidelines that protect~~

~~the public health and safety while ensuring a regulated environment to provide safe access to regulated psychedelic-assisted therapy.~~

~~3215. (a) The board shall determine which schools and programs meet the requirements of this chapter.~~

~~(b) The board shall adopt regulations governing the requirements and process for approving schools and programs for the provision of regulated psychedelic-assisted therapy training. The regulations shall include, among other things, acceptable curriculums, facility requirements, student-teacher ratios, practicum requirements, substance-specific training, and provisions for the acceptance of accreditation from a recognized accreditation body or other form of acceptance.~~

~~(c) The board may consider expedited approval or partial approval for programs that are already in existence in the state to train licensed mental health professionals in the provision of psychedelic-assisted therapy.~~

~~(d) The board shall exercise its authority to approve, deny approval of, and unapprove schools or programs and specify corrective action in keeping with the purposes set forth in subdivision (b) of Section 3200.~~

~~(e) The board may charge a reasonable fee for the inspection or approval of schools or programs, provided the fees do not exceed the reasonable cost of the inspection or approval process.~~

~~(f) The board shall post on its internet website the date that a letter proposing to deny a school or program's application for approval or reapproval or requesting corrective action has been sent to the school and the final outcome and date of that proposed action.~~

~~3216. The board may hold hearings, take testimony, administer oaths, subpoena witnesses, and issue subpoenas for the production of books, records, or documents of any kind.~~

~~Article 3. Licensure~~

~~3220. (a) To obtain licensure as a regulated psychedelic-assisted therapy facilitator, an applicant shall submit a written application and provide the board with satisfactory evidence that the applicant meets all of the following requirements for the tier of facilitator license they are applying for:~~

~~(1) The applicant is 21 years of age or older.~~

~~(2) The applicant has successfully completed the curriculum in regulated psychedelic-assisted therapy facilitation and related subjects and the number of hours established by the board, that incorporates appropriate school assessment of student knowledge and skills, prior experience accepted by the board as an equivalent to, or equivalent to a portion of, the required curricula or practicum requirement, including existing licensure in a health or mental health profession, and any practicum experience that is required by the board. All of the hours shall be from schools or programs approved by the board. For purposes of this section, "unapproved" means that the board determined that it will not accept hours from a school toward licensure.~~

~~(3) The applicant has passed a regulated psychedelic-assisted therapy facilitator competency assessment examination that meets generally recognized principles and standards and that is created and administered by the board or an entity designated by the board.~~

~~(4) The applicant has successfully passed a background investigation pursuant to Section 3222, and has not violated any of the provisions of this chapter.~~

~~(5) All fees required by the board have been paid.~~

~~(b) The board may issue a license to an applicant who meets the qualifications of this chapter if the applicant holds a current and valid registration, licensure, or license from any other state whose licensure requirements meet or exceed those defined within this chapter. If an applicant has received education at a school or program that is not approved by the board, the board shall have the discretion to give credit for comparable academic or experiential work completed by an applicant in a program outside of California, or for work completed by an applicant in a program in California before the enactment of this act.~~

~~(c) If an applicant has received education at a school or program located outside of California or a school located in a country outside of the United States that does not meet the requirements of Section 3215 to be an approved school or program, the board shall have the discretion to give credit for comparable academic or experiential work completed by an applicant toward licensure.~~

~~(d) A license issued pursuant to this chapter and any identification card issued by the board shall be surrendered to the board by any licenseholder whose license is suspended or revoked.~~

~~3221. Except as otherwise provided, a license issued pursuant to this chapter shall be subject to renewal every two years in the manner prescribed by the board. A license issued by the board shall expire after two years unless renewed as prescribed.~~

~~3222. (a) Before issuing a license to an applicant, the board shall require the applicant to submit fingerprint images as directed by the board in a form consistent with the requirements of this section.~~

~~(b) The board shall submit the fingerprint images and related information to the Department of Justice to obtaining information as to the existence and nature of a record of state and federal level convictions and of state and federal level arrests for which the Department of Justice establishes that the applicant or candidate was released on bail or on their own recognizance pending trial.~~

~~(c) Requests for federal-level criminal offender record information received by the Department of Justice pursuant to this section shall be forwarded to the Federal Bureau of Investigation by the Department of Justice. The Department of Justice shall review the information returned from the Federal Bureau of Investigation, and shall compile and disseminate a fitness determination regarding the applicant or candidate to the board. The Department of Justice shall provide information to the board pursuant to subdivision (p) of Section 11105 of the Penal Code.~~

~~(d) The Department of Justice and the board shall charge a fee sufficient to cover the cost of processing the request for state and federal level criminal offender record information.~~

~~(e) The board shall request subsequent arrest notification service from the Department of Justice, as provided under Section 11105.2 of the Penal Code, for all applicants for licensure for whom fingerprint images and related information are submitted to conduct a search for state and federal level criminal offender record information.~~

~~(f) The board may receive arrest notifications and other background materials about applicants and licenseholders from a city, county, or city and county.~~

~~3223. In addition to the other requirements of this chapter, a licenseholder shall do all of the following:~~

~~(a) Make available for display the licenseholder's original license at any location where the licenseholder provides regulated psychedelic-assisted therapy for compensation. A licenseholder~~

~~shall have their identification card in their possession while providing regulated psychedelic-assisted therapy for compensation.~~

~~(b) Provide their full name and license number upon the request of a member of the public, the board, or a member of law enforcement, or a local governmental agency charged with regulating establishments, at the location where they are providing regulated psychedelic-assisted therapy for compensation.~~

~~(c) Include the name under which the individual is licensed and their license number in any advertising of regulated psychedelic-assisted therapy for compensation.~~

~~(d) Notify the board within 30 days of any changes in the licenseholder's home address or the address of any establishment or other location where the licenseholder provides regulated psychedelic-assisted therapy for compensation. A licenseholder also shall notify the board of the licenseholder's primary email address, if any, and notify the board within 30 days of a change of the primary email address.~~

~~Article 4. Enforcement~~

~~3230. Unless otherwise specified, a violation of this chapter is a misdemeanor and shall result in suspension of the licenseholder's license for three years and a fine not to exceed one thousand dollars ($1,000).~~

~~3231. (a) It is a violation of this chapter for an applicant or a licenseholder to commit any of the following acts, the commission of which is grounds for the board to deny an application for a license or to impose discipline on a licenseholder:~~

~~(1) Unprofessional conduct, including, but not limited to, any of the following:~~

~~(A) Engaging in sexual relations with a client or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed psychedelic-assisted therapy facilitator or occurs before, during, or after a preparation, administration, or followup session.~~

~~(B) Practicing facilitation on a suspended license, practicing without a license, or practicing outside of the conditions of a license.~~

~~(C) Engaging in financial misconduct, manipulation, or a conflict of interest with a client.~~

~~(D) Engaging in fraud, coercion, or verbal abuse with a client.~~

~~(E) Violating the terms of consent or agreements entered into with the client during the preparation session.~~

~~(F) Discriminating against a client on the basis of race, color, ancestry, national origin, religion, creed, gender, sex, sexual orientation, age, disability, marital status, and any other basis enumerated under California law.~~

~~(2) Procuring or attempting to procure a license by fraud, misrepresentation, or mistake.~~

~~(3) Failing to fully disclose all information requested on the application.~~

~~(4) Impersonating an applicant or acting as a proxy for an applicant in any examination referred to in this chapter for the issuance of a license.~~

~~(5) Impersonating a licenseholder or permitting or allowing a nonlicensed person to use a license.~~

~~(6) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or any rule or regulation adopted by the board.~~

~~(7) Committing any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a licenseholder.~~

~~(8) Offering or giving commissions, rebates, or other forms of remuneration for the referral of clients.~~

~~(9) Denial of licensure, revocation, suspension, restriction, citation, or any other disciplinary action against an applicant or licenseholder by another state or territory of the United States, by any other governmental agency, or by another California healing arts professional licensing board. A certified copy of the decision, order, judgment, or citation shall be conclusive evidence of these actions.~~

~~(10) Being convicted of any felony or misdemeanor, or being held liable in an administrative or civil action for an act, that is substantially related to the qualifications, functions, or duties of a~~

licenseholder. A record of the conviction or other judgment or liability shall be conclusive evidence of the crime or liability.

(11) Failing to act within the limitations created by a physical illness, physical condition, or behavioral, mental health, or substance use disorder that renders the licensee unable to perform psychedelic-assisted therapy services with reasonable skill and safety to the participant.

(b) The board may deny an application for a license for the commission of any of the acts described in subdivision (a). The board may also discipline a licenseholder, in any manner permitted by this chapter, for the commission of any of those acts by a licenseholder.

(c) The board shall deny an application for a license, or revoke the license of a licenseholder, if the applicant or licenseholder is required to register pursuant to the Sex Offender Registration Act (Chapter 5.5 (commencing with Section 290) of Title 9 of Part 1 of the Penal Code), or is required to register as a sex offender in another state.

3232. (a) An applicant for a license shall not be denied a license and a licenseholder shall not be disciplined pursuant to this chapter except according to procedures that satisfy the requirements of this section.

(b) The board may discipline a licenseholder by any of the following methods:

(1) Placing the licenseholder on probation, which may include limitations or conditions on practice.

(2) Suspending the license and the rights conferred by this chapter on a licenseholder for a period not to exceed one year.

(3) Suspending or staying the disciplinary order, or portions of it, with or without conditions.

(4) Revoking the license.

(5) Taking other action the board deems proper, as authorized by this chapter.

(c) The board may issue an initial license on probation, with specific terms and conditions, to any applicant.

(d) Any denial or discipline shall be decided upon and imposed in good faith and in a fair and reasonable manner.

(e) Any notice required under this section may be given by any method reasonably calculated to provide actual notice. Notice given by mail shall be given by first-class or certified mail sent to

~~the last address of the applicant or licensee shown on the board's records.~~

~~(f) An applicant or licenseholder may challenge a denial or discipline decision issued pursuant to this section in a court of competent jurisdiction. Any action challenging a denial or discipline, including any claim alleging defective notice, shall be commenced within 90 days after the effective date of the denial or discipline. A license issued pursuant to this chapter is not a fundamental vested right and judicial review of denial and disciplinary decisions made by the board shall be conducted using the substantial evidence standard of review. If the action is successful, the court may order any relief, including reinstatement, that it finds equitable under the circumstances.~~

~~(g) This section governs only the procedures for denial or discipline decision and not the substantive grounds for the denial or discipline. Denial or discipline based upon substantive grounds that violates contractual or other rights of the applicant or licensee, or is otherwise unlawful, is not made valid by compliance with this section.~~

~~3233. (a) It is an unfair business practice for a person to do any of the following:~~

~~(1) To hold themselves out or to use the title of "licensed psychedelic-assisted therapy facilitator," "regulated psychedelic-assisted therapy facilitator," or any other term, such as "licensed," or "certified," in any manner that implies that the person is licensed as a psychedelic-assisted therapy facilitator, unless that person currently holds an active and valid license issued by the board pursuant to this chapter.~~

~~(2) To falsely state or advertise or put out any sign or card or other device, or to falsely represent to the public through any print or electronic media, that they or any other individual are licensed, certified, or registered by a governmental agency as a regulated psychedelic-assisted therapy facilitator.~~

~~(b) In addition to any other available remedies, engaging in any of the prohibited behaviors described in subdivision (a) constitutes unfair competition under Section 17200.~~

~~(c) Nothing in this chapter shall be construed to limit the provisions of the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991)), the Nursing~~

~~Practice Act (Chapter 6 (commencing with Section 2700)), the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2901)), the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980.04)), the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)), or any other licensed profession.~~

~~3234. (a) Notwithstanding any other law, a city, county, or city and county shall not enact or enforce an ordinance that conflicts with this chapter.~~

~~(b) A local government shall impose and enforce only reasonable and necessary fees and regulations on establishments, in keeping with the requirements of existing law and being mindful of the need to protect legitimate business owners and regulated psychedelic-assisted therapy facilitators.~~

~~3235. The superior court of a county of competent jurisdiction may, upon a petition by any person, issue an injunction or any other relief the court deems appropriate for a violation of this chapter by any person or establishment operating in that county subject to the provisions of this chapter. An injunction proceeding under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.~~

~~3236. (a) This chapter shall be liberally construed to effectuate its purposes.~~

~~(b) The provisions of this chapter are severable. If any provision of this chapter 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.~~

~~(c) If any provision of this chapter or the application of these provisions to any person or circumstance is held to be invalid, the invalidity shall not affect other provisions or applications of the chapter that can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.~~

~~3237. The board may discipline an owner of an establishment for the conduct of any individual providing regulated psychedelic-assisted therapy on the establishment's premises or under the supervision of the establishment.~~

~~3238. A person engaged in a profession or occupation subject to licensure pursuant to this division shall not be subject to~~

~~discipline by another professional licensing board solely for providing professional services related to activity permitted under this chapter or for engaging in any activity that is lawful under this chapter that is not subject to criminal penalty under state law. This act does not authorize a person to engage in malpractice or to violate the standards of professional practice for which a person is licensed.~~

~~3239. It is the public policy of the people of the State of California that contracts related to the operation of licenses under this chapter should be enforceable and no contract entered into by a licensee, its employees, or its agents, as permitted pursuant to a valid license issued by the board, or by those who allow property to be used by a licensee, its employees, or its agents, as permitted pursuant to a valid license issued by the board, shall be deemed unenforceable on the basis that the actions or conduct permitted pursuant to the license are prohibited by federal law.~~

Article 1. General Provisions

3200. This act shall be known as the Regulated Psychedelic Facilitators Act.

3201. The Board of Regulated Psychedelic Facilitators is hereby created within the Department of Consumer Affairs to carry out the responsibilities and duties set forth in this chapter.

3202. For purposes of this chapter, the following definitions apply:

(a) "Administration session" means a session conducted at an approved location during which a participant consumes and experiences the effects of a regulated psychedelic substance under the supervision of a regulated psychedelic facilitator.

(b) "Adverse event" or "adverse reaction" means any adverse reaction during or after the psychedelic experience, including, but not limited to, headache, nausea, and dizziness.

(c) "Approved location" means a location approved by the division for the provision of regulated psychedelic facilitation or a clinic, center, or other facility licensed by the State Department of Public Health.

(d) "Approved school" means a school or educational program approved by the board that meets minimum standards for training

and curriculum in regulated psychedelic facilitation and related subjects and that has not been otherwise approved by the board.

(e) "Board" means the Board of Regulated Psychedelic Facilitators.

(f) "Clinic" shall have the same meaning as set forth in Section 1200 of the Health and Safety Code.

(g) "Compensation" means a payment, loan, advance, donation, contribution, deposit, gift of money, or anything of value.

(h) "Division" means the Division of Regulated Psychedelic-Assisted Therapy established pursuant to Division 11 (commencing with Section 27000).

(i) "Expert oversight committee" means the Regulated Psychedelic Substances Expert Oversight Committee.

(j) "Followup evaluation" means contact between a participant and a regulated psychedelic facilitator that occurs within 12 to 72 hours after the completion of an administration session or sooner, if warranted, to assess well-being, screen for adverse reactions, and, if needed, make referrals to needed care, additional psychosocial support, or other interventions.

(k) "Fund" means the Regulated Psychedelic Facilitators Fund.

(l) "Integration session" means counseling provided by a regulated psychedelic facilitator or other personnel trained in postpsychedelic support that is intended to help the participant better understand their psychedelic experience and apply insights from their experience to their daily life.

(m) "License" means a valid license issued pursuant to this chapter.

(n) "Participant" means a person 21 years of age or older who purchases or receives a regulated psychedelic substance from a regulated psychedelic licensee for use in conjunction with regulated psychedelic facilitation at an approved location and under the supervision of a licensed psychedelic facilitator.

(o) "Preparation session" means a session conducted between a participant and a psychedelic facilitator before the administration of the regulated psychedelic substance. More than one preparation session may be indicated to provide participants adequate education and instruction, to develop sufficient rapport between the participant and psychedelic facilitator before the psychedelic substance administration, and to revisit informed consent and safety planning. The initial preparation session shall include review

of the safety screen and considerations for exclusion; presentation and discussion of detailed information about the psychedelic substance, including its potential risks and benefits; presentation and discussion of the therapeutic process, including administration session parameters; obtaining informed consent; safety planning; and other information as the board may determine. If three months or more have passed since the last psychedelic administration session conducted by a given participant with a given facilitator, this will be considered a new course of care, and another initial preparation session must be conducted.

(p) "Produce" means the growing, cultivating, processing, and manufacturing of regulated psychedelic substances.

(q) (1) "Regulated psychedelic substances" means the following substances as defined in Section 11054 of the Health and Safety Code:

(A) Dimethyltryptamine.

(B) Mescaline.

(C) 3,4-methylenedioxymethamphetamine (MDMA).

(D) Psilocybin.

(E) Psilocyn.

(F) Spores or mycelium capable of producing mushrooms that contain psilocybin or psilocyn.

(2) "Regulated psychedelic substances" does not include peyote, including all parts of the plant classified botanically as Lophophora williamsii, whether growing or not, its seeds, any extract from any part of the plant, and every compound, salt, derivative, mixture, or preparation of the plant, or its seeds or extracts.

(r) "Regulated psychedelic substance licensee" means an entity that holds a license in any of the categories for licensure or registration established by this division. A regulated psychedelic substance licensee may receive compensation for regulated psychedelic substances only in connection with use in regulated psychedelic facilitation provided at an approved location.

(s) "Regulated psychedelic facilitation" means services provided pursuant to this division by a regulated psychedelic facilitator to a participant before, during, and after the participant's consumption of a regulated psychedelic substance, including all of the following:

(1) A safety screen.

(2) One or more preparation sessions.

(3) An administration session.

(4) One or more followup evaluations.

(5) One or more integration sessions.

(t) "Regulated psychedelic facilitation location" or "approved location" means an approved location where psychedelic facilitation is performed.

(u) "Regulated psychedelic facilitator" means a person licensed by the Board of Regulated Psychedelic Facilitators pursuant to this division.

(v) "Safety screen" means a screening for medical conditions, mental health conditions, family history, contraindications, and pharmacological interactions that must be provided to every participant before an administration session.

(w) "Serious adverse event" or "serious adverse reaction" means an adverse reaction during or after the psychedelic experience requiring psychiatric, medical, or psychological care.

(x) "Set" means the mindset of an individual, including the individual's history, personality, and intentions going into psychedelic facilitation.

(y) "Setting" means the physical and social environment in which the psychedelic facilitation occurs.

(z) "Sole provider" means a regulated psychedelic facilitator business where the owner owns 100 percent of the business and is the only person who provides regulated psychedelic facilitation for compensation for that business pursuant to a valid and active license issued in accordance with this division.

Article 2. Administration

3210. The protection of the public shall be the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions under this chapter. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

3211. (a) The board shall consist of nine members. Seven members shall be appointed by the Governor, one public member shall be appointed by the Senate Committee on Rules, and one public member shall be appointed by the Speaker of the Assembly. Members of the board shall include five members who have

expertise in psychedelic facilitation and four public members. At least one member shall have experience as a facilitator as part of a United States Food and Drug Administration-approved clinical trial; at least one member shall have experience in training and supervising facilitators; at least one member shall be a licensed physician or licensed advanced practice clinician; at least one member shall have experience providing mental health care to veterans; and at least one member shall be a licensed marriage and family therapist, a licensed clinical social worker or board-certified chaplain.

(b) A member of the board shall be appointed for a four-year term. A person shall not serve as a member of the board for more than two consecutive terms. A member shall hold office until the appointment and qualification of the member's successor, or until one year from the expiration of the term for which the member was appointed, whichever first occurs. Any vacancy shall be filled by appointment by the appointing authority which originally appointed the member whose position has become vacant.

(c) Members of the board shall be a resident of this state for at least one year preceding the member's appointment.

(d) A person shall not be appointed as a public member if the person or the person's immediate family owns an economic interest in a college, school, or institution engaged in regulated psychedelic facilitation education. For purposes of this section, "immediate family" means the public member's spouse, domestic partner, parent, child, or child's spouse or domestic partner.

(e) Each member of the board shall receive a per diem and expenses as provided in Section 103.

(f) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in the executive officer by this chapter.

(g) Each appointing authority has power to remove from office at any time any member of the board appointed by that authority pursuant to Section 106.

3212. (a) The board may take any reasonable actions necessary to carry out the responsibilities and duties set forth in this chapter, including, but not limited to, hiring staff, employing consultants, entering into contracts, and developing policies, procedures, rules, and bylaws to implement this chapter.

(b) The board may require background checks for employees, contractors, volunteers, and board members as a condition of their employment, formation of a contractual relationship, or participation in board activities.

(c) The board shall establish educational, training, examination, practicum, and supervision requirements, different tiers of licensing, scope of practice, and qualifications for regulated psychedelic facilitators that protect participant safety, eliminate abuse, and reduce harm, and establish procedures to collect and report data to better inform use and increase equitable access to services.

(d) The board shall establish the professional standards for regulated psychedelic facilitators to provide psychedelic facilitation for both individuals and groups, including those that include veterans, and including the number of participants served.

(e) The board shall take into account considerations related to and engage in consultation with indigenous communities.

(f) The board shall develop a system to allow for the purchase and administration of regulated psychedelic substances in the presence of a facilitator but without the facilitator directly handling the regulated psychedelic substances so that the facilitator may avoid trafficking in Schedule I or Schedule II substances.

(g) The board shall issue a license to an individual applicant who satisfies the requirements of this chapter for that license.

(h) The board shall determine whether the information provided to the board in relation to the licensure of an applicant is true and accurate and meets the requirements of this chapter. If the board has any reason to question whether the information provided is true or accurate, or meets the requirements of this chapter, the board may make any investigation it deems necessary to establish that the information received is accurate and satisfies the criteria established by this chapter. The applicant has the burden to prove that they are entitled to licensure.

(i) The board shall establish fees for the reasonable regulatory costs to the board in administering this chapter. Initial license and renewal fees shall be in an amount sufficient, but shall not exceed the amount necessary, to support the functions of the board in the administration of this chapter. The renewal fee shall be reassessed biennially by the board.

(j) The meetings of the board shall be subject to the rules of the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code). The board may adopt additional policies and procedures that provide greater transparency to licenseholders and the public than required by the Bagley-Keene Open Meeting Act. To protect sensitive information it receives, and the safety and security of participants, facilitators, staff, and approved locations, the board may hold closed sessions for the purpose of reviewing and discussing confidential and proprietary materials, intellectual property, and private information, including, but not limited to, personal information contained in licenses, medical records, research studies, and complaints.

(k) The board shall have the authority to require regulated psychedelic facilitators to collect and report relevant information and data.

3213. (a) The board shall be appointed by April 1, 2025. The board shall adopt the regulations set forth in subdivision (b) on or before January 1, 2026, and begin accepting license applications by April 1, 2026.

(b) The board, consistent with recommendations made by the Regulated Psychedelic Substances Expert Oversight Committee established pursuant to Section 27018 and in compliance with this act and any regulations adopted pursuant to this act, shall adopt regulations governing the safe provision of regulated psychedelic facilitation by regulated psychedelic facilitators that include, at a minimum, all of the following:

(1) Requirements for holding and verifying completion of medical and mental health screenings, including a safety screen, at least one preparation session, an administration session, at least one followup evaluation, and at least one integration session.

