Legislative and Regulatory Affairs Committee Report and Board Action.

The following documents are attached:

A. The June 14, 2012, Committee meeting minutes.
B. The April 3, 2013, Committee meeting minutes.
C. Pending legislation, including:
   i. Assembly Bill (AB) 186 (Maienschein), Professions and vocations: military spouses: temporary licenses.
   ii. AB 213 (Logue and Pan), Healing arts: licensure and certification requirements: military experience.
   iii. AB 582 (Chesbro), Medi-Cal: custom rehabilitation technology services.
   iv. AB 633 (Salas) Emergency medical services: civil liability.
   v. AB 809 (Logue), Healing arts: telehealth.
   vi. AB 864 (Skinner), Athletic trainers.
   vii. AB 894 (Mansoor), Consumer affairs.
   viii. AB 1000 (Wieckowski), Physical therapists: direct access to services.
   ix. AB 1003 (Maienschein), Professional corps: healing arts practitioners
   x. AB 1013 (Gomez), Consumer affairs.
   xi. AB 1017 (Gomez), Incoming telephone calls: messages.
   xii. AB 1147(Gomez), Masage therapy.
   xiii. AB 1231 (Perez) Regional centers: telehealth and teledentistry.
   xiv. Senate Bill (SB) 138 (Hernandez), Confidentiality of medical information.
   xv. SB 158 (Correa), Autism services: demonstration program
   xvi. SB 305 (Price) Healing arts: boards.
   xvii. SB 306 (Price), Healing arts: boards.
   xviii. SB 381 (Yee), Healing arts: chiropractic practice.
   xix. SB 555 (Correa), Developmental services: individual program plans and individual family service plans.
   xx. SB 626 (Beall), Workers' compensation.
   xxi. SB 809 (DeSaulnier and Steinberg), Controlled substances: reporting.
   xxii. SB 816 (Committee on Health), Hospice facilities: developmental disabilities: intellectual disability.

BILL NUMBER: AB 186 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 22, 2013
AMENDED IN ASSEMBLY APRIL 1, 2013

INTRODUCED BY Assembly Member Maienschein
(Principal coauthor: Assembly Member Hagman)
(Coauthors: Assembly Members *Chávez,* Dahle, Donnelly, Beth Gaines, *Grove,* Harkey, Olsen, and Patterson)
(Coauthors: Senators Fuller and Huff)

JANUARY 28, 2013

An act to amend Section 115.5 of the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 186, as amended, Maienschein. Professions and vocations: military spouses: temporary licenses.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a license to practice within that field in another jurisdiction, as specified. *Existing law requires that the licensing fees imposed by certain boards within the department be deposited in funds that are continuously appropriated.* Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being 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 California under official active duty military orders.

~~This bill would authorize a board within the department to issue a provisional license to an applicant who qualifies for an expedited license pursuant to the above described provision. The~~

This bill would require a board within the department to issue a temporary license to an applicant who qualifies for, and requests, expedited licensure pursuant to the above-described provision if he or she meets specified requirements. The bill would require the temporary license to expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first. The bill would authorize a board to conduct an investigation of an applicant for purposes of denying or revoking a temporary license, and would authorize a criminal background check as part of that investigation. The bill would require an applicant seeking a temporary license to submit an application to the board that includes a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, as specified. The bill would also require the application to include written verification from the applicant's

original licensing jurisdiction stating that the applicant's license is in good standing.

This bill would prohibit a ~~provisional~~ *temporary* license from being provided to any applicant who has committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license at the time the act was ~~committed, or~~ *committed. The bill would provide that a violation of the above-described provision may be grounds for the denial or revocation of a temporary license. The bill would further prohibit a temporary license from being provided to any applicant who* has been disciplined by a licensing entity in another jurisdiction, or is the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. ~~The bill would require the board to approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested. The bill would require the provisional license to expire after 18 months or at the issuance of the expedited license.~~

The bill would require an applicant, upon request by a board, to furnish a full set of fingerprints for purposes of conducting a criminal background check.