(2) Health and safety warnings required to be provided to participants before regulated psychedelic facilitation begins.

(3) Educational materials required to be provided to participants before regulated psychedelic facilitation begins.

(4) A medical, mental health, family history and contraindications safety screen that a participant must complete prior to an administration session.

(5) The informed consent form that each regulated psychedelic facilitator and participant must sign before providing or receiving regulated psychedelic facilitation verifying all of the following:

(A) The participant was provided accurate and complete health information in accordance with board rules.

(B) The participant was informed the regulated psychedelic substances have not received FDA approval.

(C) The participant was informed of potential and identified risks, benefits, contraindications, and negative outcomes of the psychedelic substance, and the method of administration and facilitation process. The form shall also include agreements that the participant and the psychedelic facilitator make about how the session will be conducted and the safety measures that will be followed to ensure the participant remains safe for the duration of the session.

(6) Proper supervision during the administration session and safe transportation for the participant when the session is complete.

(7) Rules to prevent exploitation or abuse.

(8) Requirements for group administration sessions where one or more regulated psychedelic facilitators provide regulated psychedelic facilitation to more than one participant as part of the same administration session.

(9) Conditions of the set and setting in which the administration session must take place, including what should not be present, such as weapons, mirrors, intense physical stimuli, or triggering or polarizing objects, art, or signs.

(10) Proper locations for where regulated psychedelic facilitation may take place.

(11) Requirements for postsession followup and integration.

(12) The restrictions for psychedelic facilitators on advertising and marketing regulated psychedelic facilitation and substances, including prohibition on claims of beneficial health or medical use unless in compliance with the requirements of the Federal Food, Drug, and Cosmetic Act.

(13) Insurance requirements to the extent the policies are commercially available and not cost prohibitive.

(14) Age verification procedures to ensure that a participant is 21 years of age or older.

(15) The scope of practice for regulated psychedelic facilitators.

(16) The qualifications, education, and training requirements that regulated psychedelic facilitators must meet before providing regulated psychedelic facilitation that shall satisfy all of the following:

(A) Be tiered depending on the prior education, experience, or training of the psychedelic facilitator or the complexity of the conditions or the background of the participant.

(B) Include education and training on participant safety, contraindications, mental health, mental state, physical health, physical state, social and cultural considerations, physical environment, screening, preparation, administration, integration, ethics, facilitation skills, and compliance with California regulations and laws.

(C) Allow for limited waivers of education and training requirements based on an applicant's prior experience, training, or skill with regulated psychedelic substances, including, but not limited to, credit for prior training and experience when that training or experience otherwise meets the standards set by the board.

(D) Include practicum requirements with a practicum supervisor.

(E) Do not require a professional license or professional degree other than a regulated psychedelic facilitator license granted pursuant to this chapter for at least one of the tiers of licensing established pursuant to subparagraph (A).

(17) Procedures and policies that allow for compensation for regulated psychedelic facilitation.

(18) Oversight and supervision requirements for regulated psychedelic facilitators, including professional responsibility standards and continuing education requirements, including limited hours within a regulated psychedelic facilitator support network with peer support.

(19) A complaint, review, and disciplinary process for regulated psychedelic facilitators who engage in misconduct.

(20) Recordkeeping, privacy, and confidentiality requirements for regulated psychedelic facilitators, provided the recordkeeping does not result in the unauthorized disclosure to the public or any unauthorized governmental agency of personally identifiable information of participants.

(21) Deidentified data collection and reporting requirements for psychedelic facilitators pertaining to the implementation and outcomes of this act, to comprehensively measure its success, safety, quality, impact on individuals' well-being and public health, including adverse events experienced during, immediately after, or after the passage of time with information about substance, dosage, and other contextual information.

(22) Requirements for the safe and secure handling and assurance of quality control of regulated psychedelic substances by regulated psychedelic facilitators.

3214. (a) The board shall determine which schools and programs meet the requirements of this chapter.

(b) The board shall adopt regulations governing the requirements and process for approving schools and programs for the provision of regulated psychedelic facilitation training. The regulations shall include, among other things, acceptable curriculums, facility requirements, student-teacher ratios, practicum requirements, substance-specific training, and provisions for the acceptance of accreditation from a recognized accreditation body or other form of acceptance.

(c) The board may consider expedited approval or partial approval for programs that are already in existence in the state to train licensed mental health professionals in the provision of psychedelic facilitation.

(d) The board shall exercise its authority to approve, deny approval of, and unapprove schools or programs and specify corrective action.

(e) The board may charge a reasonable fee for the inspection or approval of schools or programs, provided the fees do not exceed the reasonable cost of the inspection or approval process.

(f) The board shall post on its internet website the date that a letter proposing to deny a school or program's application for approval or reapproval or requesting corrective action has been sent to the school and the final outcome and date of that proposed action.

3215. The board may hold hearings, take testimony, administer oaths, subpoena witnesses, and issue subpoenas for the production of books, records, or documents of any kind.

Article 3. Licensure

3220. (a) To obtain licensure as a regulated psychedelic facilitator, an applicant shall submit a written application and provide the board with satisfactory evidence that the applicant meets all of the following requirements for the tier of facilitator license they are applying for:

(1) The applicant is 21 years of age or older.

(2) The applicant has successfully completed the curriculum in regulated psychedelic facilitation and related subjects and the number of hours established by the board that incorporates appropriate school assessment of student knowledge and skills, prior experience accepted by the board as an equivalent to, or equivalent to a portion of, the required curricula or practicum requirement, including existing licensure in a health or mental health profession, and any practicum experience that is required by the board. All of the hours shall be from schools or programs approved by the board. For purposes of this section, "unapproved" means that the board determined that it will not accept hours from a school toward licensure.

(3) The applicant has passed a regulated psychedelic facilitator competency assessment examination that meets generally recognized principles and standards and that is created and administered by the board or an entity designated by the board.

(4) The applicant has successfully passed a background investigation pursuant to Section 27032, and has not violated any of the provisions of this chapter.

(5) All fees required by the board have been paid.

(b) The board may issue a license to an applicant who meets the qualifications of this chapter if the applicant holds a current and valid registration, licensure, or license from any other state whose licensure requirements meet or exceed those defined within this chapter. If an applicant has received education at a school or program that is not approved by the board, the board shall have the discretion to give credit for comparable academic or experiential work completed by an applicant in a program outside of California, or for work completed by an applicant in a program in California before the enactment of this act.

(c) If an applicant has received education at a school or program located outside of California or a school located in a country outside of the United States that does not meet the requirements of Section 27024 to be an approved school or program, the board shall have the discretion to give credit for comparable academic or experiential work completed by an applicant toward licensure.

(d) A license issued pursuant to this chapter and any identification card issued by the board shall be surrendered to the board by any licenseholder whose license is suspended or revoked.

3221. Except as otherwise provided, a license issued pursuant to this chapter shall be subject to renewal every two years in the manner prescribed by the board. A license issued by the board shall expire after two years unless renewed as prescribed.

3222. (a) Before issuing a license to an applicant, the board shall require the applicant to submit fingerprint images as directed by the board in a form consistent with the requirements of this section.

(b) The board shall submit the fingerprint images and related information to the Department of Justice to obtain information as to the existence and nature of a record of state- and federal-level convictions and of state- and federal-level arrests for which the Department of Justice establishes that the applicant or candidate was released on bail or on their own recognizance pending trial.

(c) Requests for federal-level criminal offender record information received by the Department of Justice pursuant to this section shall be forwarded to the Federal Bureau of Investigation by the Department of Justice. The Department of Justice shall review the information returned from the Federal Bureau of Investigation, and shall compile and disseminate a fitness determination regarding the applicant or candidate to the board. The Department of Justice shall provide information to the board pursuant to subdivision (p) of Section 11105 of the Penal Code.

(d) The Department of Justice and the board shall charge a fee sufficient to cover the cost of processing the request for state- and federal-level criminal offender record information.

(e) The board shall request subsequent arrest notification service from the Department of Justice, as provided under Section 11105.2 of the Penal Code, for all applicants for licensure for whom fingerprint images and related information are submitted to

conduct a search for state- and federal-level criminal offender record information.

(f) The board may receive arrest notifications and other background materials about applicants and licenseholders from a city, county, or city and county.

3223. In addition to the other requirements of this chapter, a licenseholder shall do all of the following:

(a) Make available for display the licenseholder's original license at any location where the licenseholder provides regulated psychedelic facilitation. A licenseholder shall have their identification card in their possession while providing regulated psychedelic facilitation.

(b) Provide their full name and license number upon the request of a member of the public, the board, or a member of law enforcement, or a local governmental agency charged with regulating establishments, at the location where they are providing regulated psychedelic facilitation.

(c) Include the name under which the individual is licensed and their license number in any advertising of regulated psychedelic facilitation.

(d) Notify the board within 30 days of any changes in the licenseholder's home address or the address of any establishment or other location where the licenseholder provides regulated psychedelic facilitation. A licenseholder also shall notify the board of the licenseholder's primary email address, if any, and notify the board within 30 days of a change of the primary email address.

Article 4. Enforcement

3230. Unless otherwise specified, any person who violates any of the provisions of this chapter is guilty of a misdemeanor punishable by imprisonment in county jail not exceeding six months, by a fine not to exceed two thousand five hundred dollars ($2500), or by both, and which may result in the suspension or revocation of the licenseholder's license.

3231. (a) It is a violation of this chapter for an applicant or a licenseholder to commit any of the following acts, the commission of which is grounds for the board to deny an application for a license or to impose discipline on a licenseholder:

(1) Unprofessional conduct, including, but not limited to, any of the acts listed in the following paragraphs in this subdivision.

(2) Engaging in sexual relations with a participant or a former participant within two years following termination of services, soliciting sexual relations with a participant, or committing an act of sexual abuse, or sexual misconduct with a participant, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed psychedelic facilitator or occurs before, during, or after a preparation, administration, followup evaluation, or integration session.

(3) Practicing facilitation on a suspended license, practicing without a license, or practicing outside of the conditions of a license.

(4) Engaging in financial misconduct, manipulation, or a conflict of interest with a participant.

(5) Engaging in fraud, coercion, or verbal abuse with a participant.

(6) Violating the terms of consent or agreements entered into with the participant during the preparation session.

(7) Discriminating against a participant on the basis of race, color, ancestry, national origin, religion, creed, gender, sex, sexual orientation, age, disability, marital status, and any other basis enumerated under California law.

(8) Procuring or attempting to procure a license by fraud, misrepresentation, or mistake.

(9) Failing to fully disclose all information requested on the application.

(10) Impersonating an applicant or acting as a proxy for an applicant in any examination referred to in this chapter for the issuance of a license.

(11) Impersonating a licenseholder or permitting or allowing a nonlicensed person to use a license.

(12) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or any rule or regulation adopted by the board.

(13) Committing any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a licenseholder.

(14) Offering or giving commissions, rebates, or other forms of remuneration for the referral of participants.

(15) Denial of licensure, revocation, suspension, restriction, citation, or any other disciplinary action against an applicant or licenseholder by another state or territory of the United States, by any other governmental agency, or by another California healing arts professional licensing board. A certified copy of the decision, order, judgment, or citation shall be conclusive evidence of these actions.

(16) Being convicted of any felony or misdemeanor, or being held liable in an administrative or civil action for an act, that is substantially related to the qualifications, functions, or duties of a licenseholder. A record of the conviction or other judgment or liability shall be conclusive evidence of the crime or liability.

(17) Failing to act within the limitations created by a physical illness, physical condition, or behavioral, mental health, or substance use disorder that renders the licenseholder unable to perform psychedelic facilitation services with reasonable skill and safety to the participant.

(b) The board may deny an application for a license for the commission of any of the acts described in subdivision (a). The board may also discipline a licenseholder, in any manner permitted by this chapter, for the commission of any of those acts by a licenseholder.

(c) The board shall deny an application for a license, or revoke the license of a licenseholder, if the applicant or licenseholder is required to register pursuant to the Sex Offender Registration Act (Chapter 5.5 (commencing with Section 290) of Title 9 of Part 1 of the Penal Code), or is required to register as a sex offender in another state.

3232. (a) An applicant for a license shall not be denied a license and a licenseholder shall not be disciplined pursuant to this chapter except according to procedures that satisfy the requirements of this section.

(b) The board may discipline a licenseholder by any of the following methods:

(1) Placing the licenseholder on probation, which may include limitations or conditions on practice.

(2) Suspending the license and the rights conferred by this chapter on a licenseholder for a period not to exceed one year.

(3) Suspending or staying the disciplinary order, or portions of it, with or without conditions.

(4) Revoking the license.

(5) Taking other action the board deems proper, as authorized by this chapter.

(6) The board may issue an initial license on probation, with specific terms and conditions, to any applicant.

(c) Any denial or discipline shall be decided upon and imposed in good faith and in a fair and reasonable manner.

(d) Any notice required under this section may be given by any method reasonably calculated to provide actual notice. Notice given by mail shall be given by first-class or certified mail sent to the last address of the applicant or licenseholder shown on the board's records.

(e) An applicant or licenseholder may challenge a denial or discipline decision issued pursuant to this section in a court of competent jurisdiction. Any action challenging a denial or discipline, including any claim alleging defective notice, shall be commenced within 90 days after the effective date of the denial or discipline. A license issued pursuant to this chapter is not a fundamental vested right and judicial review of denial and disciplinary decisions made by the board shall be conducted using the substantial evidence standard of review. If the action is successful, the court may order any relief, including reinstatement, that it finds equitable under the circumstances.

(f) This section governs only the procedures for denial or discipline decision and not the substantive grounds for the denial or discipline. Denial or discipline based upon substantive grounds that violates contractual or other rights of the applicant or licenseholder, or is otherwise unlawful, is not made valid by compliance with this section.

3233. (a) It is an unfair business practice for a person to do any of the following:

(1) To hold themselves out or to use the title of "licensed psychedelic facilitator," "regulated psychedelic facilitator," or any other term, such as "licensed," or "certified," in any manner that implies that the person is licensed as a psychedelic facilitator, unless that person currently holds an active and valid license issued by the board pursuant to this chapter.

(2) To falsely state or advertise or put out any sign or card or other device, or to falsely represent to the public through any print or electronic media, that they or any other individual are licensed, certified, or registered by a governmental agency as a regulated psychedelic facilitator.

(3) To advertise, market, or brand services that make any health or medical claims or state that the regulated psychedelic substances have been found to be safe and effective for any particular purpose.

(b) In addition to any other available remedies, engaging in any of the prohibited behaviors described in subdivision (a) constitutes unfair competition under Section 17200.

(c) Nothing in this chapter shall be construed to limit the provisions of the Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991) of Division 2), the Nursing Practice Act (Chapter 6 (commencing with Section 2700) of Division 2), the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2901) of Division 2), the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980) of Division 2), the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610) of Division 2), or any other licensed profession.

3234. (a) The board shall establish a procedure for those persons and parties affected by decisions of the board to protest and appeal those decisions.

(b) An interested person may seek judicial review of any final decision of the board.

(c) Any individual or entity may commence a legal action for a writ of mandate to compel the board to perform the acts mandated by this board.

3235. This chapter shall not be construed to permit the sale of psychedelic substances to an individual for personal use or to permit the sale of psychedelic substances for any purpose outside of use for psychedelic facilitation with a licensed psychedelic facilitator at an approved location.

3236. This chapter shall not be construed to permit the knowing transfer of any psychedelic substances, with or without remuneration, to a person under 21 years of age or to allow a person under 21 years of age to possess, use, purchase, obtain,

cultivate, process, prepare, deliver, or sell or otherwise transfer any psychedelic substance.

3237. (a) A city, county, or a city and county may reasonably regulate the time, place, and manner of regulated psychedelic facilitation within its boundaries.

(b) A city, county, or a city and county shall not ban or completely prohibit regulated psychedelic facilitators operating in accordance with this chapter and board rules within its boundaries.

(c) A city, county, or a city and county shall not ban or completely prohibit the provision of regulated psychedelic facilitation offered in accordance with this chapter and board rules.

(d) A city, county, or a city and county shall not enact a greater fine or penalty for conduct related to regulated psychedelic facilitation or substances than is allowed under state law.

(e) A city, county, or a city and county shall not require an additional license or the payment of a fee in addition to the state license and fee for conduct related to regulated psychedelic facilitation or regulated psychedelic substance licensees, other than generally applicable licenses and fees that apply to all businesses operating with the jurisdiction.

(f) A city, county, or a city and county shall not prohibit the transportation of regulated psychedelic substances through its jurisdiction on public roads by a licensee or as otherwise allowed by this chapter.

3238. (a) Notwithstanding any other law, except as otherwise provided in this chapter, a person shall not be arrested, prosecuted, penalized, sanctioned, or otherwise denied any benefit and shall not be subject to seizure or forfeiture of assets for allowing property the person owns, occupies, or manages to be used for any of the activities conducted lawfully under this chapter at an approved location or for enrolling or employing a person who engages in regulated psychedelic substance-related activities lawfully under this act.

(b) The use of regulated psychedelic substances in connection with regulated psychedelic facilitation shall not disqualify a person from any needed medical procedure or medical treatment or any other lawful health-related service.

(c) The use of regulated psychedelic substances lawfully under this act shall not, by itself, be the basis for punishing a person currently under parole, probation, or other state-supervised release, including pretrial release.

(d) Nothing in this chapter shall restrict the sale, possession, display, or cultivation of living fungi, plants, or seeds that were lawful before the enactment of this section.

(e) Engaging in regulated psychedelic substance-related activities authorized under this chapter shall not, by itself, be the basis to deny eligibility for any public assistance program, unless required by federal law.

3239. Nothing in this chapter shall be construed to affect any of the following:

(a) Laws prohibiting the sale, administering, furnishing, or giving away of psychedelic substances, or the offering to sell, administer, furnish, or give away psychedelic substances, to a person younger than 21 years of age.

(b) The ability of public and private employers to maintain, enact, and enforce workplace policies prohibiting or restricting actions or conduct otherwise permitted under this chapter in the workplace or by their employees.

(c) Laws prohibiting persons from engaging in actions or conduct that endanger others.

(d) Laws pertaining to driving or operating a motor vehicle, boat, vessel, aircraft, or other vehicle or device used for transportation under the influence of regulated psychedelic substances.

(e) The ability of a state or local governmental agency to prohibit or restrict actions or conduct otherwise permitted under this chapter within a building owned, leased, or occupied by the state or local governmental agency.

(f) The ability of an individual or private entity to prohibit or restrict actions or conduct otherwise permitted under this chapter on the individual's or entity's privately owned property.

(g) Laws pertaining to actions or conduct otherwise permitted under this chapter on the grounds of, or within, any facility or institution under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice, or on the grounds of any other facility or institution referenced in Section 4573 of the Penal Code.

(h) Laws pertaining to actions or conduct otherwise permitted under this chapter on the grounds of a school providing instruction in kindergarten or any grades 1 to 12, inclusive.

(i) Laws protecting indigenous cultures, traditions, and uses of psychedelic substances and, any protected status, or practice under other laws related to indigenous uses of psychedelic substances, or churches operating pursuant to the federal Religious Freedom Restoration Act of 1993 (42 U.S.C. Sec. 2000bb-4 et seq.).

3240. A person engaged in a profession or occupation subject to licensure shall not be subject to disciplinary action by a professional licensing board solely for providing professional services related to activity permitted under this chapter or for engaging in any activity that is lawful under this chapter that is not subject to criminal penalty under state law. This chapter does not permit a person to engage in malpractice or to violate the standards of professional practice for which a person is licensed.

Article 5. Revenue

3250. (a) The Regulated ~~Psychedelic-assisted Therapy~~ *Psychedelic Facilitators* Fund is hereby created in the State Treasury.

(b) Except as otherwise specified, all funds received pursuant to this chapter shall be ~~credited to~~ *deposited into* the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, the fund shall include any interest and dividends earned on the moneys in the fund.

(d) ~~Notwithstanding Section 13340 of the Government Code, all~~ *All* moneys in the fund shall be allocated to the board, upon appropriation by the Legislature, to carry out the purposes of this chapter.

(e) All moneys collected as a result of fees imposed under this chapter shall be deposited directly into the fund.

(f) All moneys collected as a result of penalties imposed under this division shall be deposited directly into the General Fund, to be available upon appropriation by the Legislature.

~~SEC. 4.~~

SEC. 5. Division 11 (commencing with Section 27000) is added to the Business and Professions Code, to read:

DIVISION 11. REGULATED ~~PSYCHEDELIC SUBSTANCES CONTROL~~ *PSYCHEDELIC-ASSISTED THERAPY* ACT

CHAPTER 1. GENERAL

27000. (a) This division shall be known and may be cited as the Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* Act.

(b) The purpose and intent of this division is to establish a comprehensive system to control and regulate the ~~cultivation,~~ *following:*

(1) The provision of psychedelic facilitation.

(2) The production, distribution, transportation, storage, processing, manufacturing, testing, quality control, and sale of regulated psychedelic substances for use *only* in conjunction with regulated ~~psychedelic-assisted therapy pursuant to the Regulated Psychedelic-assisted Therapy Act (Chapter 7.1 (commencing with Section 3200) of Division 2).~~ *psychedelic facilitation at approved locations.*

(3) The approval of locations where regulated psychedelic facilitation may take place.

(4) The collection and publication of deidentified and aggregate data and information on the implementation and outcomes of this act.

27001. The Division of Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* is hereby established in the Business, Consumer Services, and Housing Agency to administer this division. The division shall be under the supervision and control of a director.

27002. As used in this division, the following definitions apply:

~~(a) "Advisory committee" means the Regulated Psychedelic Substances Advisory Committee.~~

~~(b) "Board" means the Board of Regulated Psychedelic Facilitators established pursuant to Chapter 7.1 (commencing with Section 3200) of Division 2.~~

~~(c) "Clinic" shall have the same meaning as set forth in Section 1200 of the Health and Safety Code.~~

~~(d) "Cultivate" means the growing and cultivating of regulated psychedelic substances.~~

~~(e) "Division" means the Division of Regulated Psychedelic Substances Control.~~

~~(f) "Participant" means a person 21 years of age or older who purchases or receives a regulated psychedelic substance from a regulated psychedelic licensee for use in conjunction with regulated psychedelic-assisted therapy at a licensed location and under the supervision of a licensed psychedelic-assisted therapy facilitator.~~

~~(g) "Regulated psychedelic substance licensee" means an entity that holds a license in any of the categories for licensure or registration established by the division pursuant to paragraph (1) of subdivision (a) of Section 27030. A regulated psychedelic substance licensee may receive compensation for regulated psychedelic substances in connection with use in regulated psychedelic-assisted therapy provided at a licensed establishment.~~

(a) "Administration session" means a session conducted at an approved location during which a participant consumes and experiences the effects of a regulated psychedelic substance under the supervision of a regulated psychedelic facilitator.

(b) "Adverse event" or "adverse reaction" means any adverse reaction during or after the psychedelic experience, including, but not limited to, headache, nausea, and dizziness.

(c) "Approved location" means a location approved by the division for the provision of regulated psychedelic facilitation or a clinic, center, or other facility licensed by the State Department of Public Health.

(d) "Approved school" means a school or educational program approved by the board that meets minimum standards for training and curriculum in regulated psychedelic facilitation and related subjects and that has not been otherwise approved by the board.

(e) "Board" means the Board of Regulated Psychedelic Facilitators established pursuant to Chapter 7.1 (commencing with Section 3200) of Division 2.

(f) "Clinic" shall have the same meaning as set forth in Section 1200 of the Health and Safety Code.

(g) "Compensation" means a payment, loan, advance, donation, contribution, deposit, gift of money, or anything of value.

(h) "Division" means the Division of Regulated Psychedelic-Assisted Therapy.

(i) "Expert oversight committee" means the Regulated Psychedelic Substances Expert Oversight Committee.

(j) "Followup evaluation" means contact between a participant and a regulated psychedelic facilitator that occurs within 12 to 72 hours after the completion of an administration session or sooner, if warranted, to assess well-being, screen for adverse reactions, and, if needed, make referrals to needed care, additional psychosocial support, or other interventions.

(k) "Fund" means the Regulated Psychedelic-Assisted Therapy Fund.

(l) "Integration session" means counseling provided by a regulated psychedelic facilitator or other personnel trained in postpsychedelic support that is intended to help the participant better understand their psychedelic experience and apply insights from their experience to their daily life.

(m) "License" means a valid license issued pursuant to this division.

(n) "Participant" means a person 21 years of age or older who purchases or receives a regulated psychedelic substance from a regulated psychedelic licensee for use in conjunction with regulated psychedelic facilitation at an approved location and under the supervision of a licensed psychedelic facilitator.

(o) "Preparation session" means a session conducted between a participant and a psychedelic facilitator before the administration of the regulated psychedelic substance. More than one preparation session may be indicated to provide participants adequate education and instruction, to develop sufficient rapport between the participant and psychedelic facilitator before the psychedelic substance administration, and to revisit informed consent and safety planning. The initial preparation session shall include review of the safety screen and considerations for exclusion; presentation and discussion of detailed information about the psychedelic substance, including its potential risks and benefits; presentation and discussion of the therapeutic process, including administration session parameters; obtaining informed consent; safety planning; and other information as the board may determine. If three months or more have passed since the last psychedelic administration session conducted by a given participant with a given facilitator, this will be considered a new course of care, and another initial preparation session must be conducted.

(p) "Produce" means the growing, cultivating, processing, and manufacturing of regulated psychedelic substances.

~~(h)~~

(q) (1) "Regulated psychedelic substances" means the following substances as defined in Section 11054 of the Health and Safety Code:

(A) Dimethyltryptamine.

(B) Mescaline.

(C) 3,4-methylenedioxymethamphetamine (MDMA).

(D) Psilocybin.

(E) Psilocyn.

(F) Spores or mycelium capable of producing mushrooms that contain psilocybin or psilocyn.

(2) "Regulated psychedelic substances" does not include peyote, including all parts of the plant classified botanically as Lophophora williamsii, whether growing or not, its seeds, any extract from any part of the plant, and every compound, salt, derivative, mixture, or preparation of the plant, or its seeds or extracts.

~~(i) "Regulated psychedelic-assisted therapy" means services provided by a regulated psychedelic-assisted therapy facilitator in accordance with the Regulated Psychedelic-assisted Therapy Act (Chapter 7.1 (commencing with Section 3200) of Division 2).~~

~~(j) "Regulated psychedelic-assisted therapy facilitator" means a person licensed by the Board of Regulated Psychedelic Facilitators pursuant to Chapter 7.1 (commencing with Section 3200) of Division 2.~~

(r) "Regulated psychedelic substance licensee" means an entity that holds a license in any of the categories for licensure or registration established by this division. A regulated psychedelic substance licensee may receive compensation for regulated psychedelic substances only in connection with use in regulated psychedelic facilitation provided at an approved location.

(s) "Regulated psychedelic facilitation" means services provided pursuant to this division by a regulated psychedelic facilitator to a participant before, during, and after the participant's consumption of a regulated psychedelic substance, including all of the following:

(1) A safety screen.

(2) One or more preparation sessions.

(3) An administration session.

(4) One or more followup evaluations.

(5) One or more integration sessions.

(t) "Regulated psychedelic facilitation location" or "approved location" means an approved location where psychedelic facilitation is performed.

(u) "Regulated psychedelic facilitator" means a person licensed by the Board of Regulated Psychedelic Facilitators pursuant to Chapter 7.1 (commencing with Section 3200) of Division 2.

(v) "Safety screen" means a screening for medical conditions, mental health conditions, family history, contraindications, and pharmacological interactions that must be provided to every participant before an administration session.

(w) "Serious adverse event" or "serious adverse reaction" means an adverse reaction during or after the psychedelic experience requiring psychiatric, medical, or psychological care.

(x) "Set" means the mindset of an individual, including the individual's history, personality, and intentions going into psychedelic facilitation.

(y) "Setting" means the physical and social environment in which the psychedelic facilitation occurs.

(z) "Sole provider" means a regulated psychedelic facilitator business where the owner owns 100 percent of the business and is the only person who provides regulated psychedelic facilitation for compensation for that business pursuant to a valid and active license issued in accordance with this division.

Chapter 2. Administration

27010. (a) The Governor shall appoint the director of the division, subject to confirmation by the Senate. The director shall serve under the direction and supervision of the Secretary of Business, Consumer Services, and Housing and at the pleasure of the Governor.

(b) Every power granted to or duty imposed upon the director under this division may be exercised or performed in the name of the director by a deputy or assistant director or by a chief, subject to conditions and limitations that the director may prescribe.

(c) The director may employ and appoint all employees necessary to properly administer the work of the division, in accordance with civil service laws and regulations.

(d) The division has the power, duty, purpose, responsibility, and jurisdiction to regulate regulated psychedelic substances *and*

the provision of psychedelic facilitation, and to approve locations where psychedelic facilitation may take place, as provided in this division.

27011. The protection of the public shall be the highest priority for the division in exercising its licensing, regulatory, and disciplinary functions under this division. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

27012. (a) It being a matter of statewide concern, except as otherwise authorized in this division, the division shall have the sole authority to create, issue, deny, renew, discipline, condition, suspend, or revoke ~~regulated psychedelic substance licenses.~~ *licenses issued pursuant to this division.*

(b) The division may collect fees in connection with activities it regulates. The division may create ~~licenses~~ *licenses, permits, and registrations* in addition to those identified in this division that the division deems necessary to effectuate its duties under this division.

(c) For the performance of its duties, the division has the power conferred by Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

27013. (a) The division shall provide on its internet website information regarding the status of every license issued by the division in accordance with the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

(b) The information provided on the division's internet website pursuant to subdivision (a) shall include information on suspensions and revocations of licenses and final decisions adopted by the division pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) relating to persons or businesses licensed or regulated by the division.

(c) The information provided on the division's internet website shall include deidentified and aggregate data on the implementation and outcomes of this act that is required to be collected and published pursuant to this division.

27014. (a) The division shall adopt regulations *as recommended by the expert oversight committee and* as may be necessary to implement, administer, and enforce its duties under this division in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. ~~Those rules and regulations shall be consistent with the purposes and intent of the Regulated Psychedelic-assisted Therapy Act (Chapter 7.1 (commencing with Section 3200) of Division 2), as specified in Section 3200.~~

(b) (1) The division may adopt emergency regulations to consolidate, clarify, or make consistent regulations.

(2) The division may readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted as authorized by this section. Any readoption shall be limited to one time for each regulation.

(3) Notwithstanding any other law, the adoption of emergency regulations and the readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations and the readopted emergency regulations authorized by this section shall be each submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(c) Regulations issued under this division shall be necessary to achieve the purposes of this division, based on best available evidence, and shall mandate only commercially feasible procedures, technology, or other requirements, and shall not unreasonably restrain or inhibit the development of alternative procedures or technology to achieve the same substantive requirements, nor shall the regulations make compliance so onerous that the operation under a license is not worthy of being carried out in practice by a reasonably prudent businessperson.

(d) The division shall adopt regulations concerning psilocybin, psilocyn, *the spores or mycelium capable of producing mushrooms that contain psilocybin and psilocyn,* and 3,4-methylenedioxymethamphetamine (MDMA) not later than January 1, 2026. At least every two years thereafter, the division shall adopt regulations concerning additional substances identified

as regulated psychedelic substances in subdivision (h) of Section 27002, if recommended by the ~~advisory~~ *expert oversight* committee.

27015. (a) Notice of any action of the division required by this division to be given may be signed and given by the director or an authorized employee of the division and may be made personally or in the manner prescribed by Section 1013 of the Code of Civil Procedure, or in the manner prescribed by Section 124 of this code.

(b) Notwithstanding subdivision (c) of Section 11505 of the Government Code, whenever written notice, including a notice, order, or document served pursuant to Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), or Chapter 5 (commencing with Section 11500), of Part 1 of Division 3 of Title 2 of the Government Code, is required to be given by the division, the notice may be given by regular mail addressed to the last known address of the licensee or by personal service, at the option of the division.

27016. (a) The division may make or cause to be made any investigation it deems necessary to carry out its duties under this division.

(b) The chief of enforcement and all investigators, inspectors, and deputies of the division identified by the director have the authority of peace officers while engaged in exercising the powers granted or performing the duties imposed upon them in investigating the laws administered by the division or commencing directly or indirectly any criminal prosecution arising from any investigation conducted under these laws. All persons herein referred to shall be deemed to be acting within the scope of employment with respect to all acts and matters set forth in this section.

(c) The division may employ individuals, who are not peace officers, to provide investigative services.

(d) Notwithstanding any other law, the division may employ peace officers and shall be exempt from the requirements of Section 13540 of the Penal Code.

27017. For any hearing held pursuant to this division, the division may delegate the power to hear and decide to an administrative law judge. Any hearing before an administrative law judge shall be pursuant to the procedures, rules, and limitations

prescribed in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

27018. (a) No later than April 1, 2025, the division shall convene an ~~advisory~~ *expert oversight* committee, to be known as the Regulated Psychedelic Substances ~~Advisory~~ *Expert Oversight* Committee, to advise the division and the board on the development of standards and regulations pursuant to this ~~division and the Regulated Psychedelic-assisted Therapy Act (Chapter 7.1 (commencing with Section 3200) of Division 2),~~ *division,* including best practices and guidelines that protect public health and safety while ensuring a regulated environment to provide safe access to regulated ~~psychedelic-assisted therapy.~~ *psychedelic facilitation.*

(b) There shall be 14 members of the expert oversight committee appointed by the Governor.

~~(b)~~

(c) The ~~advisory~~ *expert oversight* committee members shall include, but not be limited to, at least one person with expertise in ~~all~~ *each* of the following:

(1) Mental or behavioral health.

(2) ~~Regulated psychedelic-assisted therapy.~~ *Psychedelic facilitation.*

(3) Issues confronting veterans.

(4) Developing and implementing evaluation methodologies to assess the outcomes of a program, including its achievements, safety, quality, and impact on individuals.

(5) Health care insurance or barriers in access to health care.

(6) Emergency medical services or first responders.

(7) Mycology and regulated psychedelic substance cultivation.

(8) Training ~~regulated psychedelic-assisted therapy~~ *psychedelic* facilitators.

~~(9) Harm reduction.~~

~~(10) Municipal psychedelic policy.~~

(9) The provision of harm reduction.

(10) Harm reduction systems.

(11) Regulated psychedelic substance research.

(12) Indigenous uses of ~~regulated~~ psychedelic substances.

(13) Public health data collection.

(14) Expertise in naturopathic medicine.

(d) The members of the expert oversight committee shall reside in the State of California.

(e) Each member of the expert oversight committee shall be appointed for a term of four years with staggered terms. A vacancy on the committee shall be filled by appointment for the unexpired term.

(f) Not later than the first of June of each calendar year, the committee shall elect a chairperson and a vice chairperson from its membership.

~~(c)~~

(g) The ~~advisory~~ *expert oversight* committee shall:

(1) Consider all matters submitted to it by the division or the board.

(2) Create subcommittees for particular aspects of the work.

~~(2)~~

(3) Advise the division and the board on guidelines, rules, and regulations that include:

(A) Accurate and culturally appropriate public health approaches regarding use, effect, and risk reduction for regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* and regulated psychedelic substances and the content and scope of related educational campaigns.

(B) Research related to the efficacy and regulation of regulated psychedelic substances, including recommendations related to product safety, harm reduction, and cultural responsibility.

(C) Affordable, equitable, ethical, inclusive, and culturally responsible access to regulated psychedelic-assisted therapy and requirements to ensure access to regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* is affordable, equitable, ethical, inclusive, and culturally responsible.

(D) Identifying existing state funds and programs for improving public health outcomes and advising as to how these funds and programs may include psychedelic *facilitation and* services as options and be used to make access to psychedelic *facilitation and* services more affordable to low-income individuals.

(E) Education, training curricula, and training for first responders and multiresponders, including law enforcement, emergency medical services, social services, and fire services.

~~(E)~~

(F) Requirements, methods, *data collection,* reporting, and publication of information pertaining to the implementation and outcomes of this act, in order to comprehensively measure its

success, safety, quality, impact on individuals' well-being and public health.

~~(F)~~

(G) Sustainability issues related to regulated psychedelic substances and impact on Indigenous cultures and ~~document~~ existing reciprocity efforts and continuing support measures that are needed.

~~(G) Whether other substances should be added pursuant to subdivision (d) of Section 27014.~~

(H) Potential future ~~regulation~~ *regulation, policy reform,* and use of additional psychedelic substances with therapeutic potential, beyond those included in ~~this division and the Regulated Psychedelic-assisted Therapy Act (Chapter 7.1 (commencing with Section 3200) of Division 2).~~ *subdivision (d) of Section 27014.*

~~(d)~~

(h) Commencing on January 1, 2026, the ~~advisory~~ *expert oversight* committee shall publish on ~~its~~ *the division's* internet website an annual report describing its activities including, but not limited to, the recommendations the ~~advisory~~ *expert oversight* committee made to the division and the board during the immediately preceding calendar year and whether those recommendations were implemented by the division.

~~(e)~~

(i) Each member of the ~~advisory~~ *expert oversight* committee shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties. The payments in each instance shall be made only from the fund *from which the expenses of the division are paid* and shall be subject to the availability of moneys.

Chapter 3. *General* Licensing

27030. (a) Except as specified in Section 27014, the division shall, ~~in consultation with the advisory~~ *consistent with the recommendations of the expert oversight* committee and in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), adopt regulations consistent with this division for the administration and enforcement of laws regulating

regulated psychedelic substances and services. The regulations shall do all of the following:

(1) License qualified persons or entities for activities related to regulated psychedelic substances that include:

(A) Establishing categories of licensure and registration including, but not limited to, the following:

(i) A cultivation, processing, ~~manufacture, delivery, or sales-only license that would allow for the provision and sale of regulated psychedelic substances at the premises of a separately licensed psychedelic-assisted therapy center or approved location for use during an administration session at that psychedelic-assisted therapy center or~~ *or manufacture license that would allow solely for the provision and sale of regulated psychedelic substances at the premises of an approved location for use during the administration session of a regulated psychedelic facilitation at that* approved location.

(ii) A testing license for the testing of regulated psychedelic substances for quality, concentration, and contaminants.

(B) Approving locations where psychedelic substances may be provided to participants in conjunction with psychedelic facilitation by a regulated psychedelic facilitator.

~~(B)~~

(C) Establishing license application, issuance, denial, renewal, suspension, and revocation procedures.

~~(C)~~

(D) Establishing application, licensing, and renewal fees that shall be sufficient, but not exceed the amount necessary, to cover the cost of administering this division, and, for licensing and renewal fees, scaled based on either the volume of business of the licensee or the gross annual revenue of the licensee.

(2) In collaboration with the Board of Regulated Psychedelic Facilitators, establish requirements governing the safe provision of regulated psychedelic substances to participants *at approved locations* that include:

(A) Contraindications due to medical condition, mental health history, *family history,* and pharmacological interactions and contraindications for the particular substances being used.

(B) Health and safety warnings to be provided to participants before regulated psychedelic substances are provided.

(C) Recommended dosages of regulated psychedelic substances.

(D) Documentation that the regulated ~~psychedelic-assisted therapy~~ *psychedelic* facilitator is properly licensed pursuant to ~~Chapter 7.1 (commencing with Section 3200) of Division 2.~~ *this division.*

(E) Documentation that the location of the regulated psychedelic facilitation is properly licensed or approved pursuant to regulations promulgated pursuant to this division.

~~(E)~~

(F) Safe transportation for the participant when the session is complete.

~~(F)~~

(G) Provisions to allow a ~~psychedelic-assisted therapy center or facilitator to refuse to provide regulated psychedelic substances or therapy~~ *psychedelic facilitation center or psychedelic facilitator to refuse to provide regulated psychedelic substances or facilitation* to a participant.

~~(G)~~

(H) Procedures for handling and reporting *adverse reactions and serious* adverse reactions.

(I) Limitations on the number of licenses for cultivation, processing, or manufacture of regulated psychedelic substances and the volume of regulated psychedelic substances produced by licensees to ensure the amount of regulated psychedelic substances does not exceed the amount necessary to meet the demand for regulated psychedelic facilitation.

~~(H)~~

(J) The requirements and standards for testing ~~of~~ regulated psychedelic substances for quality, concentration, and contaminants.

(K) The requirements for labeling regulated psychedelic substances.

~~(I)~~

(L) Prohibitions on advertising, branding, and marketing regulated psychedelic ~~substances or making~~ *substances, including prohibitions on claiming the regulated psychedelic substance is safe and effective or making health or* medical claims about regulated psychedelic ~~substances.~~ *substances unless in compliance with the Federal Food, Drug, and Cosmetic Act (21 U.S.C. Sec. 301 et seq.).*

~~(J)~~

(M) Insurance requirements to the extent that the policies are commercially available and not cost prohibitive.

~~(K)~~

(N) Age verification procedures to ensure that a participant is 21 years of age or older.

(3) Establish the requirements governing the licensing and operation of ~~psychedelic-assisted therapy~~ *licensees, including psychedelic facilitation* centers and approved locations that include:

(A) Oversight requirements for regulated psychedelic licensees.

(B) Recordkeeping, privacy, and confidentiality requirements for regulated psychedelic licensees, provided the recordkeeping does not result in the disclosure to the public or any *unauthorized* governmental agency of personally identifiable information of participants.

(C) Deidentified data collection and reporting requirements for pertaining to the implementation and outcomes of this act.

(D) Security requirements for regulated psychedelic licensees, including requirements for protection of each licensed ~~psychedelic-assisted therapy~~ *psychedelic facilitation* center location.

(E) Procedures and policies that allow for regulated psychedelic licensees to receive compensation for ~~services and~~ regulated psychedelic substances provided in conjunction with ~~therapeutic services.~~ *facilitation services at approved locations.*

(F) Procedures and policies to ensure statewide access to regulated ~~psychedelic-assisted therapy.~~ *psychedelic facilitation.*

~~(G) Rules that prohibit an individual from having a financial interest in more than five psychedelic-assisted therapy locations.~~

~~(H)~~

(G) Rules that allow for regulated psychedelic licensees to share the same premises with other regulated psychedelic licensees or to share the same premises with health care ~~facilities so that a participant may receive regulated psychedelic substances from one regulated psychedelic licensee and complete the administration session at a separately owned and approved location.~~ *facilities.*

~~(I)~~

(H) Rules that allow a regulated ~~psychedelic-assisted therapy~~ *psychedelic* facilitator to provide regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* to a participant at an approved location.

~~(J)~~

(I) Rules that allow for approval of locations where regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* may be provided by licensed ~~psychedelic-assisted therapy~~ *psychedelic* facilitators, including, but not limited to, health care facilities, clinics, and private residences.

(4) Establish procedures, policies, and programs to ensure that the licensing of regulated psychedelic substances and the provision of regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* is equitable and inclusive and to promote the licensing of and the provision of regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* to persons from low-income communities; to persons who face barriers to access to health care; to persons who have a history of traditional or indigenous use of regulated psychedelic substances; to persons who are or were first responders; and to persons who are veterans. The procedures, policies, and programs shall include, but are not limited to:

(A) Reduced fees for licensure and other support services for applicants, which may include loans and grants.

(B) Incentivizing the provision of regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* at a reduced cost to low-income individuals.

(C) Incentivizing geographic and cultural diversity in licensing and the provision and availability of ~~regulated psychedelic-assisted therapy.~~ *psychedelic facilitation.*

(D) A process for annually reviewing the effectiveness of the policies and programs promulgated under this paragraph.

~~(5) Gather and publish, on an annual basis, adequate information to evaluate the implementation, safety, equity, quality, and outcomes of this division and Chapter 7.1 (commencing with Section 3200) of Division 2, following sound data and privacy protocols, without revealing any identifiable details pertaining to individual participants.~~

~~(6)~~

(5) Adopt, amend, and repeal rules as necessary to implement this division and to protect the public health and safety.

(b) Upon receiving a complete application for a license under this division, the division shall have 120 days to issue its decision on the application.

(c) The division may suspend or revoke a regulated psychedelic substances license under regulations made pursuant to this division upon written notice of a violation and, if applicable, an opportunity to cure any violation within 30 days of the notice.

(d) The division shall enforce the laws and regulations relating to the cultivation, *producing, manufacturing, processing,* preparing, delivery, storage, sale, and testing of regulated psychedelic substances. The division shall conduct investigations of compliance with this division and shall perform regular inspections of licensees and the books and records of licensees as necessary to enforce this division. The division shall cooperate with appropriate state and local organizations to provide training to law enforcement officers of the state and its political subdivisions.

(e) The division shall annually publish a report of its actions during each year containing a comprehensive description of its activities and a statement of revenue and expenses of the division.

(f) The division shall have the authority to collect available and relevant information and data necessary to performs its functions and duties under this act, but must not disclose the identity of any participant or publicly disclose any information that could disclose the identity of a participant.

(g) The division shall deposit all license fees, registration fees, and monetary penalties collected pursuant to this division in the Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* Fund established in Section ~~27060.~~ *27080.*

(h) In carrying out its duties under this division, the division shall ~~consult with~~ *be guided by* the Regulated Psychedelic Substances ~~Advisory~~ *Expert Oversight* Committee and may also consult with other state agencies or any other individual or entity the division finds necessary.

27031. (a) ~~Actions~~ *Notwithstanding any other law, actions* and conduct by a licensee that are authorized pursuant to a valid license issued by the division, and by those who allow property to be used by a licensee, as permitted pursuant to a valid license issued by the division, are lawful under state and local law, and shall not be a violation of state or local law.

(b) No state or local governmental agency shall impose any criminal, civil, or administrative penalty on any licensee or on those who allow property to be used by a licensee solely for actions

or conduct permitted pursuant to a valid license issued by the division.