~~By creating provisional licenses for which a fee may be collected and deposited into a continuously appropriated fund, this bill would make an appropriation.~~

Because the bill would authorize the expenditure of continuously appropriated funds for a new purpose, the bill would make an appropriation.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 115.5 of the Business and Professions Code is amended to read:

115.5. (a) A board within the department shall expedite the licensure process for an applicant who meets both of the following requirements:

(1) Supplies evidence satisfactory to the board that the applicant 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 who is assigned to a duty station in this state under official active duty military orders.

(2) Holds a current license in another state, district, or territory of the United States in the profession or vocation for which he or she seeks a license from the board.

~~(b) (1) For each applicant who is eligible for an expedited license pursuant to subdivision (a) and meets the requirements in paragraph (2), the board shall provide a provisional license while the board processes the application for licensure. The board shall approve a provisional license based on an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested. The provisional license shall expire 18 months after issuance or upon issuance of the expedited license.~~

(b) (1) A board shall, after appropriate investigation, issue a temporary license to an applicant who is eligible for, and requests,

expedited licensure pursuant to subdivision (a) if the applicant meets the requirements described in paragraph (3). The temporary license shall expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first.

(2) The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this subdivision. This investigation may include a criminal background check.

(3) (A) An applicant seeking a temporary license issued pursuant to this subdivision shall submit an application to the board which shall include a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, to the best of his or her knowledge. The application shall also include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.

~~(2) (A)~~

(B) The applicant shall not have 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. *A violation of this subparagraph may be grounds for the denial or revocation of a temporary license issued by the board.*

~~(B)~~

(C) The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

(D) The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.

(c) A board may adopt regulations necessary to administer this section.

BILL NUMBER: AB 213 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 18, 2013
AMENDED IN ASSEMBLY APRIL 15, 2013
AMENDED IN ASSEMBLY APRIL 1, 2013

INTRODUCED BY Assembly Member Logue
(Principal coauthor: Assembly Member Pan)
(Coauthors: Assembly Members Conway, Beth Gaines, Harkey, Jones, Morrell, Nestande, and Wilk)

JANUARY 31, 2013

An act to add Section 712 to the Business and Professions Code, and to add Section 131136 to the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 213, as amended, Logue. Healing arts: licensure and certification requirements: military experience.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Existing law requires the rules and regulations of these healing arts boards to provide for methods of evaluating education, training, and experience obtained in military service if such training is applicable to the requirements of the particular profession or vocation regulated by the board. Under existing law, specified other healing arts professions and vocations are licensed or certified and regulated by the State Department of Public Health. In some instances, a board with the Department of Consumer Affairs or the State Department of Public Health approves schools offering educational course credit for meeting licensing or certification qualifications and requirements.

This bill would require the State Department of Public Health, upon the presentation of evidence by an applicant for licensure or certification, to accept education, training, and practical experience completed by an applicant in military service toward the qualifications and requirements to receive a license or certificate for specified professions and vocations if that education, training, or experience is equivalent to the standards of the department. If a board within the Department of Consumer Affairs or the State Department of Public Health accredits or otherwise approves schools offering educational course credit for meeting licensing and certification qualifications and requirements, the bill would, not later than January 1, 2015, require those schools seeking accreditation or approval to have procedures in place to evaluate an applicant's military education, training, and practical experience toward the completion of an educational program that would qualify a person to apply for licensure or certification, as specified.

Under existing law, the Department of Veterans Affairs has specified powers and duties relating to various programs serving veterans. Under existing law, the Chancellor of the California State University and the Chancellor of the California Community Colleges have specified powers and duties relating to statewide health education programs.

With respect to complying with the bill's requirements and obtaining specified funds to support compliance with these provisions, this bill would require the Department of Veterans Affairs, the Chancellor of the California State University, and the Chancellor of the California Community Colleges to provide technical assistance to the healing arts boards within the Department of Consumer Affairs, the State Department of Public Health, and to the schools offering, or seeking to offer, educational course credit for meeting licensing qualifications and requirements.

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. This act shall be known, and may be cited, as the Veterans Health Care Workforce Act of 2013.