(c) Actions and conduct by a licensee that are permitted pursuant to a valid license issued by the division, and by those who allow property to be used by a licensee, as permitted pursuant to a valid license issued by the division, shall not be a basis for seizure or forfeiture of any products, materials, equipment, property, or assets under state or local law.

(d) Nothing in this section shall be construed or interpreted to:

(1) Prevent the division from enforcing its rules and regulations against a licensee.

(2) Prevent a state or local governmental agency from enforcing a law, rule, or regulation that is not in conflict with the provisions of this division or the rules and regulations of the ~~division, and is consistent with the intents and purposes of the Regulated Psychedelic-assisted Therapy Act (Chapter 7.1 (commencing with Section 3200) of Division 2), as specified in Section 3200.~~ *division.*

(3) Prevent a city, county, or a city and county from enforcing a local zoning ordinance, local ordinance of general application, or local ordinance enacted pursuant to Section ~~27046.~~ *27055*.

27032. (a) Not later than April 1, 2026, the division shall begin to accept and process applications for licensure.

(b) Upon receipt of an application for licensure and any applicable fee, the division shall make a thorough investigation to determine whether the applicant and the premises qualify for the license and have complied with the provisions of this division.

(c) The division shall deny an application under either of the following circumstances:

(1) The applicant or the premises for which the license is applied do not qualify for licensure under rules and regulations enacted by the division pursuant to this division.

(2) Issuance would conflict with any local zoning ordinance, local ordinance of general application, or local ordinance enacted pursuant to Section ~~27046.~~ *27055*.

(d) The division may refuse to issue any license for premises located within 1,000 feet of a school providing instruction in kindergarten or any of grades 1 to 12, inclusive.

CHAPTER 4. ENFORCEMENT

27040. A violation of this division is a misdemeanor and shall ~~result in~~ *be punishable by imprisonment in county jail for six months*, a fine of not less than one thousand dollars ~~($1,000)~~ *($1,000), or both,* and forfeiture of any license granted under this ~~division for three years.~~ *division.*

27041. (a) The division shall work with state and local law enforcement agencies for the purposes of implementing, administering, and enforcing the division's rules and regulations and taking appropriate action against licensees and others who fail to comply with these rules and regulations or with state law.

(b) The division may bring a legal action to enjoin a violation or potential violation of, or to compel compliance with, any provision of this division or rules and regulations promulgated by the division. The legal action shall be brought in the county in which the violation occurred or may occur. Any proceedings brought pursuant to this section shall conform to the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

(c) State and local law enforcement agencies shall immediately notify the division of any arrests made that involve a licensee or a licensed premises and actions or conduct under the division's jurisdiction. The division shall promptly investigate whether the arrests warrant suspension or revocation of a license.

(d) Nothing in this division shall be construed or interpreted to limit a state or local law enforcement agency's ability to investigate unlawful activity in relation to a licensee or licensed premises.

27042. (a) The division shall establish a procedure for those persons and parties affected by decisions of the division to protest and appeal those decisions.

(b) An interested person may seek judicial review of any final decision of the division.

(c) Any individual or entity may commence a legal action for a writ of mandate to compel the division to perform the acts mandated by this division.

27043. This division shall not be construed to permit the sale of psychedelic substances to an individual for personal ~~use.~~ *use or to permit the sale of psychedelic substances for any purpose*

outside of use for psychedelic facilitation with a licensed psychedelic facilitator at an approved location.

27044. This division shall not be construed to permit the knowing transfer of any psychedelic substances, with or without remuneration, to a person under 21 years of age or to allow a person under 21 years of age to possess, use, purchase, obtain, cultivate, process, prepare, deliver or sell or otherwise transfer any psychedelic substance.

27046. (a) A city, county, or a city and county may reasonably regulate the time, place, and manner of the operation of regulated psychedelic substance licensees pursuant to this division within its boundaries.

(b) A city, county, or a city and county shall not ban or completely prohibit the establishment or operation of regulated psychedelic *substance* licensees operating in accordance with this division and division rules within its boundaries.

(c) A city, county, or a city and county shall not ban or completely prohibit the provision of regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* offered in accordance with this division and division rules.

(d) A city, county, or a city and county shall not enact a greater fine or penalty for conduct related to regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* or substances than is allowed under state law.

(e) A city, county, or *a* city and county shall not require an additional license or the payment of a fee in addition to the state license and fee for conduct related to regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* or regulated ~~psychedelic-assisted~~ *psychedelic* substance licensees, other than generally applicable licenses and fees that apply to all businesses operating with the jurisdiction.

(f) A city, county, or a city and county shall not prohibit the transportation of regulated psychedelic substances through its jurisdiction on public roads by a licensee or as otherwise allowed by this division.

27047. (a) Notwithstanding any other law, except as otherwise provided in this division, a person shall not be arrested, prosecuted, penalized, sanctioned, or otherwise denied any benefit and shall not be subject to seizure or forfeiture of assets for allowing property the person owns, occupies, or manages to be used for any of the

activities conducted lawfully under this division *at an approved location* or for enrolling or employing a person who engages in regulated psychedelic substance-related activities lawfully under this act.

(b) The use of regulated psychedelic substances *in connection with regulated psychedelic facilitation* shall not disqualify a person from any needed medical procedure or medical treatment or any other lawful health-related service.

(c) The use of regulated psychedelic substances lawfully under this act shall not, by itself, be the basis for punishing a person currently under parole, probation, or other state-supervised release, including pretrial release.

(d) Nothing in this division shall restrict the sale, possession, display, or cultivation of living fungi, plants, or seeds that were lawful before the enactment of this section.

(e) Engaging in regulated psychedelic substance-related activities authorized under this division shall not, by itself, be the basis to deny eligibility for any public assistance program, unless required by federal law.

27048. Nothing in this division shall be construed to affect any of the following:

(a) Laws prohibiting the sale, administering, furnishing, or giving away of psychedelic substances, or the offering to sell, administer, furnish, or give away psychedelic substances, to a person younger than 21 years of age.

(b) The ability of public and private employers to maintain, enact, and enforce workplace policies prohibiting or restricting actions or conduct otherwise permitted under this division in the workplace or by their employees.

(c) Laws prohibiting persons from engaging in actions or conduct that endanger others.

(d) Laws pertaining to driving or operating a motor vehicle, boat, vessel, aircraft, or other vehicle or device used for transportation under the influence of regulated psychedelic substances.

(e) The ability of a state or local governmental agency to prohibit or restrict actions or conduct otherwise permitted under this division within a building owned, leased, or occupied by the state or local governmental agency.

(f) The ability of an individual or private entity to prohibit or restrict actions or conduct otherwise permitted under this division on the individual's or entity's privately owned property.

(g) Laws pertaining to actions or conduct otherwise permitted under this division on the grounds of, or within, any facility or institution under the jurisdiction of the ~~division~~ *Department* of Corrections and Rehabilitation or the Division of Juvenile Justice, or on the grounds of any other facility or institution referenced in Section 4573 of the Penal Code.

(h) Laws pertaining to actions or conduct otherwise permitted under this division on the grounds of a school providing instruction in kindergarten or any grades 1 to 12, inclusive.

(i) Laws protecting indigenous cultures, traditions, and uses of psychedelic substances and, any protected status, or practice under other laws related to indigenous uses of psychedelic substances, or churches operating pursuant to the federal Religious Freedom Restoration Act of 1993 (42 U.S.C. Sec. 2000bb-4 et ~~seq).~~ *seq.).*

27049. A person engaged in a profession or occupation subject to licensure shall not be subject to disciplinary action by a professional licensing board solely for providing professional services related to activity permitted under this division or for engaging in any activity that is lawful under this division that is not subject to criminal penalty under state law. This division does not permit a person to engage in malpractice or to violate the standards of professional practice for which a person is licensed.

27050. Notwithstanding any other law, unless required by federal law, mental health, substance use disorder, or behavioral health services otherwise covered under the California Medical Assistance Program set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be denied on the basis that they are covered in conjunction with regulated ~~psychedelic-assisted therapy~~ *psychedelic facilitation* or that regulated psychedelic substances are prohibited by federal law. No insurance or insurance provider is required to cover the cost of a regulated psychedelic substance itself.

27051. It is the public policy of the people of the State of California that contracts related to the operation of licenses under this chapter and the Regulated Psychedelic Facilitators Act (Chapter 7.1 (commencing with Section 3200) of Division 2) should

be enforceable and no contract entered into by a licensee, its employees, or its agents, as permitted pursuant to a valid license issued by the board or division, or by those who allow property to be used by a licensee, its employees, or its agents, as permitted pursuant to a valid license issued by the board or division, shall be deemed unenforceable on the basis that the actions or conduct permitted pursuant to the license are prohibited by federal law.

~~27051.~~

27052. The provisions of this division are severable. If any provision of this division 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.

CHAPTER 5. COLLECTION AND REVIEW OF INFORMATION

27060. The division shall collect and annually publish information on the division's website pertaining to the implementation and outcomes of this act to comprehensively measure its success, safety, quality, and impact on individuals' well-being and public health.

27061. The division shall consult with the State Department of Public Health on the best data collection, processing, and reporting methodologies.

27062. The division may contract or collaborate with one or more California public universities to research and evaluate the implementation and outcomes of this act pertaining to its success, safety, quality, and impact on individuals' well-being and public health, and the potential benefits and risks of regulated psychedelic substances and psychedelic facilitation.

27063. The division shall ensure that any information shared publicly is deidentified or aggregated such that no individual participant is identified.

27064. Information and data collected pursuant to the requirements of this division shall not be sold.

CHAPTER ~~5.~~*6.* REVENUE

~~27060.~~

27070. (a) The Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* Fund is hereby created within the State Treasury.

(b) All fees collected pursuant to this division shall be deposited into the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, the fund shall include any interest and dividends earned on the moneys in the fund.

(d) ~~Notwithstanding Section 13340 of the Government Code, all~~ *All* moneys in the fund shall be allocated, upon appropriation by the Legislature, to the division solely for the purposes of implementing, administering, and enforcing this division, including, but not limited to, the costs incurred by the division for its administrative expenses.

(e) All moneys collected as a result of penalties imposed under this division shall be deposited directly into the General Fund, to be available upon appropriation by the Legislature.

~~27061.~~

27071. The ~~Regulated~~ Psychedelic Substances *Public* Education and Harm Reduction Fund is hereby established in the State Treasury. Moneys in the fund shall be available to the Office of Community Partnerships and Strategic Communications upon appropriation by the Legislature. The division may accept moneys from private sources to supplement state funds, which may be appropriated by the Legislature to the fund. Moneys in the fund may be used by the Office of Community Partnerships and Strategic Communications to award grants for the following purposes:

(a) Public education relating to psychedelic ~~substances.~~ *substances, including their limitations and potential risks, and mitigation measures, in addition to potential benefits.*

(b) Harm reduction relating to psychedelic substances.

(c) The office shall solicit input from the expert oversight committee and other subject matter experts and service providers with relevant expertise as to the administration of the grant program. In addition, the office shall periodically evaluate each program it is funding to determine the effectiveness of the program.

~~SEC. 5.~~

SEC. 6. Section 1550.6 is added to the Civil Code, to read:

1550.6. Notwithstanding any law, it is the public policy of the people of the State of California that contracts related to the operation of licenses under the Regulated ~~Psychedelic-assisted Therapy~~ *Psychedelic Facilitators* Act (Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code) or the Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* Act (Division 11 (commencing with Section 27000) of the Business and Professions Code) shall be enforceable. No contract entered into by a licensee, as permitted pursuant to a valid license issued by the Division of Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* or the Board of Regulated Psychedelic Facilitators, or by those who allow property to be used by a licensee, as permitted pursuant to a valid license issued by the Division of Regulated ~~Psychedelic Substances Control~~ *Psychedelic-Assisted Therapy* or the Board of Regulated Psychedelic Facilitators, shall be deemed unenforceable on the basis that the actions or conduct permitted pursuant to the license are prohibited by federal law.

~~SEC. 6.~~

SEC. 7. Section 11350 of the Health and Safety Code is amended to read:

11350. (a) Except as otherwise provided in this ~~division and in~~ *division, Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or* Division 11 (commencing with Section 27000) of the Business and Professions Code, every person who possesses (1) any controlled substance specified in subdivision (b), (c), (e), or paragraph (1) of subdivision (f) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or specified in subdivision (h) of Section 11056, or (2) any controlled substance classified in Schedule III, IV, or V that is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in a county jail for not more than one year, except that such person shall instead be punished pursuant to subdivision (h) of Section 1170 of the Penal Code if that person has one or more prior convictions for an offense specified in clause (iv) of subparagraph (C) of paragraph

(2) of subdivision (e) of Section 667 of the Penal Code or for an offense requiring registration pursuant to subdivision (c) of Section 290 of the Penal Code.

(b) Except as otherwise provided in this division, *Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or Division 11 (commencing with Section 27000) of the Business and Professions Code*, whenever a person who possesses any of the controlled substances specified in subdivision (a), the judge may, in addition to any punishment provided for pursuant to subdivision (a), assess against that person a fine not to exceed seventy dollars ($70) with proceeds of this fine to be used in accordance with Section 1463.23 of the Penal Code. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of their inability to pay the fine permitted under this subdivision.

(c) Except in unusual cases in which it would not serve the interest of justice to do so, whenever a court grants probation pursuant to a felony conviction under this section, in addition to any other conditions of probation that may be imposed, the following conditions of probation shall be ordered:

(1) For a first offense under this section, a fine of at least one thousand dollars ($1,000) or community service.

(2) For a second or subsequent offense under this section, a fine of at least two thousand dollars ($2,000) or community service.

(3) If a defendant does not have the ability to pay the minimum fines specified in paragraphs (1) and (2), community service shall be ordered in lieu of the fine.

(d) It is not unlawful for a person other than the prescription holder to possess a controlled substance described in subdivision (a) if both of the following apply:

(1) The possession of the controlled substance is at the direction or with the express authorization of the prescription holder.

(2) The sole intent of the possessor is to deliver the prescription to the prescription holder for its prescribed use or to discard the substance in a lawful manner.

(e) This section does not permit the use of a controlled substance by a person other than the prescription holder or permit the distribution or sale of a controlled substance that is otherwise inconsistent with the prescription.

~~SEC. 7.~~

SEC. 8. Section 11351 of the Health and Safety Code is amended to read:

11351. Except as otherwise provided in this ~~division and in~~ *division, Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or* Division 11 (commencing with Section 27000) of the Business and Professions Code, every person who possesses for sale or purchases for purposes of sale (1) any controlled substance specified in subdivision (b), (c), or (e) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or specified in subdivision (h) of Section 11056, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for two, three, or four years.

~~SEC. 8.~~

SEC. 9. Section 11352 of the Health and Safety Code is amended to read:

11352. (a) Except as otherwise provided in this ~~division and in~~ *division, Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or* Division 11 (commencing with Section 27000) of the Business and Professions Code, every person who transports, imports into this state, sells, furnishes, administers, or gives away, or offers to transport, import into this state, sell, furnish, administer, or give away, or attempts to import into this state or transport (1) any controlled substance specified in subdivision (b), (c), or (e), or paragraph (1) of subdivision (f) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or specified in subdivision (b) or (c) of Section 11055, or specified in subdivision (h) of Section 11056, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for three, four, or five years.

(b) Notwithstanding the penalty provisions of subdivision (a), any person who transports any controlled substances specified in subdivision (a) within this state from one county to another

noncontiguous county shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for three, six, or nine years.

(c) For purposes of this section, "transports" means to transport for sale.

(d) This section does not preclude or limit the prosecution of an individual for aiding and abetting the commission of, or conspiring to commit, or acting as an accessory to, any act prohibited by this section.

~~SEC. 9. Section 11364 of the Health and Safety Code is amended to read:~~

~~11364. (a) Except as provided in Division 11 (commencing with Section 27000) of the Business and Professions Code, it is unlawful to possess an opium pipe or any device, contrivance, instrument, or paraphernalia used for unlawfully injecting or smoking (1) a controlled substance specified in subdivision (b), (c), or (e) or paragraph (1) of subdivision (f) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, specified in subdivision (b) or (c) of Section 11055, or specified in paragraph (2) of subdivision (d) of Section 11055, or (2) a controlled substance that is a narcotic drug classified in Schedule III, IV, or V.~~

~~(b) This section shall not apply to hypodermic needles or syringes that have been containerized for safe disposal in a container that meets state and federal standards for disposal of sharps waste.~~

~~(c) Until January 1, 2026, as a public health measure intended to prevent the transmission of HIV, viral hepatitis, and other bloodborne diseases among persons who use syringes and hypodermic needles, and to prevent subsequent infection of sexual partners, newborn children, or other persons, this section shall not apply to the possession solely for personal use of hypodermic needles or syringes.~~

SEC. 10. Section 11364.7 of the Health and Safety Code is amended to read:

11364.7. (a) (1) Except as provided in *Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code or* Division 11 (commencing with Section 27000) of the Business and Professions Code and as otherwise authorized by law, any person who delivers, furnishes, or transfers, possesses

with intent to deliver, furnish, or transfer, or manufactures with the intent to deliver, furnish, or transfer, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance, except as provided in subdivision (b), in violation of this division, is guilty of a misdemeanor.

(2) A public entity, its agents, or employees shall not be subject to criminal prosecution for distribution of hypodermic needles or syringes or any materials deemed by a local or state health department to be necessary to prevent the spread of communicable diseases, or to prevent drug overdose, injury, or disability to participants in clean needle and syringe exchange projects authorized by the public entity pursuant to Chapter 18 (commencing with Section 121349) of Part 4 of Division 105.

(b) Except as authorized by law, any person who manufactures with intent to deliver, furnish, or transfer drug paraphernalia knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body cocaine, cocaine base, heroin, phencyclidine, or methamphetamine in violation of this division shall be punished by imprisonment in a county jail for not more than one year, or in the state prison.

(c) Except as authorized by law, any person, 18 years of age or over, who violates subdivision (a) by delivering, furnishing, or transferring drug paraphernalia to a person under 18 years of age who is at least three years younger, or who, upon the grounds of a public or private elementary, vocational, junior high, or high school, possesses a hypodermic needle, as defined in paragraph (7) of subdivision (a) of Section 11014.5, with the intent to deliver, furnish, or transfer the hypodermic needle, knowing, or under circumstances where one reasonably should know, that it will be used by a person under 18 years of age to inject into the human body a controlled substance, is guilty of a misdemeanor and shall be punished by imprisonment in a county jail for not more than

one year, by a fine of not more than one thousand dollars ($1,000), or by both that imprisonment and fine.

(d) The violation, or the causing or the permitting of a violation, of subdivision (a), (b), or (c) by a holder of a business or liquor license issued by a city, county, or city and county, or by the State of California, and in the course of the licensee's business shall be grounds for the revocation of that license.

(e) All drug paraphernalia defined in Section 11014.5 is subject to forfeiture and may be seized by any peace officer pursuant to Section 11471 unless its distribution has been authorized pursuant to subdivision (a).

(f) If any provision of this section or the application thereof to any person or circumstance is held invalid, it is the intent of the Legislature that the invalidity shall not affect other provisions or applications of this section that can be given effect without the invalid provision or application and to this end the provisions of this section are severable.

SEC. 11. Section 11377 of the Health and Safety Code is amended to read:

11377. (a) Except as authorized by law and as otherwise provided in subdivision (b) or Section 11375, or in Article 7 (commencing with Section 4211) of Chapter 9 of Division ~~2 or in~~ *2, Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or* Division 11 (commencing with Section 27000) of the Business and Professions Code, every person who possesses any controlled substance that is (1) classified in Schedule III, IV, or V, and that is not a narcotic drug, (2) specified in subdivision (d) of Section 11054, except paragraphs (13), (14), (15), and (20) of subdivision (d), (3) specified in paragraph (11) of subdivision (c) of Section 11056, (4) specified in paragraph (2) or (3) of subdivision (f) of Section 11054, or (5) specified in subdivision (d), (e), or (f) of Section 11055, unless upon the prescription of a physician, dentist, podiatrist, or veterinarian, licensed to practice in this state, shall be punished by imprisonment in a county jail for a period of not more than one year, except that such person may instead be punished pursuant to subdivision (h) of Section 1170 of the Penal Code if that person has one or more prior convictions for an offense specified in clause (iv) of subparagraph (C) of paragraph (2) of subdivision (e) of Section 667 of the Penal Code or for an offense requiring

registration pursuant to subdivision (c) of Section 290 of the Penal Code.

(b) The judge may assess a fine not to exceed seventy dollars ($70) against any person who violates subdivision (a), with the proceeds of this fine to be used in accordance with Section 1463.23 of the Penal Code. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of their inability to pay the fine permitted under this subdivision.

(c) It is not unlawful for a person other than the prescription holder to possess a controlled substance described in subdivision (a) if both of the following apply:

(1) The possession of the controlled substance is at the direction or with the express authorization of the prescription holder.

(2) The sole intent of the possessor is to deliver the prescription to the prescription holder for its prescribed use or to discard the substance in a lawful manner.

(d) This section does not permit the use of a controlled substance by a person other than the prescription holder or permit the distribution or sale of a controlled substance that is otherwise inconsistent with the prescription.

SEC. 12. Section 11378 of the Health and Safety Code is amended to read:

11378. Except as otherwise provided in Article 7 (commencing with Section 4110) of Chapter 9 of Division ~~2 or in~~ *2, Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or* Division 11 (commencing with Section 27000) of the Business and Professions Code, a person who possesses for sale a controlled substance that meets any of the following criteria shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code:

(a) The substance is classified in Schedule III, IV, or V and is not a narcotic drug, except the substance specified in subdivision (g) of Section 11056.

(b) The substance is specified in subdivision (d) of Section 11054, except paragraphs (13), (14), (15), (20), (21), (22), and (23) of subdivision (d).

(c) The substance is specified in paragraph (11) of subdivision (c) of Section 11056.

(d) The substance is specified in paragraph (2) or (3) of subdivision (f) of Section 11054.

(e) The substance is specified in subdivision (d), (e), or (f), except paragraph (3) of subdivision (e) and subparagraphs (A) and (B) of paragraph (2) of subdivision (f), of Section 11055.

SEC. 13. Section 11379 of the Health and Safety Code is amended to read:

11379. (a) Except as otherwise provided in subdivision (b) and in Article 7 (commencing with Section 4211) of Chapter 9 of Division ~~2 or in~~ *2, Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code, or* Division 11 (commencing with Section 27000) of the Business and Professions Code, every person who transports, imports into this state, sells, furnishes, administers, or gives away, or offers to transport, import into this state, sell, furnish, administer, or give away, or attempts to import into this state or transport any controlled substance that is (1) classified in Schedule III, IV, or V and that is not a narcotic drug, except subdivision (g) of Section 11056, (2) specified in subdivision (d) of Section 11054, except paragraphs (13), (14), (15), (20), (21), (22), and (23) of subdivision (d), (3) specified in paragraph (11) of subdivision (c) of Section 11056, (4) specified in paragraph (2) or (3) of subdivision (f) of Section 11054, or (5) specified in subdivision (d) or (e), except paragraph (3) of subdivision (e), or specified in subparagraph (A) of paragraph (1) of subdivision (f), of Section 11055, unless upon the prescription of a physician, dentist, podiatrist, or veterinarian, licensed to practice in this state, shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for a period of two, three, or four years.