SEC. 2. (a) The Legislature finds and declares all of the following:

(1) Lack of health care providers continues to be a significant barrier to access to health care services in medically underserved urban and rural areas of California.

(2) Veterans of the United States Armed Forces and the California National Guard gain invaluable education, training, and practical experience through their military service.

(3) According to the federal Department of Defense, as of June 2011, one million veterans were unemployed nationally and the jobless rate for post-9/11 veterans was 13.3 percent, with young male veterans 18 to 24 years of age experiencing an unemployment rate of 21.9 percent.

(4) According to the federal Department of Defense, during the 2011 federal fiscal year, 8,854 enlisted service members with medical classifications separated from active duty.

(5) According to the federal Department of Defense, during the 2011 federal fiscal year, 16,777 service members who separated from active duty listed California as their state of residence.

(6) It is critical, both to veterans seeking to transition to civilian health care professions and to patients living in underserved urban and rural areas of California, that the Legislature ensures that veteran applicants for licensure by healing arts boards within the Department of Consumer Affairs or the State Department of Public Health are expedited through the qualifications and requirements process.

(b) It is the intent of the Legislature to ensure that boards within the Department of Consumer Affairs and the State Department of Public Health and schools offering educational course credit for meeting licensing qualifications and requirements fully and expeditiously recognize and provide credit for an applicant's military education, training, and practical experience.

SEC. 3. Section 712 is added to the Business and Professions Code, to read:

712. (a) Not later than January 1, 2015, if a board under this division accredits or otherwise approves schools offering educational course credit for meeting licensing qualifications and requirements, the board shall require a school seeking accreditation or approval to submit to the board proof that the school has procedures in place to evaluate, upon presentation of satisfactory evidence by the applicant, the applicant's military education, training, and practical experience toward the completion of an educational program that would qualify a person to apply for licensure if the school

determines that the education, training, or practical experience is equivalent to the standards of the board. A board that requires a school to be accredited by a national organization shall not impose requirements on the school that conflict with the standards of the national organization.

(b) With respect to ~~complying~~ *compliance* with the requirements of this section , including the determination of equivalency between the education, training, or practical experience of an applicant and the board's standards, and obtaining state, federal, or private funds to support compliance with this section, the Department of Veterans Affairs, the Chancellor of the California State University, and the Chancellor of the California Community Colleges shall provide technical assistance to the boards under this division and to the schools under this section.

(c) Nothing in this section shall interfere with an educational, certification, or licensing requirement or standard set by a licensing entity or certification board or other appropriate healing arts regulatory agency or entity, to practice health care in the state.

SEC. 4. Section 131136 is added to the Health and Safety Code, to read:

131136. (a) Notwithstanding any other provision of law, the department shall, upon the presentation of satisfactory evidence by an applicant for licensure or certification in one of the professions described in subdivision (b), accept the education, training, and practical experience completed by the applicant as a member of the United States Armed Forces or Military Reserves of the United States, the national guard of any state, the military reserves of any state, or the naval militia of any state, toward the qualifications and requirements for licensure or certification by the department if the department determines that the education, training, or practical experience is equivalent to the standards of the department.

(b) The following professions are subject to this section:

(1) Medical laboratory technician as described in Section 1260.3 of the Business and Professions Code.

(2) Clinical laboratory scientist as described in Section 1261 of the Business and Professions Code.

(3) Radiologic technologist as described in Chapter 6 (commencing with Section 114840) of Part 9 of Division 104.

(4) Nuclear medicine technologist as described in Chapter 4 (commencing with Section 107150) of Part 1 of Division 104.

(5) Certified nurse assistant as described in Article 9 (commencing with Section 1337) of Chapter 2 of Division 2.

(6) Certified home health aide as described in Section 1736.1.

(7) Certified hemodialysis technician as described in Section 1247.61 of the Business and Professions Code.

(8) Nursing home administrator as described in Section 1416.2.