(b) Notwithstanding the penalty provisions of subdivision (a), *and* except as provided in *Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code or* Division 11 (commencing with Section 27000) of the Business and Professions Code, any person who transports any controlled substances specified in subdivision (a) within this state from one county to another noncontiguous county shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code for three, six, or nine years.

(c) For purposes of this section, “transports” means to transport for sale.

(d) This section does not preclude or limit prosecution under an aiding and abetting theory, accessory theory, or a conspiracy theory.

SEC. 14. Section 11390 of the Health and Safety Code is amended to read:

11390. Except as provided in *Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code or* Division 11 (commencing with Section 27000) of the Business and Professions Code and as otherwise authorized by law, every person who, with intent to produce a controlled substance specified in paragraph (18) or (19) of subdivision (d) of Section 11054, cultivates any spores or mycelium capable of producing mushrooms or other material that contains such a controlled substance shall be punished by imprisonment in the county jail for a period of not more than one year or in the state prison.

SEC. 15. Section 11391 of the Health and Safety Code is amended to read:

11391. (a) Except as provided in *Chapter 7.1 (commencing with Section 3200) of Division 2 of the Business and Professions Code or* Division 11 (commencing with Section 27000) of the Business and Professions Code and as otherwise authorized by law, every person who transports, imports into this state, sells, furnishes, gives away, or offers to transport, import into this state, sell, furnish, or give away any spores or mycelium capable of producing mushrooms or other material that contain a controlled substance specified in paragraph (18) or (19) of subdivision (d) of Section 11054 for the purpose of facilitating a violation of Section 11390 shall be punished by imprisonment in the county jail for a period of not more than one year or in the state prison.

(b) For purposes of this section, "transport" means to transport for sale.

(c) This section does not preclude or limit prosecution for any aiding and abetting or conspiracy offenses.

SEC. 16. This act shall not be construed to require a person to violate a federal law, exempt a person from a federal law, or obstruct the enforcement of a federal law.

SEC. 17. The provisions of this act are severable. If any provision of this act 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.

~~SEC. 17.~~

SEC. 18. The Legislature finds and declares that, in order to protect the health, safety, and welfare of persons in the entire state, establishing a uniform standard of licensure for regulated ~~psychedelic-assisted therapy regulated psychedelic-assisted therapy~~ *psychedelic* facilitators upon which consumers may rely to identify individuals who have achieved specified levels of education, training, and skill is a matter of statewide concern and is not a municipal affair as that term is used in Section 5 of Article XI of the California Constitution. Therefore, ~~Sections 3 and 4 of this act adding Chapter 7.1 (commencing with Section 3200) to Division 2 of, and~~ *Section 5 of this act* adding Division 11 (commencing with Section 27000) ~~to,~~ *to* the Business and Professions Code ~~apply~~ *applies* to all cities, including charter cities.

~~SEC. 18. The provisions of this act are severable. If any provision of this act 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.~~

~~SEC. 19. 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. 20.~~

SEC. 19. The Legislature finds and declares that ~~Sections 3 and 4~~ *Section 5* of this act, which ~~add Sections 3214 and 27030, respectively,~~ *adds Sections 27023, 27040, and 27073* to the Business and Professions Code, ~~impose~~ *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:

In order to establish appropriate recordkeeping by licensees engaging in activities authorized by this act while also protecting

the privacy of members of the public seeking or engaging in regulated ~~psychedelic-assisted therapy,~~ *psychedelic facilitation*, it is necessary that personally identifiable information of members of the public remain confidential.

SEC. 20. 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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SENATE COMMITTEE ON APPROPRIATIONS
Senator Anna Caballero, Chair
2023 - 2024 Regular Session

SB 1012 (Wiener) - The Regulated Psychedelic Facilitators Act and the Regulated Psychedelic-Assisted Therapy Act

Version: March 20, 2024
Policy Vote: B., P. & E.D. 7 - 4, PUB. S. 3 - 2
Urgency: No
Mandate: Yes
Hearing Date: May 13, 2024
Consultant: Janelle Miyashiro

Bill Summary: SB 1012 establishes the Regulated Psychedelic Facilitators Act and Regulated Psychedelic-Assisted Therapy Act, to be administered by three new state entities: a Division of Regulated Psychedelic-Assisted Therapy, a Board of Regulated Psychedelic Facilitators, and a Regulated Psychedelic Substances Oversight Committee. SB 1012 tasks each new entity with specified regulatory oversight responsibilities to determine, define, and establish standards for psychedelic facilitation in California.

Fiscal Impact:

- Unknown significant ongoing costs, likely ranging in the low millions of dollars to establish and maintain the Board (General Fund and Regulated Psychedelic Facilitators Fund). The Board would require General Fund or other special fund support until it establishes and collects license fee revenue sufficient to support its operations. It is unknown at what level fees would need to be set, and will depend on the number of applicants who would seek licensure as a facilitator when the Board is required to accept applications in April 2026 and the extent that licensing may grow or be maintained in later years.

  Based on boards of similar size, the Department of Consumer Affairs (DCA) estimates total costs of approximately $1.96 million in Fiscal Year (FY) 2025-26, $1.87 million in FY 2026-27, and $1.98 in FY 2027-28 and annually ongoing to establish and maintain the Board. Costs would generally include at least 10.0 staff to support the Board's executive, licensing, and enforcement activities. Other costs would include board member training, per diem, IT expenses, and Attorney General and Office of Administrative Hearings costs. While the estimated fee revenue required to recover the Board's costs is unknown at this time, DCA estimates fees would need to be at least $4,960 biennially between initial applications, renewals, and other licensing categories.

  DCA's Office of Information Services (OIS) estimates an unabsorbable one-time cost of $557,000 and ongoing costs of $153,000 associated with setting up a new licensing and enforcement system and will likely require a delayed implementation date to complete necessary IT work.

- Unknown significant ongoing costs, ranging in the millions of dollars to establish and maintain the Division and Committee (General Fund and Regulated Psychedelic-Assisted Therapy Fund). Like the Board, the Division and Committee will also likely

require General Fund support until the Division can establish and collect fee revenue sufficient to support its operations. (See Staff Comments for additional detail.)

- The California Department of Public Health reports ongoing costs of approximately $200,000 annually to provide guidance and best practices related to data collection, processing, and reporting methods for the Division (General Fund).

- Unknown fiscal impact to the Department of Justice's (DOJ) applicant services program to intake and process fingerprint and related background information from and transmit state- and federal-level criminal offender record information on applicants to the Board. The DOJ may recover its costs to intake and process requests through fees charged to the Board. Actual costs to DOJ will depend on, among other things, the volume of applicants the program will have to process. To the extent there are a significant number of applicants applying for licensure under the Acts, the DOJ may have significant workload impacts.

- Unknown, potentially significant cost pressure to the state funded trial court system (Trial Court Trust Fund, General Fund) to adjudicate the crime created by this bill. Certain rights to the defendants are attached to criminal proceedings, including the right to a jury trial and the right to counsel (at public expense if the defendants are unable to afford the costs of representation) and creating new crimes, with increased penalties, could lead to lengthier and more complex court proceedings with attendant workload and resource costs to the court. An eight hour court day costs approximately $8,000 in staff in workload. If the bill results in 12 or more days spent in court, trial court costs could be in the hundreds of thousands of dollars.

  While the courts are not funded on a workload basis, an increase in workload could result in delayed court services and would put pressure on the General Fund to fund additional staff and resources. For example, the 2021-22 Budget included $90 million one time General Fund to address case backlogs—with $30 million specifically for certain criminal case backlogs and $60 million for backlogs across all case types. The Governor's 2024-25 state budget proposes $83.1 million ongoing General Fund to continue to backfill the Trial Court Trust Fund for expected revenue declines.

- Unknown, potentially significant reimbursable annual costs (General Fund, local funds) to counties in the hundreds of thousands of dollars to low millions of dollars to counties for increased incarceration costs. The average annual cost to incarcerate a defendant in county jail is approximately $29,000. If 10 defendants statewide are sentenced annually to an average of six months in county jail for any specified violation of the Acts, the total cost to counties would be $145,000.

Background: Hallucinogens are a diverse group of drugs that alter a person's perception or awareness of their surroundings. Some hallucinogens are found in plants and fungi, and some are synthetically produced. According to the National Institute on Drug Abuse, hallucinogens are commonly split into two categories: classic hallucinogens and dissociative drugs. Both types can cause hallucinations, and dissociative drugs can cause the user to feel disconnected from their body or environment. Hallucinogens can be consumed in a variety of ways, including swallowed

as tablets, pills, or liquid, consumed raw or dried, snorted, injected, inhaled, vaporized, smoked, or absorbed through the lining of the mouth using drug-soaked pieces of paper. Common hallucinogens include DMT, psilocybin, peyote, and mescaline.

Many hallucinogenic substances, including DMT, mescaline, psilocybin, and psilocin are classified as Schedule I substances under the state's Uniform Controlled Substances Act. Schedule I substances are defined as those controlled substances having no medical utility and that have a high potential for abuse. There is research, however, that indicates that many of these substances have therapeutic benefits.

Oregon Measure 109, Psilocybin Mushroom Services Program Initiative. In 2020, Oregon voters approved Measure 109, the Psilocybin Services Act, which directed the Oregon Health Authority to create a state-licensed, psilocybin-assisted therapy program over a two-year period. In implementing Measure 109, Oregon had to determine how to license and regulate the manufacturing, transportation, delivery, sale and purchase of psilocybin products as well as the provision of psilocybin services. Following the two-year development period for psilocybin services, the state began taking license applications on January 2, 2023. Psilocybin services refers to preparation, administration, and integration sessions provided by a licensed facilitator. Psilocybin services are available to individuals aged 21 and older and do not require a prescription or medical referral. The psilocybin products consumed must be cultivated or produced by a licensed psilocybin manufacturer and can only be provided to a client at a licensed psilocybin service center during an administration session.

Proposed Law:

Provisions related to the Psychedelic Facilitators Act, the Board of Regulated Psychedelic Facilitators, and Licensed Facilitators

- Establishes the Board of Regulated Psychedelic Facilitators within the Department of Consumer Affairs. Requires the Board to be appointed by April 1, 2025, adopt regulations before January 1, 2026, and begin accepting license applications by April 1, 2026.
    - Requires the Board to carry out all necessary activities in the regulation of licensed psychedelic facilitators, as specified. This includes, among other things, adopting regulations consistent with recommendations made by the Regulations Psychedelic Substances Expert Oversight Committee; establishing educational, training, examination, practicum, and supervision requirements; establishing professional standards for facilitators; and establishing requirements and processes for approving schools and programs offering regulated psychedelic facilitation training.
    - Requires the Board to establish reasonable initial license and renewal fees to cover its operational costs. Requires the Board to assess renewal license fees biennially. Establishes the Regulated Psychedelic Facilitators Fund in the State Treasury.

- Establishes requirements for licensure as a regulated psychedelic facilitator, as specified. Provides that a license is valid for two years.

Provisions related to the Regulated Psychedelic-Assisted Therapy Act, Division of Regulated Psychedelic-Assisted Therapy, and Marketplace Regulation for Psychedelic Facilitation

- Establishes the Regulated Psychedelic-Assisted Therapy Act to regulate:
    - The provision of psychedelic facilitation.
    - The production, distribution, transportation, storage, processing, manufacturing, testing, quality control, and sale of regulated psychedelic substances for use only in conjunction with regulated psychedelic facilitation at approved locations.
    - The approval of locations where regulated psychedelic facilitation may take place.
    - The collection and publication of deidentified and aggregate data and information on the implementation and outcomes of the Act.

- Establishes the Division of Regulated Psychedelic-Assisted Therapy in the Business, Consumer Services, and Housing Agency. Provides that the Division has the power, duty, purpose, responsibility, and jurisdiction to regulate regulated psychedelic substances and the provision of psychedelic facilitation, and to approve locations where psychedelic facilitation may take place.
    - Requires the Division to convene the Regulated Psychedelic Substances Expert Oversight Committee by April 1, 2025. Tasks the Committee with advising the Division and the Board on the development of standards and regulations that protect public health and safety while ensuring a regulate environment to provide safe access to regulated psychedelic facilitation.
    - Requires the Division to establish categories of licensure and registration, as specified.
    - Tasks the Division with enforcing the laws and regulations relating to the cultivation, producing, manufacturing, processing, preparing, delivery, storage, sale, and testing of regulated psychedelic substances.
    - Requires the Division to begin to accept and process applications for licensure by April 1, 2026.
    - Authorizes the Division to establish license fees. Establishes the Regulated Psychedelic-Assisted Therapy Fund in the State Treasury to support the Division's administrative and enforcement operations.

Other Provisions

- Establishes a Psychedelic Substances Public Education and Harm Reduction Fund. Provides that moneys in the Fund be available to the Office of Community Partnerships and Strategic Communications within the Governor's Office of Planning and Research upon appropriation by the Legislature to award grants for public education relating to psychedelic substances, including their limitations and potential risks, and mitigation measures, in addition to potential benefits as well as harm reduction.

- Establishes specified prohibitions for licenseholders and subjects them to enforcement and discipline by the Board and Division.
    - Creates a new misdemeanor and establishes specified penalties.

  - Provides that any penalties collected by the Board and Division be deposited directly into the General Fund.

- Authorizes a city, county, or a city and county to reasonably regulate the time, place, and manner of regulated psychedelic facilitation within its boundaries but prohibits a city, county, or a city and county from banning or completely prohibiting facilitator operations and regulated psychedelic facilitation.

- Prohibits a city, county, or a city and county from enacting a greater fine or penalty for conduct related to regulated psychedelic facilitation or substances than is allowed under state law. Additionally prohibits these jurisdictions from requiring an additional license or the payment of a fee in addition to the state license and fee for conduct related to regulated psychedelic facilitation or regulated psychedelic substance licensees, other than generally applicable licenses and fees that apply to all businesses operating with the jurisdiction.

- Prohibits a city, county, or a city and county from prohibiting the transportation of regulated psychedelic substances through its jurisdiction on public roads by a licensee or as otherwise allowed by the Acts.

- Specifies that an individual shall not be arrested, prosecuted, penalized, sanctioned, or otherwise denied any benefit. Specifies an individual shall not be subject to seizure or forfeiture of assets for allowing property the person owns, occupies, or manages to be used for any of the activities conducted lawfully under the Acts at an approved location or for enrolling or employing a person who engages in regulated psychedelic substance-related activities lawfully.

- Specifies that the use of regulated psychedelic substances in connection with regulated psychedelic facilitation shall not disqualify a person from any needed medical procedure or medical treatment or any other lawful health-related service, shall not, by itself, be the basis for punishing a person currently under parole, probation, or other state-supervised release, including pretrial release.

- Specifies that the Acts shall not restrict the sale, possession, display, or cultivation of living fungi, plants, or seeds that were lawful before the enactment of the Acts and that engaging in regulated psychedelic substance-related activities shall not, by itself, be the basis to deny eligibility for any public assistance program, unless required by federal law.

- States legislative declarations and intent.

- Establishes definitions for purposes of the new Acts.

Related Legislation: SB 58 (Weiner, 2023) would have decriminalized the use of certain psychedelics for personal use by individuals 21 years of age or older. SB 58 would have also created a workgroup to study and recommend a framework for governing the therapeutic use of psychedelics. SB 58 also would have defined "facilitated or supported use" as supervised or assisted personal use of a psychedelic by an individual or group of persons 21 years of age or older, or the assisting or

supervising of such persons in such use, within the context of spiritual guidance, community-based healing, or related service. SB 58 was vetoed.

Staff Comments: While the total fiscal impact of this bill is unknown at this time, one-time and ongoing costs will likely range in the millions of dollars and will depend on the scope and size of the licensing programs and the ability for the Board, Division, and Committee to meet their responsibilities on the timeline required by the bill. The programs will likely need significant General Fund or other special fund support until fees established by the Acts can support their operations.

For comparison, the Oregon Psilocybin Services (OPS) section in the Oregon Health Authority is tasked with similar regulatory responsibilities as those required of the Board, Division, and Committee under this bill.

Oregon passed its Measure 109 and after a two-year development process from January 1, 2021 to December 31, 2022 to establish regulations for implementation of the measure, OPS adopted rules on December 21, 2022 and began accepting applications for licensure on January 2, 2023. OPS received $2.5 million General Fund and $760,000 other special fund for start-up costs and 22.0 staff positions for the 2021-23 biennium to begin implementation. OPS additionally received $3.1 million General Fund for the 2023-25 biennium, as OPS anticipated fees would take several months to a year following when it began accepting license applications before these fees could cover the cost of OPS's work[1]. OPS regulates four license types: Facilitator, Manufacturer, Service Center, and Laboratory.

This bill requires the Board to be appointed by April 1, 2025, adopt regulations by January 1, 2026, and begin accepting license applications by April 1, 2026. The bill requires the Division to convene the Committee by April 1, 2025, adopt regulations concerning psilocybin, psilocin, and MDMA by January 1, 2026, and begin accepting license applications by April 1, 2026. The bill also requires the Committee to publish its first annual report on its activities and recommendations by January 1, 2026. It is unknown if the Board, Division, and Committee may complete all necessary work—including hiring staff, developing and adopting regulations, conducting meetings and stakeholder outreach, approving programs, building an IT licensing system, and establishing professional qualifications for education, training, experience, professional practice, standards of care, and ethics—before the Board and Division would be required to start accepting license applications. To meet these timelines, these programs will likely have higher start-up costs that may necessitate greater General Fund or other special fund support until fee revenue is sufficient to cover their costs.

-- END --

[1] 2023-25 Oregon Health Authority Legislatively Adopted Budget. Noted in the Center for Health Protection Program Unit Summary.

California Board of PSYCHOLOGY

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May 15, 2024

The Honorable Anna M. Caballero
Chair, Senate Committee on Appropriations
State Capitol, Room 412
Sacramento, CA 95814

RE: SB 1012 – The regulated Psychedelic Facilitators Act and The Regulated Psychedelic-Assisted Therapy Act - Oppose

Dear Senator Caballero:

The Board of Psychology (Board) protects consumers of psychological services by licensing psychologists, and associated professionals, regulating the practice of psychology, and supporting the ethical evolution of the profession.

At its May 10, 2024 meeting, the Board adopted an **Oppose** position on SB 1012. This bill would establish the Board of Regulated Psychedelic Facilitators in the Department of Consumer Affairs to license and regulate psychedelic-assisted therapy facilitators.

The Board has many concerns with SB 1012. First, much of the data regarding psychedelic-assisted therapy and the long-term effects of psychedelics is incomplete. Research on psychedelic-assisted therapy is in the nascent stages. The long-term effects of psychedelic drugs on individuals and the mental health benefits are entirely unclear. Recent research on these drugs indicates substantial adverse effects for the use of such drugs in some individuals, even under controlled conditions, including the onset of psychotic disorders and suicidality. The Board believes with the shortfall of data and research on psychedelic-assisted therapy and the hasty creation of a new licensing board which would be licensing facilitators without extensive mental health training to administer psychedelic-assisted therapy, it has the serious potential to cause short-term and long-term issues with consumer protection and the mental health of our communities.

Additionally, the Board believes there will also be impacts to the scope of therapy, as in some cases, based on experience with current treatment protocols with “psychedelic-assisted therapy,” individuals may receive only psychedelics and not receive the much-needed therapy, since the bill permits non-licensed professionals to administer psychedelics without referral from a licensed mental health professional where evidence is found that psychedelic-assisted therapy might be beneficial. The bill excludes any requirement that a licensed mental health professional be included as part of the treatment team to ensure that the individual who is receiving therapy receives not only the mental health treatment but the understanding of the treatment and the prolonged therapy that is needed to address individual needs and care. Also, since the bill excluded stakeholder engagement and engagement with other licensing boards in the

realm of mental health, the Board feels that the bill is delving into the areas of not only psychology but other mental health fields and professionals and the licensing of those individuals. These concerns are echoed by the Board's stakeholders at our most recent meeting who feel that SB 1012 may have a vast impact on consumer protection, consumer wellbeing, and the efficacy of mental health treatment.

The Board understands that the regulatory scheme proposed is in direct reaction to Governor Newsom's veto of the legalization of psychedelic drugs. To rush through a hastily constructed scheme to create a licensing board for quasi-professionals without stakeholder engagement when dealing with such a potentially harmful treatment protocol is not the answer. To do so may seriously and permanently harm California consumers.

If you have any questions or concerns, please feel free to contact the Board's Executive Officer, Antonette Sorrick, at (916) 574-8938 or Antonette.Sorrick@dca.ca.gov. Thank you.

Sincerely,

Lea Tate, PsyD
President, Board of Psychology

cc: Senator Brian Jones (Vice Chair)
Members of the Senate Committee on Appropriations
Senator Scott D. Wiener
Janelle Miyashiro, Consultant, Senate Committee on Appropriations
Kayla Williams, Senate Republican Caucus

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(c)(7) – Bills with Active Positions Taken by the Board SB 1067 (Smallwood-Cuevas) Healing arts: expedited licensure process: medically underserved area or population.

Background

On February 12, 2024, SB 1067 was introduced by Senator Smallwood-Cuevas.

SB 1067 would require each healing arts board under the Department of Consumer Affairs to develop a process to expedite the licensure process by giving priority to applicants who are seeking licensure if they demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population.

Health and Safety Code (HSC) 128552 defines “Medically underserved area” as a health professional shortage area or an area of the state where unmet priority needs for physicians exist. HSC 128552 also defines “medically underserved population” as individuals in the Medi-Cal program and uninsured populations.

On February 21, 2024, SB 1067 was referred to the Senate Committee on Business, Professions and Economic Development (BP&ED).

On April 8, 2024, SB 1067 passed the Committee on BP&ED and was referred to the Committee on Appropriations.

On April 12, 2024, SB 1067 was presented to the Legislative and Regulatory Affairs Committee for possible position recommendation.

The Committee expressed the concerns regarding the bill language specifically to the lack of clarification regarding the definition of “Medically underserved area” or “medically underserved population” and which documentation would be required.

On May 10, 2024, the Board adopted a Support if Amended position on SB 1067.

On May 15, 2024, Board Staff submitted a Support if Amended Position Letter with the proposed amendments to the Members of the Senate Appropriations Committee.

On May 16, 2024, SB 1067 passed the Appropriations Committee with amendments which included clarification on which healing arts boards would be required to expedite licensure applicants. The amendments did not include the Board in the amended language.

Board Staff removed the current position of Support if Amended to a watch position.

Board Staff will continue to monitor SB 1067.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: SB 1067 Bill Text
Attachment #2: SB 1067 – Senate Floor Analyses
Attachment #3: SB 1067 – Support if Amended Position Letter – Senate Appropriations Committee

AMENDED IN SENATE MAY 16, 2024

SENATE BILL No. 1067

Introduced by Senator Smallwood-Cuevas

February 12, 2024

An act to add Section 871 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1067, as amended, Smallwood-Cuevas. Healing arts: expedited licensure process: medically underserved area or population.

Existing law establishes various boards within the Department of Consumer Affairs to license and regulate various health professionals. Existing law requires specified boards to expedite the licensure process of an applicant who can demonstrate that they intend to provide abortions within their scope of practice and specifies the documentation an applicant is required to provide to demonstrate their intent.

This bill would require ~~each healing arts board, as defined,~~ *the Board of Behavioral Sciences, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the California State Board of Pharmacy, the Dental Board of California, the Dental Hygiene Board of California, and the Physician Assistant Board* to develop a process to expedite the licensure process by giving priority review status to the application of an applicant for a license who demonstrates that they intend to practice in a medically underserved area or serve a medically underserved population, as defined. The bill would authorize an applicant for a license to demonstrate their intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including, but not limited to, a letter from an ~~employer,~~

~~located in a medically underserved area or which serves a medically underserved population, indicating that the applicant has accepted employment and stating the start date.~~ *employer that includes prescribed information. The bill would provide that compliance with the bill does not require the department or any of the boards to open a regulatory or rulemaking process to change their licensee application process and would deem a board to be in compliance if it includes a supplemental letter or cover statement to their application explaining the availability of the expedited licensure process and indicating what an applicant's employer would need to provide to the board for the applicant to qualify for the priority review status.*

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 871 is added to the Business and Professions Code, to read:

871. (a) ~~Each healing arts board~~ *The Board of Behavioral Sciences, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the California State Board of Pharmacy, the Dental Board of California, the Dental Hygiene Board of California, and the Physician Assistant Board,* shall develop a process to expedite the licensure process by giving priority review status to the application of an applicant for a license who demonstrates that they intend to practice in a medically underserved area or serve a medically underserved population, as defined in Section 128552 of the Health and Safety Code.

(b) An applicant for a license may demonstrate their intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including, but not limited to, a letter from an ~~employer, located in a medically underserved area or which serves a medically underserved population, indicating that the applicant has accepted employment and stating the start date.~~ *employer that does all of the following:*

(1) Indicating the employer is located in a medically underserved area or indicating the employer serves a medically underserved population and identifying which is applicable.

(2) Indicating that the applicant has accepted employment.

(3) Stating the applicant's proposed start date.

~~(c) As used in this section, "healing arts board" means any board, division, or examining committee in the Department of Consumer Affairs that licenses or certifies health professionals.~~

(c) Compliance with this section does not require the Department of Consumer Affairs or any of the boards listed in subdivision (a) to open a regulatory or rulemaking process to change their licensee application process. A board shall be deemed to be in compliance with this section if it includes a supplemental letter or cover statement to their application explaining the availability of this expedited licensure process and indicating what an applicant's employer would need to provide to the board for the applicant to qualify for the priority review status.

O

Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 1067
Author: Smallwood-Cuevas (D)
Introduced: 2/12/24
Vote: 21

SENATE BUS., PROF. & ECON. DEV. COMMITTEE: 9-0, 4/8/24
AYES: Ashby, Alvarado-Gil, Archuleta, Dodd, Eggman, Glazer, Menjivar, Smallwood-Cuevas, Wilk
NO VOTE RECORDED: Nguyen, Becker, Niello, Roth

SENATE APPROPRIATIONS COMMITTEE: 7-0, 5/16/24
AYES: Caballero, Jones, Ashby, Becker, Bradford, Seyarto, Wahab

SUBJECT: Healing arts: expedited licensure process: medically underserved area or population

SOURCE: California Primary Care Association Advocates

DIGEST: This bill requires the Board of Behavioral Sciences (BBS), Board of Registered Nursing (BRN), Board of Vocational Nursing and Psychiatric Technicians (BVNPT), Board of Pharmacy (BOP), Dental Board of California (DBC), Dental Hygiene Board (DHB), and Physician Assistant Board (PAB) to give priority review status to the application of an applicant for licensure who demonstrates that they intend to practice in a medically underserved area or serve a medically underserved population.

ANALYSIS:

Existing law:

1) Requires all DCA boards to expedite and assist the initial licensure process for an applicant who supplies satisfactory evidence to the board that the applicant has served as an active duty member of the Armed Forces of the United States and was honorably discharged, or is the spouse or domestic partner of an active duty member of the Armed Forces who is currently assigned to a duty station in

California under official active duty military orders and if the spouse or domestic partner holds a current license another state, district, or territory of the United States in the profession or vocation for which the applicant seeks a license. (BPC §§ 115.4; 115.5)

2) Requires all DCA boards to expedite and assist the initial licensure process for an applicant who supplies satisfactory evidence to the board that they have been admitted to the United States as a refugee under Section 1157 of Title 8 of the United States Code, have been granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to Section 1158 of Title 8 of the United States Code, or they have a special immigrant visa (SIV) that has been granted a status under Section 1244 of Public Law 110-181, under Public Law 109-163, or under Section 602(b) of Title VI of Division F of Public Law 111-8. (BPC § 135.4)

3) Requires a board, other than a board that has a process by which an out-of-state licensed applicant in good standing who is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States is able to receive expedited, temporary authorization to practice while meeting state-specific requirements for a period of at least one year or is able to receive an expedited license by endorsement with no additional requirements, to issue a temporary license to practice a profession or vocation to an applicant who meets certain requirements, including:

   a) They provide evidence that they are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

   b) They hold a current, active, and unrestricted license from another state that authorizes them to practice the profession or vocation within the same scope for which the applicant seeks a temporary license from the board.

   c) They submit an application that includes written verification from their original licensing jurisdiction stating that they are in good standing in that jurisdiction.

   d) They have not committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed.

e) They have not been disciplined by a licensing entity in another jurisdiction and are not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

4) Requires a board to issue the temporary license within 30 days of receiving documentation that the applicant has met the requirements and specifies authority for the license to be terminated if they do not meet the requirements or if they engaged in unprofessional conduct or any other act that is a cause for discipline by the board. Specifies that the temporary licenses is not renewable and expires 12 months after being issued or when a standard license is issued or denied.

5) Requires the Medical Board of California (MBC), the Osteopathic Medical Board of California (OMBC), BRN, and the PAB to expedite the licensure process for an applicant who demonstrates that they intend to provide abortions, accompanied by a letter from an employer or health care entity indicating that the applicant has accepted employment or entered into a contract to provide abortions, the applicant's starting date, the location where the applicant will be providing abortions, and that the applicant will be providing abortions within the scope of practice of their license. (BPC § 870)

6) Requires the MBC to develop a process to give priority review status to the application of an applicant for a physician and surgeon's certificate who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population. (BPC § 2092)

This bill:

1) Requires BBS, BRN, BVNPT, BOP, DBC, DHB, and PAB to give priority review status to the application of an applicant for licensure who demonstrates that they intend to practice in a medically underserved area or serve a medically underserved population.to develop a process to expedite the licensure process by giving priority review status to the application of an applicant for a license who demonstrates that they intend to practice in a medically underserved area or serve a medically underserved population.

2) Specifies that an applicant may demonstrate their intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including, but not limited to, a letter from an employer that meets specified requirements.

3) Clarifies that the boards are not required to promulgate regulations to change their respective licensee application processes.

Background

Expedited and Priority Licensing. The DCA currently requires that three populations receive priority review for licensure from DCA entities: (1) members of the Armed Forces who have served on active duty and were honorably discharged, (2) spouses or domestic partners of active duty members of the Armed Forces who are currently assigned to a duty station in California under official active duty military orders, and (3) refugees who have been granted asylum by the Secretary of Homeland Security or the Attorney General of the United States or those with an SIV. In addition, the MBC also grants expedited licensure review to physician and surgeon's certificate applicants who can demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population and MBC, OMBC, BRN, and PAB expedite the licensure process for an applicant who demonstrates that they intend to provide abortions.

Temporary Licenses. If licensed in another state, and depending on the license, military spouses and other applicants may be able to issue to utilize provisions that recognize out-of-state licenses, also known as reciprocity or licensure by endorsement. However, depending on the specific license requirements and the potential differences in requirements between states, concerns about applicants still experiencing long wait times as their qualifications are reviewed have been the source of numerous efforts and bills.

In general, temporary licenses allow an applicant to practice for a limited period, allowing them to practice while the remainder of the qualifications is obtained or verified. Since license requirements are intended to protect the public, applicants usually must be able to immediately demonstrate meeting some of the qualifications required for licensure and pass a background check. Some programs authorize temporary practice for a specified period of time to individuals who do not intend to become permanently licensed in California but in response to concerns about the inability for individuals to become employed while waiting for licensing processing, boards are now required to issue temporary licenses for up to 12-months to military spouses.

Related/Prior Legislation

AB 2442 (Zbur, 2024) requires MBC, OMBC, BRN, and PAB to expedite the licensure process for an applicant who demonstrates that they intend to provide

gender-affirming health care or gender-affirming mental health care services within the scope of practice of their license.

AB 883 (Mathis, 2023) requires a DCA licensing program, after July 1, 2024, to expedite, and authorizes the program to assist with, the initial licensure process for an applicant who supplies satisfactory evidence they are an active duty member of a regular component of the Armed Forces of the United States enrolled in the United States Department of Defense SkillBridge program.

SB 1168 (Morrell, 2020) would have required a state agency that issues a business license to establish a process to expedite licensing services for a person or business that meets specified criteria, including that the person or business has been displaced by an emergency proclaimed or declared within 365 days of the request for licensing services.

AB 2113 (Low, 2020) requires DCA Boards to expedite licensure applications for refugees, asylees, and special immigrant visa holders.

Comments

Despite statutory attempts to ensure swifter licensing timeframes for specified applicants, factors beyond a program's control (deficiencies in applications, the length of time fingerprint clearance is provided, delays in receiving transcripts and education program completion verification, and more) can lead to lengthy holdups in the process, regardless of the program's internal efforts to expedite processing.

Programs that bill proponents cite as having lengthy application processing timeframes are actually processing licenses in shorter timeframes than their internal goals and historic averages. For example, DBC reported during its 2024 sunset review oversight that complete applications for licensure licenses are being processed within about 24 days. PAB has been on target to meet its 30-day licensing timeframe for completed applications but is taking twice that long for applications that are missing information. Between October 2023 and December 2023 PAB processed the 126 complete physician assistant applications they received within 30 days, but they also received 327 incomplete applications. It is unclear whether a mandate to expedite the licensing process will increase the capacity of critical healthcare workforce personnel delivering important care to patients throughout the state.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Senate Appropriations Committee:

This bill will result in unknown, potentially minor workload impacts to impacted healing arts boards, as DCA notes that the majority of its boards generally have a process in place for expediting applications. Actual fiscal impact will depend on how many applicants for licensure would qualify for expedited application review under each board.

SUPPORT: (Verified 5/16/24)

CPCA Advocates, Subsidiary of The California Primary Care Association (source)
Alameda Health Consortium
Altamed Health Services Corporation
Apla Health
Arroyo Vista Family Health Center
Asian Health Services
California Association for Health Services At Home
California Association of Rural Health Clinics
California Consortium for Urban Indian Health
CAPA
Chapa-de Indian Health
Communicare+ole
Community Clinic Association of Los Angeles County
Comprehensive Community Health Centers
DAP Health
Dientes Community Dental
Eisner Health
El Proyecto Del Barrio, INC.
Family Health Centers of San Diego
Friends of Family Health Center
Golden Valley Health Centers
Health Alliance of Northern California
Health and Life Organization, Inc./ Dba Sacramento Community Clinics
Health Center Partners of Southern California
Hill Country Community Clinic
Inland Family Community Health Center
La Clinica De La Raza, INC.
La Maestra Community Health Centers
Lifelong Medical Care
Neighborhood Healthcare
North Coast Clinics Network

North East Medical Services
Northeast Valley Health Corporation
Petaluma Health Center
Sac Health
San Diego Regional Chamber of Commerce
San Ysidro Health
Share Our Selves
Shasta Cascade Health Centers
Shasta Community Health Center
St. John's Community Health
The Children's Clinic, "serving Children and Their Families"/TCC Family Health
Truecare
Unicare Community Health Center
Venice Family Clinic
Wellspace Health
West County Health Centers, INC.

OPPOSITION: (Verified 5/16/24)

None received

ARGUMENTS IN SUPPORT: Supporters state that community health center workforce challenges continue to worsen, noting that the pandemic led to burnout, which contributed to a significant loss of professionals from the healthcare sector. Supporters state that health professional licensing boards have prolonged backlogs for processing applications for licensure, often preventing a provider from joining the workforce in a timely and efficient manner…delays create bottlenecks and further exacerbate recruitment and retention challenges.

Prepared by: Sarah Mason / B., P. & E.D. /
5/17/24 11:56:24

****** END ******

California Board of PSYCHOLOGY

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May 15, 2024

The Honorable Anna M. Caballero
Chair, Senate Committee on Appropriations
State Capitol, Room 412
Sacramento, CA 95814

RE: **SB 1067 (Smallwood-Cuevas) – Healing arts: expedited licensure process: medically underserved area or population – SUPPORT IF AMENDED**

Dear Senator Caballero:

The Board of Psychology (Board) protects consumers of psychological services by licensing psychologists, and associated professionals, regulating the practice of psychology, and supporting the ethical evolution of the profession.

At its May 10, 2024, meeting, the Board adopted a **Support if Amended** position on SB 1067 (Smallwood-Cuevas). This would require each healing arts board under the Department of Consumer Affairs to develop a process to expedite the licensure process by giving priority to applicants who are seeking licensure if they demonstrate that they intend to practice in a medically underserved area or serve a medically underserved population.

The Board supports and agrees with the author's intent in expediting applicants who demonstrate their intent to practice in a medically underserved area or serve a medically underserved population, however, the Board requests the following amendments to clarify the definition of medically underserved according to federal guidelines to ensure proper expedition of the application process for qualified individuals:

SECTION 1.
Section 871 is added to the Business and Professions Code, to read:
871.
(a) Each healing arts board shall develop a process to expedite the licensure process by giving priority review status to the application of an applicant for a license who demonstrates that they ~~intend~~ will be performing services within their scope in a medically underserved area or serve a medically underserved population, as defined in Section 128552 of the Health and Safety Code.
(b) An applicant for a license may demonstrate ~~their intent~~ that they will be performing services within their scope ~~to practice~~ in a medically underserved area or serve a medically underserved population by providing proper documentation, including, but not limited to, a letter from an employer, located in a medically underserved area or which serves a medically underserved population as specified in 128552 of the Health and Safety Code , ~~indicating that the applicant has accepted employment and stating the start date.~~ The letter must include the proposed employment start date, the name and address of the facility(s) where the services will be provided, and the specialty of the

services that will be provided, and the specific underserved area or underserved population that will be treated.
(c) As used in this section, “healing arts board” means any board, division, or examining committee in the Department of Consumer Affairs that licenses or certifies health professionals.

If you have any questions or concerns, please feel free to contact the Board’s Executive Officer, Antonette Sorrick, at (916) 574-8938 or Antonette.Sorrick@dca.ca.gov. Thank you.

Sincerely,

Lea Tate, PsyD
President, Board of Psychology

cc: Senator Brian Jones (Vice Chair)
Members of the Senate Committee on Appropriations
Senator Lola Smallwood-Cuevas
Janelle Miyashiro, Consultant, Senate Committee on Appropriations
Kayla Williams, Senate Republican

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(d)(1) Watch Bills – AB 2282 (McKinnor) Family reunification services

Background

On February 8, 2024, AB 2282 was introduced by Assembly Member McKinnor.

Current law provides that reunification services do not need to be provided to a parent or guardian when the court finds, by clear and convincing evidence, certain circumstances exist, including that the parent or guardian of the child has been convicted of a violent felony, as defined.

AB 2282 would instead provide that reunification services do not need to be provided to a parent or guardian when the court finds that the parent or guardian of the child has been convicted of a violent felony against a child.

AB 2282 would limit criminal convictions used to deny reunification services to families in the family regulation system. It would amend the law to deny services only to the most serious and violent felons who have endangered children or their family.

On March 4, 2024, AB 2282 was referred to the Assembly Committees on Judiciary and Human Services.

On April 9, 2024, AB 2282 passed the Committee on Judiciary.

On April 12, 2024, AB 2282 was presented to the Legislative and Regulatory Affairs Committee for possible position recommendation. The Committee determined to watch AB 2282.

On April 24, 2024, AB 2282 passed the Committee on Human Services and was referred to the Committee on Appropriations.

On May 16, 2024, AB 2282 passed the Committee on Appropriations.

Board Staff is continuing to monitor AB 2282.

Action Requested

This item is for informational purposes only. There is not action required at this time.

Attachment #1: AB 2282 Bill Text
Attachment #2: AB 2282 – Assembly Floor Analysis

ASSEMBLY BILL No. 2282

Introduced by Assembly Member McKinnor

February 8, 2024

An act to amend Sections 361.5 of the Welfare and Institutions Code, relating to juveniles.

LEGISLATIVE COUNSEL'S DIGEST

AB 2282, as introduced, McKinnor. Family reunification services.

Existing law establishes the jurisdiction of the juvenile court, which may adjudge children to be dependents of the court under certain circumstances, including when the child suffered or there is a substantial risk that the child will suffer serious physical harm, or a parent fails to provide the child with adequate food, clothing, shelter, or medical treatment. Existing law establishes the grounds for removal of a dependent child from the custody of the child's parents or guardian, and requires the court to order the social worker to provide designated child welfare services, including family reunification services, as prescribed. Existing law provides that reunification services do not need to be provided to a parent or guardian when the court finds, by clear and convincing evidence, certain circumstances exist, including that the parent or guardian of the child has been convicted of a violent felony, as defined.

This bill would instead provide that reunification services do not need to be provided to a parent or guardian when the court finds that the parent or guardian of the child has been convicted of a violent felony against a child. By expanding the scope of individuals requiring reunification services, the bill would impose additional duties on county

child welfare departments, thereby imposing 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.

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 361.5 of the Welfare and Institutions Code is amended to read:

361.5. (a) Except as provided in subdivision (b), or when the parent has voluntarily relinquished the child and the relinquishment has been filed with the State Department of Social Services, or upon the establishment of an order of guardianship pursuant to Section 360, or when a court adjudicates a petition under Section 329 to modify the court's jurisdiction from delinquency jurisdiction to dependency jurisdiction pursuant to subparagraph (A) of paragraph (2) of subdivision (b) of Section 607.2 and the parents or guardian of the ward have had reunification services terminated under the delinquency jurisdiction, whenever a child is removed from a parent's or guardian's custody, the juvenile court shall order the social worker to provide child welfare services to the child and the child's mother and statutorily presumed father or guardians. Upon a finding and declaration of paternity by the juvenile court or proof of a prior declaration of paternity by any court of competent jurisdiction, the juvenile court may order services for the child and the biological father, if the court determines that the services will benefit the child.

(1) Family reunification services, when provided, shall be provided as follows:

(A) Except as otherwise provided in subparagraph (C), for a child who, on the date of initial removal from the physical custody of the child's parent or guardian, was three years of age or older, court-ordered services shall be provided beginning with the dispositional hearing and ending 12 months after the date the child

entered foster ~~care~~ *care*, as provided in Section 361.49, unless the child is returned to the home of the parent or guardian.

(B) For a child who, on the date of initial removal from the physical custody of the child's parent or guardian, was under three years of age, court-ordered services shall be provided for a period of 6 months from the dispositional ~~hearing~~ *hearing*, as provided in subdivision (e) of Section 366.21, but no longer than 12 months from the date the child entered foster care, as provided in Section 361.49, unless the child is returned to the home of the parent or guardian.

(C) For the purpose of placing and maintaining a sibling group together in a permanent home should reunification efforts fail, for a child in a sibling group whose members were removed from parental custody at the same time, and in which one member of the sibling group was under three years of age on the date of initial removal from the physical custody of the child's parent or guardian, court-ordered services for some or all of the sibling group may be limited as set forth in subparagraph (B). For the purposes of this paragraph, "a sibling group" shall mean two or more children who are related to each other as full or half siblings.

(2) Any motion to terminate court-ordered reunification services prior to the hearing set pursuant to subdivision (f) of Section 366.21 for a child described by subparagraph (A) of paragraph (1), or prior to the hearing set pursuant to subdivision (e) of Section 366.21 for a child described by subparagraph (B) or (C) of paragraph (1), shall be made pursuant to the requirements set forth in subdivision (c) of Section 388. A motion to terminate court-ordered reunification services shall not be required at the hearing set pursuant to subdivision (e) of Section 366.21 if the court finds by clear and convincing evidence one of the following:

(A) That the child was removed initially under subdivision (g) of Section 300 and the whereabouts of the parent are still unknown.

(B) That the parent has failed to contact and visit the child.

(C) That the parent has been convicted of a felony indicating parental unfitness.

(3) (A) Notwithstanding subparagraphs (A), (B), and (C) of paragraph (1), court-ordered services may be extended up to a maximum time period not to exceed 18 months after the date the child was originally removed from physical custody of the child's parent or guardian if it can be shown, at the hearing held pursuant

to subdivision (f) of Section 366.21, that the permanent plan for the child is that the child will be returned and safely maintained in the home within the extended time period. The court shall extend the time period only if it finds that there is a substantial probability that the child will be returned to the physical custody of the child's parent or guardian within the extended time period, or that reasonable services have not been provided to the parent or guardian. Additionally, in the case of an Indian child, the court shall extend the time period if it finds active efforts, as defined in subdivision (f) of Section 224.1, to reunite the child with their family have not been made. In determining whether court-ordered services may be extended, the court shall consider the special circumstances of an incarcerated or institutionalized parent or parents, parent or parents court-ordered to a residential substance abuse treatment program, or a parent who has been arrested and issued an immigration hold, detained by the United States Department of Homeland Security, or deported to the parent's country of origin, including, but not limited to, barriers to the parent's or guardian's access to services and ability to maintain contact with their child. The court shall also consider, among other factors, good faith efforts that the parent or guardian has made to maintain contact with the child. If the court extends the time period, the court shall specify the factual basis for its conclusion that there is a substantial probability that the child will be returned to the physical custody of the child's parent or guardian within the extended time period, that reasonable services have not been provided to the parent or guardian, or, in the case of an Indian child, that active efforts to reunite the child with their family have not been made. The court also shall make findings pursuant to subdivision (a) of Section 366 and subdivision (e) of Section 358.1.

(B) When counseling or other treatment services are ordered, the parent or guardian shall be ordered to participate in those services, unless the parent's or guardian's participation is deemed by the court to be inappropriate or potentially detrimental to the child, or unless a parent or guardian is incarcerated or detained by the United States Department of Homeland Security and the corrections facility in which the parent or guardian is incarcerated does not provide access to the treatment services ordered by the court, or has been deported to their country of origin and services ordered by the court are not accessible in that country. Physical

custody of the child by the parents or guardians during the applicable time period under subparagraph (A), (B), or (C) of paragraph (1) shall not serve to interrupt the running of the time period. If at the end of the applicable time period, a child cannot be safely returned to the care and custody of a parent or guardian without court supervision, but the child clearly desires contact with the parent or guardian, the court shall take the child's desire into account in devising a permanency plan.

(C) In cases where the child was under three years of age on the date of the initial removal from the physical custody of the child's parent or guardian or is a member of a sibling group as described in subparagraph (C) of paragraph (1), the court shall inform the parent or guardian that the failure of the parent or guardian to participate regularly in any court-ordered treatment programs or to cooperate or avail themselves of services provided as part of the child welfare services case plan may result in a termination of efforts to reunify the family after six months. The court shall inform the parent or guardian of the factors used in subdivision (e) of Section 366.21 to determine whether to limit services to six months for some or all members of a sibling group as described in subparagraph (C) of paragraph (1).

(4) (A) Notwithstanding paragraph (3), court-ordered services may be extended up to a maximum time period not to exceed 24 months after the date the child was originally removed from physical custody of the child's parent or guardian if it is shown, at the hearing held pursuant to paragraph (1) of subdivision (b) of Section 366.22, that the permanent plan for the child is that the child will be returned and safely maintained in the home within the extended time period. The court shall extend the time period only if it finds that, (i) it is in the child's best interest to have the time period extended and that there is a substantial probability that the child will be returned to the physical custody of the child's parent or guardian who is described in subdivision (b) of Section 366.22 within the extended time period, (ii) reasonable services have not been provided to the parent or guardian, or (iii) in the case of an Indian child, active efforts, as defined in subdivision (f) of Section 224.1, to reunite the child with their family have not been made. If the court extends the time period, the court shall specify the factual basis for its conclusion that there is a substantial probability that the child will be returned to the physical custody

of the child's parent or guardian within the extended time period, or that reasonable services have not been provided to the parent or guardian. The court also shall make findings pursuant to subdivision (a) of Section 366 and subdivision (e) of Section 358.1.

(B) When counseling or other treatment services are ordered, the parent or guardian shall be ordered to participate in those services, in order for substantial probability to be found. Physical custody of the child by the parents or guardians during the applicable time period under subparagraph (A), (B), or (C) of paragraph (1) shall not serve to interrupt the running of the time period. If at the end of the applicable time period, the child cannot be safely returned to the care and custody of a parent or guardian without court supervision, but the child clearly desires contact with the parent or guardian, the court shall take the child's desire into account in devising a permanency plan.

(C) Except in cases where, pursuant to subdivision (b), the court does not order reunification services, the court shall inform the parent or parents of Section 366.26 and shall specify that the parent's or parents' parental rights may be terminated.

(b) Reunification services need not be provided to a parent or guardian described in this subdivision when the court finds, by clear and convincing evidence, any of the following:

(1) That the whereabouts of the parent or guardian are unknown. A finding pursuant to this paragraph shall be supported by an affidavit or by proof that a reasonably diligent search has failed to locate the parent or guardian. The posting or publication of notices is not required in that search.

(2) That the parent or guardian is suffering from a mental disability that is described in Chapter 2 (commencing with Section 7820) of Part 4 of Division 12 of the Family Code and that renders the parent or guardian incapable of utilizing those services.

(3) That the child or a sibling of the child has been previously adjudicated a dependent pursuant to any subdivision of Section 300 as a result of physical or sexual abuse, that following that adjudication the child had been removed from the custody of the child's parent or guardian pursuant to Section 361, that the child has been returned to the custody of the parent or guardian from whom the child had been taken originally, and that the child is being removed pursuant to Section 361, due to additional physical or sexual abuse.

(4) That the parent or guardian of the child has caused the death of another child through abuse or neglect.

(5) That the child was brought within the jurisdiction of the court under subdivision (e) of Section 300 because of the conduct of that parent or guardian.

(6) (A) That the child has been adjudicated a dependent pursuant to any subdivision of Section 300 as a result of severe sexual abuse or the infliction of severe physical harm to the child, a sibling, or a half sibling by a parent or guardian, as defined in this subdivision, and the court makes a factual finding that it would not benefit the child to pursue reunification services with the offending parent or guardian.

(B) A finding of severe sexual abuse, for the purposes of this subdivision, may be based on, but is not limited to, sexual intercourse, or stimulation involving genital-genital, oral-genital, anal-genital, or oral-anal contact, whether between the parent or guardian and the child or a sibling or half sibling of the child, or between the child or a sibling or half sibling of the child and another person or animal with the actual or implied consent of the parent or guardian; or the penetration or manipulation of the child's, sibling's, or half sibling's genital organs or rectum by any animate or inanimate object for the sexual gratification of the parent or guardian, or for the sexual gratification of another person with the actual or implied consent of the parent or guardian.

(C) A finding of the infliction of severe physical harm, for the purposes of this subdivision, may be based on, but is not limited to, deliberate and serious injury inflicted to or on a child's body or the body of a sibling or half sibling of the child by an act or omission of the parent or guardian, or of another individual or animal with the consent of the parent or guardian; deliberate and torturous confinement of the child, sibling, or half sibling in a closed space; or any other torturous act or omission that would be reasonably understood to cause serious emotional damage.

(7) That the parent is not receiving reunification services for a sibling or a half sibling of the child pursuant to paragraph (3), (5), or (6).

(8) That the child was conceived by means of the commission of an offense listed in Section 288 or 288.5 of the Penal Code, or by an act committed outside of this state that, if committed in this

state, would constitute one of those offenses. This paragraph only applies to the parent who committed the offense or act.

(9) That the child has been found to be a child described in subdivision (g) of Section 300; that the parent or guardian of the child willfully abandoned the child, and the court finds that the abandonment itself constituted a serious danger to the child; or that the parent or other person having custody of the child voluntarily surrendered physical custody of the child pursuant to Section 1255.7 of the Health and Safety Code. For the purposes of this paragraph, "serious danger" means that without the intervention of another person or agency, the child would have sustained severe or permanent disability, injury, illness, or death. For purposes of this paragraph, "willful abandonment" shall not be construed as actions taken in good faith by the parent without the intent of placing the child in serious danger.

(10) (A) That the court ordered termination of reunification services for any siblings or half siblings of the child because the parent or guardian failed to reunify with the sibling or half sibling after the sibling or half sibling had been removed from that parent or guardian pursuant to Section 361 and that parent or guardian is the same parent or guardian described in subdivision (a) and that, according to the findings of the court, this parent or guardian has not subsequently made a reasonable effort to treat the problems that led to removal of the sibling or half sibling of that child from that parent or guardian.

(B) This paragraph does not apply if the only times the court ordered termination of reunification services for any siblings or half siblings of the child were when the parent was a minor parent, a nonminor dependent parent, or adjudged a ward of the juvenile court pursuant to Section 601 or 602. For purposes of this subparagraph, "minor parent" and "nonminor dependent parent" have the same meaning as in Section 16002.5.

(11) (A) That the parental rights of a parent over any sibling or half sibling of the child had been permanently severed, and this parent is the same parent described in subdivision (a), and that, according to the findings of the court, this parent has not subsequently made a reasonable effort to treat the problems that led to removal of the sibling or half sibling of that child from the parent.

(B) This paragraph does not apply if the only times the court permanently severed parental rights over any siblings or half siblings of the child were when the parent was a minor parent, a nonminor dependent parent, or adjudged a ward of the juvenile court pursuant to Section 601 or 602. For purposes of this subparagraph, "minor parent" and "nonminor dependent parent" have the same meaning as in Section 16002.5.

(12) That the parent or guardian of the child has been convicted of a violent felony, as defined in subdivision (c) of Section 667.5 of the Penal ~~Code.~~ *Code, against a child.*

(13) That the parent or guardian of the child has a history of extensive, abusive, and chronic use of drugs or alcohol and has resisted prior court-ordered treatment for this problem during a three-year period immediately prior to the filing of the petition that brought that child to the court's attention, or has failed or refused to comply with a program of drug or alcohol treatment described in the case plan required by Section 358.1 on at least two prior occasions, even though the programs identified were available and accessible. For purposes of this paragraph, "resisted" means the parent or guardian refused to participate meaningfully in a prior court-ordered drug or alcohol treatment program and does not include "passive resistance," as described in In re B.E. (2020) 46 Cal.App.5th 932.

(14) (A) That the parent or guardian of the child has advised the court that the parent or guardian is not interested in receiving family maintenance or family reunification services or having the child returned to or placed in the parent's or guardian's custody and does not wish to receive family maintenance or reunification services.

(B) The parent or guardian shall be represented by counsel and shall execute a waiver of services form to be adopted by the Judicial Council. The court shall advise the parent or guardian of any right to services and of the possible consequences of a waiver of services, including the termination of parental rights and placement of the child for adoption. The court shall not accept the waiver of services unless it states on the record its finding that the parent or guardian has knowingly and intelligently waived the right to services.

(15) That the parent or guardian has on one or more occasions willfully abducted the child or child's sibling or half sibling from

their placement and refused to disclose the child's or child's sibling's or half sibling's whereabouts, refused to return physical custody of the child or child's sibling or half sibling to their placement, or refused to return physical custody of the child or child's sibling or half sibling to the social worker.

(16) That the parent or guardian has been required by the court to be registered on a sex offender registry under the federal Adam Walsh Child Protection and Safety Act of 2006 (42 U.S.C. Sec. 16913(a)), as required in Section 106(b)(2)(B)(xvi)(VI) of the federal Child Abuse Prevention and Treatment Act (42 U.S.C. Sec. 5106a(2)(B)(xvi)(VI)).

(17) That the parent or guardian knowingly participated in, or permitted, the sexual exploitation, as described in subdivision (c) or (d) of Section 11165.1 of, or subdivision (c) of Section 236.1 of, the Penal Code, of the child. This shall not include instances in which the parent or guardian demonstrated by a preponderance of the evidence that the parent or guardian was coerced into permitting, or participating in, the sexual exploitation of the child.

(c) (1) In deciding whether to order reunification in any case in which this section applies, the court shall hold a dispositional hearing. The social worker shall prepare a report that discusses whether reunification services shall be provided. When it is alleged, pursuant to paragraph (2) of subdivision (b), that the parent is incapable of utilizing services due to mental disability, the court shall order reunification services unless competent evidence from mental health professionals establishes that, even with the provision of services, the parent is unlikely to be capable of adequately caring for the child within the time limits specified in subdivision (a).

(2) The court shall not order reunification for a parent or guardian described in paragraph (3), (4), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), or (17) of subdivision (b) unless the court finds, by clear and convincing evidence, that reunification is in the best interest of the child.

(3) In addition, the court shall not order reunification in any situation described in paragraph (5) of subdivision (b) unless it finds that, based on competent evidence, those services are likely to prevent reabuse or continued neglect of the child or that failure to try reunification will be detrimental to the child because the child is closely and positively attached to that parent. The social worker shall investigate the circumstances leading to the removal

of the child and advise the court whether there are circumstances that indicate that reunification is likely to be successful or unsuccessful and whether failure to order reunification is likely to be detrimental to the child.

(4) The failure of the parent to respond to previous services, the fact that the child was abused while the parent was under the influence of drugs or alcohol, a past history of violent behavior, or testimony by a competent professional that the parent's behavior is unlikely to be changed by services are among the factors indicating that reunification services are unlikely to be successful. The fact that a parent or guardian is no longer living with an individual who severely abused the child may be considered in deciding that reunification services are likely to be successful, provided that the court shall consider any pattern of behavior on the part of the parent that has exposed the child to repeated abuse.

(d) If reunification services are not ordered pursuant to paragraph (1) of subdivision (b) and the whereabouts of a parent become known within six months of the out-of-home placement of the child, the court shall order the social worker to provide family reunification services in accordance with this subdivision.

(e) (1) If the parent or guardian is incarcerated, institutionalized, or detained by the United States Department of Homeland Security, or has been deported to the parent's or guardian's country of origin, the court shall order reasonable services unless the court determines, by clear and convincing evidence, those services would be detrimental to the child. In determining detriment, the court shall consider the age of the child, the degree of parent-child bonding, the length of the sentence, the length and nature of the treatment, the nature of the crime or illness, the degree of detriment to the child if services are not offered and, for children 10 years of age or older, the child's attitude toward the implementation of family reunification services, the likelihood of the parent's discharge from incarceration, institutionalization, or detention within the reunification time limitations described in subdivision (a), and any other appropriate factors. In determining the content of reasonable services, the court shall consider the particular barriers to an incarcerated, institutionalized, detained, or deported parent's access to those court-mandated services and ability to maintain contact with the child, and shall document this information in the child's case plan. Reunification services are

subject to the applicable time limitations imposed in subdivision (a). Services may include, but shall not be limited to, all of the following:

(A) Maintaining contact between the parent and child through collect telephone calls.

(B) Transportation services, when appropriate.

(C) Visitation services, when appropriate.

(D) (i) Reasonable services to extended family members or foster parents providing care for the child if the services are not detrimental to the child.

(ii) An incarcerated or detained parent may be required to attend counseling, parenting classes, or vocational training programs as part of the reunification service plan if actual access to these services is provided. The social worker shall document in the child's case plan the particular barriers to an incarcerated, institutionalized, or detained parent's access to those court-mandated services and ability to maintain contact with the child.

(E) Reasonable efforts to assist parents who have been deported to contact child welfare authorities in their country of origin, to identify any available services that would substantially comply with case plan requirements, to document the parents' participation in those services, and to accept reports from local child welfare authorities as to the parents' living situation, progress, and participation in services.

(2) The presiding judge of the juvenile court of each county may convene representatives of the county welfare department, the sheriff's department, and other appropriate entities for the purpose of developing and entering into protocols for ensuring the notification, transportation, and presence of an incarcerated or institutionalized parent at all court hearings involving proceedings affecting the child pursuant to Section 2625 of the Penal Code. The county welfare department shall utilize the prisoner locator system developed by the Department of Corrections and Rehabilitation to facilitate timely and effective notice of hearings for incarcerated parents.

(3) Notwithstanding any other law, if the incarcerated parent is a woman seeking to participate in the community treatment program operated by the Department of Corrections and Rehabilitation pursuant to Chapter 4.8 (commencing with Section

1174) of Title 7 of Part 2 of, Chapter 4 (commencing with Section 3410) of Title 2 of Part 3 of, the Penal Code, the court shall determine whether the parent's participation in a program is in the child's best interest and whether it is suitable to meet the needs of the parent and child.

(4) Parents and guardians in custody prior to conviction shall not be denied reunification services pursuant to paragraph (1). In determining the content of reasonable services, the court shall consider the particular barriers to an incarcerated, institutionalized, detained, or deported parent's or guardian's access to those court-mandated services and ability to maintain contact with the child, and shall document this information in the child's case plan. Reunification services are subject to the applicable time limitations imposed in subdivision (a). Nothing in this paragraph precludes denial of reunification services pursuant to subdivision (b).

(f) If the court, pursuant to paragraph (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), or (17) of subdivision (b) or paragraph (1) of subdivision (e), does not order reunification services, it shall, at the dispositional hearing, that shall include a permanency hearing, determine if a hearing under Section 366.26 shall be set in order to determine whether adoption, guardianship, placement with a fit and willing relative, or another planned permanent living arrangement, or, in the case of an Indian child, in consultation with the child's tribe, tribal customary adoption, is the most appropriate plan for the child, and shall consider in-state and out-of-state placement options. If the court so determines, it shall conduct the hearing pursuant to Section 366.26 within 120 days after the dispositional hearing. However, the court shall not schedule a hearing so long as the other parent is being provided reunification services pursuant to subdivision (a). The court may continue to permit the parent to visit the child unless it finds that visitation would be detrimental to the child.

(g) (1) Whenever a court orders that a hearing shall be held pursuant to Section 366.26, including, when, in consultation with the child's tribe, tribal customary adoption is recommended, it shall direct the agency supervising the child and the county adoption agency, or the State Department of Social Services when it is acting as an adoption agency, to prepare an assessment that shall include:

(A) Current search efforts for an absent parent or parents and notification of a noncustodial parent in the manner provided for in Section 291.

(B) A review of the amount of and nature of any contact between the child and the child's parents and other members of the child's extended family since the time of placement. Although the extended family of each child shall be reviewed on a case-by-case basis, "extended family" for the purpose of this subparagraph shall include, but not be limited to, the child's siblings, grandparents, aunts, and uncles.

(C) (i) An evaluation of the child's medical, developmental, scholastic, mental, and emotional status.

(ii) The evaluation pursuant to clause (i) shall include, but is not limited to, providing a copy of the complete health and education summary as required under Section 16010, including the name and contact information of the person or persons currently holding the right to make educational decisions for the child.

(iii) In instances where it is determined that disclosure pursuant to clause (ii) of the contact information of the person or persons currently holding the right to make educational decisions for the child poses a threat to the health and safety of that individual or those individuals, that contact information shall be redacted or withheld from the evaluation.

(D) A preliminary assessment of the eligibility and commitment of any identified prospective adoptive parent or guardian, including a prospective tribal customary adoptive parent, particularly the caretaker, to include a social history, including screening for criminal records and prior referrals for child abuse or neglect, the capability to meet the child's needs, and the understanding of the legal and financial rights and responsibilities of adoption and guardianship. If a proposed guardian is a relative of the minor, the assessment shall also consider, but need not be limited to, all of the factors specified in subdivision (a) of Section 361.3 and in Section 361.4. As used in this subparagraph, "relative" means an adult who is related to the minor by blood, adoption, or affinity within the fifth degree of kinship, including stepparents, stepsiblings, and all relatives whose status is preceded by the words "great," "great-great," or "grand," or the spouse of any of those persons even if the marriage was terminated by death or dissolution. If the proposed permanent plan is guardianship with

an approved relative caregiver for a minor eligible for aid under the Kin-GAP Program, as provided for in Article 4.7 (commencing with Section 11385) of Chapter 2 of Part 3 of Division 9, "relative" as used in this section has the same meaning as "relative" as defined in subdivision (c) of Section 11391.

(E) The relationship of the child to any identified prospective adoptive parent or guardian, including a prospective tribal customary parent, the duration and character of the relationship, the degree of attachment of the child to the prospective relative guardian or adoptive parent, the relative's or adoptive parent's strong commitment to caring permanently for the child, the motivation for seeking adoption or guardianship, a statement from the child concerning placement and the adoption or guardianship, and whether the child over 12 years of age has been consulted about the proposed relative guardianship arrangements, unless the child's age or physical, emotional, or other condition precludes the child's meaningful response, and, if so, a description of the condition.

(F) An analysis of the likelihood that the child will be adopted if parental rights are terminated.

(G) In the case of an Indian child, in addition to subparagraphs (A) to (F), inclusive, an assessment of the likelihood that the child will be adopted, when, in consultation with the child's tribe, a tribal customary adoption, as defined in Section 366.24, is recommended. If tribal customary adoption is recommended, the assessment shall include an analysis of both of the following:

(i) Whether tribal customary adoption would or would not be detrimental to the Indian child and the reasons for reaching that conclusion.

(ii) Whether the Indian child cannot or should not be returned to the home of the Indian parent or Indian custodian and the reasons for reaching that conclusion.

(2) (A) A relative caregiver's preference for legal guardianship over adoption, if it is due to circumstances that do not include an unwillingness to accept legal or financial responsibility for the child, shall not constitute the sole basis for recommending removal of the child from the relative caregiver for purposes of adoptive placement.

(B) Regardless of a relative caregiver's immigration status, a relative caregiver shall be given information regarding the

permanency options of guardianship and adoption, including the long-term benefits and consequences of each option, prior to establishing legal guardianship or pursuing adoption. If the proposed permanent plan is guardianship with an approved relative caregiver for a minor eligible for aid under the Kin-GAP Program, as provided for in Article 4.7 (commencing with Section 11385) of Chapter 2 of Part 3 of Division 9, the relative caregiver shall be informed about the terms and conditions of the negotiated agreement pursuant to Section 11387 and shall agree to its execution prior to the hearing held pursuant to Section 366.26. A copy of the executed negotiated agreement shall be attached to the assessment.

(h) If, at any hearing held pursuant to Section 366.26, a guardianship is established for the minor with an approved relative caregiver and juvenile court dependency is subsequently dismissed, the minor shall be eligible for aid under the Kin-GAP ~~Program~~ *Program*, as provided for in Article 4.5 (commencing with Section 11360) or Article 4.7 (commencing with Section 11385), as applicable, of Chapter 2 of Part 3 of Division 9.

(i) In determining whether reunification services will benefit the child pursuant to paragraph (6) or (7) of subdivision (b), the court shall consider any information it deems relevant, including the following factors:

(1) The specific act or omission comprising the severe sexual abuse or the severe physical harm inflicted on the child or the child's sibling or half sibling.

(2) The circumstances under which the abuse or harm was inflicted on the child or the child's sibling or half sibling.

(3) The severity of the emotional trauma suffered by the child or the child's sibling or half sibling.

(4) Any history of abuse of other children by the offending parent or guardian.

(5) The likelihood that the child may be safely returned to the care of the offending parent or guardian within 12 months with no continuing supervision.

(6) Whether or not the child desires to be reunified with the offending parent or guardian.

(j) When the court determines that reunification services will not be ordered, it shall order that the child's caregiver receive the child's birth certificate in accordance with Sections 16010.4 and

16010.5. Additionally, when the court determines that reunification services will not be ordered, it shall order, when appropriate, that a child who is 16 years of age or older receive the child's birth certificate.

(k) The court shall read into the record the basis for a finding of severe sexual abuse or the infliction of severe physical harm under paragraph (6) of subdivision (b), and shall also specify the factual findings used to determine that the provision of reunification services to the offending parent or guardian would not benefit the child.

SEC. 2. To the extent that this act has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation within the meaning of Section 36 of Article XIII of the California Constitution, it shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Any new program or higher level of service provided by a local agency pursuant to this act above the level for which funding has been provided shall not require a subvention of funds by the state or otherwise be subject to Section 6 of Article XIII B of the California Constitution.

O

ASSEMBLY THIRD READING
AB 2282 (McKinnor)
As Introduced February 8, 2024
Majority vote

SUMMARY

Makes more parents and guardians whose children are in the foster care system eligible for services that could allow them to reunify with their child.

Major Provisions
Removes the presumption in current law that a parent or guardian who has been convicted of a violent felony is ineligible for services to reunify with their child, so long as the parent or guardian is not convicted of a violent felony against a child.

COMMENTS

Many parents in the foster care system have also been involved in the criminal justice system. Both of these systems have a disparate impact on communities of color. In fact, 11.4% of Black children and 3.5% of Latino children have an incarcerated parent (as opposed to 1.8% of white children). It is not uncommon for parents in the juvenile dependency court to have a prior conviction for a felony offense, including an offense that meets the definition of a "violent felony." Current law makes a parent or guardian who has been convicted of a "violent felony" presumptively ineligible for services designed for them to reunify with their child in the foster care system.

This bill, co-sponsored by Los Angeles Dependency Lawyers and Dependency Legal Services, modifies state law so that more parents and guardians whose children are in the foster care system would qualify for services that *could* allow them to reunify with their children. Specifically, it would modify existing law so that a parent or guardian who has been convicted of violent felony would be eligible for reunification services, so long as their conviction were not for a violent felony against a child. This change in the law would align California with the vast majority of other states and effectively allow more parents with past felony convictions to have the *opportunity* to reunify with their children in the foster care system.

Reunification services. When it is necessary for a child to be removed from the home of their parent or guardian, the primary objective of the child welfare system is to safely reunify the child with those caregivers. To support this objective, in most cases the juvenile court orders reunification services, such as counseling for the family and parenting classes and drug or alcohol treatment for the child's parents. If the child is under the age of three, these reunification services are only offered for a period of six months. If the child is over the age of three, the services are offered for twelve months. In some circumstances, the time period for reunification services can be extended up to 24 months.

During dependency proceedings, a court must hold periodical review hearings at least every six months, including at six and 12 months after the dispositional hearing. (Welfare & Institutions Code (WIC) Section 366.21(e)(1).) At each hearing, except for the permanency and permanency review hearings, the court must find by clear and convincing evidence that the parent was adequately provided reunification services. At a permanency hearing, a judge must find, also by clear and convincing evidence, that reunification services were provided. (WIC Section 366.26.)

Barriers to Parents with Criminal Convictions Reunifying with their Children. Reunification services must be provided to most parents. In a number of exceptional cases, however, reunification services "need not" be provided if the court finds, by clear and convincing evidence, that one of the following specified conditions exist:

1) The parent is suffering from a mental disability that renders the parent incapable of using the reunification services;

2) The parent has caused the death of another child through abuse or neglect;

3) The child or a sibling of the child has on more than one occasion been adjudicated a dependent as a result of physical or sexual abuse and removed from the custody of the parent or guardian because of such abuse;

4) *The parent has been convicted of a violent felony*; or

5) The parent has a history of drug or alcohol abuse and has failed to comply with treatment programs as provided. (WIC Section 361.5(b).)

Under current law, a parent who previously was convicted of a violent felony is presumed to be ineligible for the services necessary to reunify with their child, even when the underlying conviction occurred decades in the past and/or long before they became a parent. While a court *may* order that reunification services to be provided to the parent, such an order can only be made when the court finds, by clear and convincing evidence, that reunification is in the child's best interest. (WIC Section 361.5(c)(2) - (4).) The restriction in current law, making all parents and guardians who have been convicted of a "violent felony" presumptively ineligible to reunify with their children, arguably is a vestige of outmoded generalizations about -- and prejudice against -- parents who have prior involvement with the prison system.

Comparison to the law in other states. California's restriction on parental eligibility for reunification services appears to be far more restrictive than the vast majority of other states. According to background provided to the Committee by the author, two states – Montana and New Mexico – have no restriction whatsoever on the provision of reunification services to parents based upon their past criminal history. On the other extreme, California and Illinois are the only two states that deny reunification services to a parent who has been convicted of a violent felony. Virtually all other states have restrictions that are somewhere in between these two extremes. If California were to modify its law in the manner proposed by this bill, it would join 32 other states that restrict reunification services to parents based upon their prior conviction for a crime only when the conviction was for a violent felony involving a child.

No restriction related to a criminal conviction: Montana, New Mexico

Restrictions for violent crimes involving a child: Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Iowa, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Wisconsin, Wyoming

Restrictions for violent crimes involving the other parent or child: Alabama, Alaska, Florida, Massachusetts, Nebraska, New Hampshire, South Carolina, Utah, Virginia, Washington, West Virginia

Restrictions for murder or manslaughter: Idaho, Nevada

Restrictions for any murder, manslaughter, or felony battery: Kansas

Restrictions for any violent felony: California and Illinois

This bill only makes a parent eligible for reunification services, like the vast majority of parents. A parent who is provided with reunification services is not guaranteed to be reunified with their child. Rather, should they participate in such services and make progress in their parenting skills and relationship with their child by means of those services, they will have the *opportunity* – by the end of the period when those services are required to be provided – to be reunified. A juvenile court would continue to review the parent's progress toward reunification with their child at hearings every six months.

As the author points out, "[P]eople should not have their past held against them and violent felony convictions do not dictate how well of a parent someone will be. These people have served their time and should be given a chance to reunite with their children. Also when people are released from prison, one way to reduce recidivism is to reunite them with their family and especially their children."

According to the Author

AB 2282 seeks to help reunite families by allowing people with a past violent felony conviction the opportunity to be reunited with their children. This would benefit children by increasing the likelihood that they can return safely to their family, therefore reducing the need for foster placements. Furthermore this would help formerly incarcerated parents retain the positive family relationships that reduce recidivism.

Arguments in Support

Dependency Advocacy Center writes the following to explain why the bill is an important measure for equity, as well as child safety:

At Dependency Advocacy Center, through the work we have done supporting parents on probation and with criminal justice system involvement, it is apparent that the reasons for criminal justice system involvement are nuanced and multifaceted. Many of the parents we work with have criminal convictions that predate them becoming parents, or where their conviction is predicated on a theory of accomplice liability where they were not the violent actor or the result of a plea bargain where the potential collateral child welfare consequences of that criminal conviction were not thoroughly explained. We have countless success stories of parents with violent criminal convictions changing the trajectory of their lives and not only being safe parents for their children but role models for children, for other parents, and for the community.

By narrowing the circumstances in which a parent with a criminal history can be denied an opportunity to reunify with their child, this bill will benefit children by increasing the likelihood that they can return safely to their families and thus reduce the need for children to remain in foster care. Furthermore, by protecting and promoting family relationships between

formerly incarcerated parents and their children, this bill incidentally helps to support recidivism as well.

Arguments in Opposition
No opposition on file.

FISCAL COMMENTS

According to the Assembly Appropriations analysis, costs (local funds, General Fund) of an unknown but potentially significant amount to county child welfare agencies. This bill expands eligibility for reunification services to parents with specified criminal convictions, who are not currently eligible to receive such services. Actual costs will depend on the volume of court-ordered reunification services that must be provided to newly-eligible parents. Although these county costs are mandated by the state, they are not reimbursable, but instead must be paid by the state pursuant to Proposition 30 of 2012. Proposition 30 provides that legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by realignment (including child welfare services and foster care) applies to local agencies only to the extent the state provides annual funding for the cost increase.

VOTES

ASM JUDICIARY: 8-0-4
YES: Kalra, Ting, Bryan, Connolly, Haney, McKinnor, Pacheco, Reyes
ABS, ABST OR NV: Dixon, Maienschein, Sanchez, Waldron

ASM HUMAN SERVICES: 5-1-1
YES: Lee, Calderon, Gipson, Jackson, Ortega
NO: Essayli
ABS, ABST OR NV: Mathis

ASM APPROPRIATIONS: 11-2-2
YES: Wicks, Arambula, Bryan, Calderon, Wendy Carrillo, Mike Fong, Grayson, Haney, Hart, Pellerin, Villapudua
NO: Sanchez, Jim Patterson
ABS, ABST OR NV: Dixon, Ta

UPDATED

VERSION: February 8, 2024

CONSULTANT: Alison Merrilees / JUD. / (916) 319-2334 FN: 0002992

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 5(d)(2) Watch Bills – AB 2862 (Gipson) Licenses: African American applicants

Background

On February 15, 2024, AB 2862 was introduced by Assembly Member Gipson.

Current law prescribes requirements for licensure and regulation of various businesses and professions, including healing arts and real estate businesses and professions, by various boards, bureaus, commissions, committees, and departments.

AB 2862 would require various business and professions, including healing arts board under the Department of Consumer Affairs to prioritize African American applicants seeking licensure, especially applicants who are descended from a person who was enslaved in the United States.

On March 11, 2024, AB 2862 was referred to the Assembly Committee on Business and Professions and Judiciary.

On April 12, 2024, AB 2862 was presented to the Legislative and Regulatory Affairs Committee for possible position recommendation, which the committee determined to watch AB 2862.

On April 17, 2024, AB 2862 was amended to include that the provision will remain in effect until January 1, 2029.

On April 18, 2024, AB 2862 passed the Committees on Business and Professions and Judiciary.

On April 23, 2024, AB 2862 was referred to the Committee on Appropriations.

On May 16, 2024, AB 2862 passed the Committee on Appropriations.

Board Staff is continuing to monitor AB 2862.

Action Requested

This item is for informational purposes only. There is no action required at this time.

Attachment #1: AB 2862 Bill Text
Attachment #2: AB 2862 – Assembly Floor Analysis

AMENDED IN ASSEMBLY APRIL 17, 2024

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 2862

Introduced by Assembly Member Gipson
(Coauthors: Assembly Members Juan Carrillo and Lowenthal)

February 15, 2024

An act to add ~~Division 1.1 (commencing with Section 473) to~~ *and repeal Section 115.7 of* the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2862, as amended, Gipson. ~~Licenses:~~ *Department of Consumer Affairs:* African American applicants.

Existing law ~~prescribes requirements for licensure and regulation of various businesses and professions, including healing arts and real estate businesses and professions, by various boards, bureaus, commissions, committees, and departments.~~ *establishes the Department of Consumer Affairs, which is composed of specified boards that license and regulate various professions.*

This bill would require *those* boards to prioritize African American applicants seeking licenses under these provisions, especially applicants who are descended from a person enslaved in the United States. The bill would ~~define various terms for these purposes.~~ *repeal those provisions on January 1, 2029.*

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 115.7 is added to the Business and Professions Code, to read:

115.7. (a) Notwithstanding any other law, a board shall prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States.

(b) This section shall remain in effect only until January 1, 2029, and as of that date is repealed.

~~SECTION 1. Division 1.1 (commencing with Section 473) is added to the Business and Professions Code, to read:~~

~~DIVISION 1.1. PRIORITIZATION OF LICENSES~~

~~473. (a) For purposes of this division:~~

~~(1) "Board" includes "bureau," "commission," "committee," "department," "division," "examining committee," "program," and "agency."~~

~~(2) "License" includes certificate, registration, or other means to engage in a business or profession regulated by this code.~~

~~(b) Notwithstanding any other law, a board shall prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States.~~

O

ASSEMBLY THIRD READING
AB 2862 (Gipson)
As Amended April 17, 2024
Majority vote

SUMMARY

Requires state licensing boards under the Department of Consumer Affairs (DCA) to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States, until January 1, 2029.

Major Provisions

1) Requires boards to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States.

2) Provides that the provisions of the bill shall remain in effect only until January 1, 2029.

COMMENTS

Expedited Licensure. The DCA consists of 36 boards, bureaus, and other entities responsible for licensing, certifying, or otherwise regulating professionals in California. As of March 2023, there are over 3.4 million licensees overseen by programs under the DCA, including health professionals regulated by healing arts boards under Division 2 of the Business and Professions Code. Each licensing program has its own unique requirements, with the governing acts for each profession providing for various prerequisites including prelicensure education, training, and examination. Most boards additionally require the payment of a fee and some form of background check for each applicant.

The average length of time between the submission of an initial license application and approval by an entity under the DCA can vary based on a number of circumstances, including increased workload, delays in obtaining an applicant's criminal history, and deficiencies in an application. Boards typically set internal targets for application processing timelines and seek adequate staffing in an effort to meet those targets consistently. License processing timelines are then regularly evaluated through the Legislature's sunset review oversight process.

The first expedited licensure laws specifically related to the unique needs of military families. The Syracuse University Institute for Veterans and Military Families found that up to 35% of military spouses are employed in fields requiring licensure. Because each state possesses its own licensing regime for professional occupations, military family members are required to obtain a new license each time they move states, with one-third of military spouses reportedly moving four or more times while their partner is on active duty. Because of the barriers encountered by military family members who seek to relocate their licensed work to a new state, it is understood that continuing to work in their field is often challenging if not impossible.

In an effort to address these concerns, Assembly Bill 1904 (Block) was enacted in 2012 to require boards and bureaus under the DCA to expedite the licensure process for military spouses and domestic partners of a military member who is on active duty in California. Two years later, Senate Bill 1226 (Correa) was enacted to similarly require boards and bureaus under the DCA to expedite applications from honorably discharged veterans, with the goal of enabling these individuals to quickly transition into civilian employment upon retiring from service.

Statute requires entities under the DCA to annually report the number of applications for expedited licensure that were submitted by veterans and active-duty spouses and partners. For example, in Fiscal Year 2022-23, the MBC received 14 applications from military spouses or partners and 101 applications from honorably discharged veterans subject to expedited processing. In 2023, the federal Servicemembers Civil Relief Act (SCRA) imposed new requirements on states to recognize qualifying out-of-state licenses for service members and their spouses. This new form of enhanced license portability potentially displaces the need for expedited licensure for these applicants.

A decade after the first expedited licensure laws were enacted for military families, the Legislature enacted Assembly Bill 2113 (Low) in 2020 to require licensing entities under the DCA to expedite licensure applications for refugees, asylees, and Special Immigrant Visa holders. The intent of this bill was to address the urgency of allowing those forced to flee their homes to restart their lives upon acceptance into California with refugee status. It is understood that the population of license applicants who have utilized this new expedited licensure program across all DCA entities is, to date, relatively small.

Subsequently in 2022, the Legislature enacted Assembly Bill 657 (Cooper) to add another category of applicants eligible for expedited licensure. This bill required the MBC, OMBC, the BRN, and the PAB to expedite the license application for an applicant who demonstrates that they intend to provide abortions. This bill was passed in the wake of the Supreme Court's decision to overturn *Roe v. Wade*, which led to concerns that with approximately half of all states likely to seek to ban abortion, patients in those states would come to California to receive abortion services, creating a swell in demand for abortion providers. Assembly Bill 657 was passed to ensure that there is an adequate health care provider workforce to provide urgent reproductive care services.

State Efforts to Provide Reparations to Descendants of Slavery. In 2020, the Legislature enacted Assembly Bill 3121 (Weber), which established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States. The bill's findings and declarations acknowledged that "more than 4,000,000 Africans and their descendants were enslaved in the United States and the colonies that became the United States from 1619 to 1865." The bill further found that as "a result of the historic and continued discrimination, African Americans continue to suffer debilitating economic, educational, and health hardships," including, among other hardships, "an unemployment rate more than twice the current white unemployment rate."

The Task Force created by AB 3121 was given responsibility for studying and developing reparation proposals for African Americans as a result of slavery and numerous subsequent forms of discrimination based on race. The Task Force was then required to recommend appropriate remedies in consideration of its findings, which were submitted as a report to the Legislature on June 29, 2023. The *California Reparations Report*, drafted with staff assistance from the California Department of Justice, totals over a thousand pages and provides a comprehensive history of the numerous past injustices and persistent inequalities and discriminatory practices. The report also includes a number of recommendations for how the state should formally apologize for slavery, provide compensation and restitution, and address the pervasive effects of enslavement and other historical atrocities.

Chapter 10 of the Task Force's report, titled "Stolen Labor and Hindered Opportunity," addresses how African Americans have historically been excluded from occupational licenses. As discussed in the report, "state licensure systems worked in parallel to exclusion by unions and professional societies in a way that has been described by scholars as "particularly effective" in excluding Black workers from skilled, higher paid jobs. White craft unions implemented unfair tests, conducted exclusively by white examiners to exclude qualified Black workers."

The report additionally describes how as the use of licensure to regulate jobs increased beginning in the 1950s, African American workers continued to be excluded from economic opportunity, in large part due to laws disqualifying licenses for applicants with criminal records, which disproportionately impacted African Americans. This specific issue was previously addressed in California through the Legislature's enactment of Assembly Bill 2138 (Chiu/Low) in 2018, which reduced barriers to licensure for individuals with prior criminal histories by limiting the discretion of most regulatory boards to deny a new license application to cases where the applicant was formally convicted of a substantially related crime or subjected to formal discipline by a licensing board, with nonviolent offenses older than seven years no longer eligible for license denial.

In its discussion of issues relating to professional licensure, the Task Force concludes by stating that "while AB 2138 represents progress, other schemes remain in California which continue to have a racially discriminatory impact." The Task Force then provides several recommendations on how the Legislature could "expand on AB 2138." This includes a recommendation in favor of "prioritizing African American applicants seeking occupational licenses, especially those who are descendants [of slavery]."

On January 31, 2024, the California Legislative Black Caucus announced the introduction of the 2024 Reparations Priority Bill Package, consisting of a series of bills introduced by members of the caucus to implement the recommendations in the Task Force's report. As part of that package, this bill seeks to implement the Task Force's recommendation by requiring boards to prioritize African American applicants seeking licenses, especially applicants who are descended from a person enslaved in the United States. This requirement would be similar to existing expedited licensure processes for military families, refugee applicants, and abortion providers. While this bill would only represent a single step in what could be considered a long journey toward addressing the malignant consequences of slavery and systemic discrimination, the author believes it would meaningfully address the specific impact those transgressions have had on African Americans seeking licensure in California.

According to the Author
"AB 2465 would provide an imperative initiative of the prioritization of African Americans when seeking occupational licenses, especially those who are descendants of slaves. There has been historical long-standing deficiencies and internal barriers to African Americans seeking professional work, and by prioritizing their applications, we are bridging the gap of professional inequities of under representation and under compensation."

Arguments in Support
The California African American Chamber of Commerce supports this bill, writing: "By prioritizing African American applicants, especially those with ancestral ties to slavery, AB 2862 seeks to promote equity and provide opportunities for economic advancement within our community. This legislation is crucial in fostering diversity and inclusivity in various industries,

paving the way for greater representation and participation of African Americans in the workforce. Furthermore, AB 2862 aligns with the California African American Chamber of Commerce's mission to drive economic opportunity and wealth creation for African American businesses. By ensuring fair access to licensure, this bill contributes to our overarching goal of promoting economic empowerment and prosperity for African American entrepreneurs and professionals across the state."

Arguments in Opposition
The Pacific Legal Foundation (PLF) writes in opposition to this bill: "Fewer barriers to entering the workforce, not more, will meaningfully advance opportunity in California. Barriers based on race are especially odious and detrimental. Licensing laws already hinder opportunity, and the government does not need to make things worse by injecting racial discrimination into the system." The PLF further argues that this bill violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations, minor and absorbable workload to various boards and bureaus within the DCA; five programs with a non-absorbable impact totaling $1.04 million; and one-time costs of $168,000 to the DCA's Office of Information Services.

VOTES

ASM BUSINESS AND PROFESSIONS: 13-2-3
YES: Berman, Bains, Juan Carrillo, Grayson, Irwin, Jackson, Ward, Lowenthal, McKinnor, Stephanie Nguyen, Pellerin, Soria, Zbur
NO: Dixon, Sanchez
ABS, ABST OR NV: Flora, Alanis, Chen

ASM JUDICIARY: 9-2-1
YES: Kalra, Bauer-Kahan, Bryan, Connolly, Haney, Maienschein, McKinnor, Pacheco, Reyes
NO: Dixon, Sanchez
ABS, ABST OR NV: Waldron

ASM APPROPRIATIONS: 11-4-0
YES: Wicks, Arambula, Bryan, Calderon, Wendy Carrillo, Mike Fong, Grayson, Haney, Hart, Pellerin, Villapudua
NO: Sanchez, Dixon, Jim Patterson, Ta

UPDATED

VERSION: April 17, 2024

CONSULTANT: Robert Sumner / B. & P. / (916) 319-3301 FN: 0002994

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MEMORANDUM

DATE	June 14, 2024
TO	Legislative and Regulatory Affairs Committee Members
FROM	Troy Polk, Legislative and Regulatory Analyst
SUBJECT	Agenda Item 7(a),(b),(c),(d),(e),(f),(g) – Regulatory Update

The following is a list of the Board of Psychology's (Board) remaining regulatory packages, and their status in the regulatory process:

a) Update on 16 CCR sections 1391.13 and 1391.14 – Inactive Psychological Associates Registration and Reactivating a Psychological Associate Registration

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

This package is in the Production Stage. Revised proposed regulatory language was adopted at the May 19, 2023, Board Meeting. At the August 18, 2023, Board Meeting the Board resolved additional issues regarding the inactive timeframe, and voted to adopt the proposed regulatory language as amended. On December 15, 2023, the DCA Budget Office completed the fiscal impact of this rulemaking.

On January 18, 2024, Board Staff submitted the regulation package to the Regulations Coordinator to be submitted for review by the DCA Director and the Business Consumer Services and Housing Agency (Agency).

On January 28, 2024, the regulation package was approved by the DCA Director, and on January 30, 2024, the regulations package was submitted to Agency.

On March 21, 2024, the regulatory package was approved by Agency and sent to OAL for approval of publishing. The regulatory package was approved for publishing by OAL. The 45-day public comment period started on April 5, 2024, and was completed on May 21, 2024. Board Staff is currently drafting final documentation for final submission.

b) Update on 16 CCR sections 1395.2 – Disciplinary Guidelines and Uniform Standards Related to Substance Abusing Licensees

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

This package is in the Production Stage. This phase includes Board-approved Text, and collaborative reviews by Board staff, legal counsel, and Budget staff to prepare the initial documents for submission to the Director and Agency.

At the August 18, 2023, Board Meeting the Board voted to adopt the proposed regulatory language and staff is preparing the initial submission documents for DCA and Agency review before filing with OAL for notice publication.

c) Update on 16 CCR sections 1380.3, 1381.1, 1381.2, 1381.4, 1381.5, 1382, 1382.3, 1382.4, 1382.5, 1386, 1387.1, 1387.2, 1387.3, 1387.4, 1387.5, 1387.6, 1391, 1391.1, 1391.3, 1391.4, 1391.5, 1391.6, 1391.8, 1391.11, and 1391.12 – Pathways to Licensure

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

d) Update on 16 CCR sections 1380.6, 1393, 1396, 1396.1, 1396.2, 1396.4, 1396.5, 1397, 1397.1, 1397.2, 1397.35, 1397.37, 1397.39, 1397.50, 1397.51, 1397.52, 1397.53, 1397.54, 1397.55 - Enforcement Provisions

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

e) Update on 16 CCR sections 1397.35 – 1397.40 - Corporations

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

f) Update on 16 CCR sections 1381, 1387.10, 1388, 1388.6, 1389, and 1389.1 – EPPP-2

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

On May 19, 2023, the Board approved the statutory and regulatory changes to implement the EPPP part 2 Skills Exam, effective January 1, 2026.

On May 10, 2024, the Board approved the amendment to the regulatory language.

g) Update on 16 CCR sections 1367, 1367.1, 1367.2, 1368, 1369, 1370, 1371, 1373, 1373.1, 1374, 1375, 1376, 1376.1, 1377, 1377.5, 1378, 1378.5– Research Psychoanalyst

Preparing Regulatory Package	Initial Departmental Review	Notice with OAL and Hearing	Notice of Modified Text and Hearing	Preparation of Final Documentation	Final Departmental Review	Submission to OAL for Review	OAL Approval and Board Implementation

Drafting Phase. This phase includes preparation of the regulatory package and collaborative reviews by Board staff and legal counsel.

On April 12, 2024, The Research Psychoanalyst Ad Hoc Committee (Committee) agreed with Counsel's advice that two regulatory packages should be pursued for the creation of regulations for Research Psychoanalysts.

On May 10, 2024, the Board approved the adoption of the amended regulations with non-material changes added for necessity and clarity to move the current regulations from the Medical Board of California to the Board of Psychology.

Action Requested:

No action required at this time. This is for informational purposes only.