(c) Not later than January 1, 2015, if the department accredits or otherwise approves schools offering educational course credit for meeting licensing and certification qualifications and requirements, the department shall require a school seeking accreditation or approval to submit to the board proof that the school has procedures in place to fully accept an applicant's military education, training, and practical experience toward the completion of an educational program that would qualify a person to apply for licensure or certification if the school determines that the education, training, or practical experience is equivalent to the standards of the department. If the department requires a school to be accredited by a national organization, the requirement of the department shall not, in any way, conflict with standards set by the national organization.

(d) With respect to complying with the requirements of this section including the determination of equivalency between the education, training, or practical experience of an applicant and the department's standards, and obtaining state, federal, or private funds to support compliance with this section, the Department of Veterans Affairs, the Chancellor of the California State University, and the Chancellor of the California Community Colleges shall provide technical assistance to the department, to the State Public Health Officer, and to the schools described in this section.

(e) Nothing in this section shall interfere with an educational, certification, or licensing requirement or standard set by a licensing entity or certification board or other appropriate healing arts regulatory agency or entity, to practice health care in California.

BILL NUMBER: AB 582 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 1, 2013

INTRODUCED BY Assembly Member Chesbro

FEBRUARY 20, 2013

An act to ~~amend~~ *repeal and add* Section 14105.485 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 582, as amended, Chesbro. Medi-Cal: ~~custom~~ *complex* rehabilitation ~~technology services.~~ *technology.*

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires the department to establish a list of covered services and maximum allowable reimbursement rates for durable medical equipment and requires the list to be published in provider manuals. *Existing law requires a provider of custom rehabilitation equipment and custom rehabilitation technology services, as defined, to have a qualified rehabilitation professional on staff, as prescribed, and requires a medical provider to conduct a physical examination of an individual before prescribing a motorized wheelchair or scooter for a Medi-Cal beneficiary.*

~~This bill would require the department, for purposes of establishing reimbursement rates, to recognize custom rehabilitation technology services, as defined, as a separate benefit.~~

This bill would recast these provisions to apply to complex rehabilitation technology, as defined. The bill would require that complex rehabilitation technology be recognized as a separate benefit by the Medi-Cal program in both fee-for-service and managed care delivery systems and would require that the technology be reimbursed through a specified methodology. The bill would require complex rehabilitation technology be subject to a prior authorization process, as specified, and would authorize the department to adopt additional utilization controls, as appropriate.

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. It is the intent of the Legislature to do all of the following:

(a) Provide the support necessary for patients with complex rehabilitation technology needs to stay in their homes or community settings, prevent avoidable institutionalization, and reduce secondary medical complications.

(b) Ensure adequate access to appropriate complex rehabilitation technology and support services for complex needs patients.

(c) Recognize the value of preventive and specialized services in the treatment of complex needs patients.

(d) Acknowledge the importance of the hands-on professional resources required for effective evaluation and configuration of complex rehabilitation technology.

(e) Establish or improve safeguards related to the delivery of complex rehabilitation technology.

(f) Ensure cost efficiency in the provision of complex rehabilitation technology.

SEC. 2. Section 14105.485 of the Welfare and Institutions Code is repealed.

~~14105.485. (a) Commencing July 1, 2006, any provider of custom rehabilitation equipment and custom rehabilitation technology services to a Medi-Cal beneficiary shall have on staff, either as an employee or independent contractor, or have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment.~~

~~(b) Commencing January 1, 2006, a medical provider shall conduct a physical examination of an individual before prescribing a motorized wheelchair or scooter for a Medi-Cal beneficiary. The medical provider shall complete a certificate of medical necessity, developed by the department, that documents the medical condition that necessitates the motorized wheelchair or scooter, and verifies that the patient is capable of using the wheelchair or scooter safely.~~

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

~~(1) "Custom rehabilitation equipment" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.~~

~~(2) "Custom rehabilitation technology services" means the application of enabling technology systems designed and assembled to meet the needs of a specific person experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate, the documentation of medical necessity, the selection, fit, customization, maintenance, assembly, repair, replacement, pick up and delivery, and testing of equipment and parts, and the training of an assistant caregiver and of a patient who will use the equipment or individuals who will assist the client in using the equipment.~~

~~(3) "Qualified rehabilitation professional" means an individual to whom any one of the following applies:~~

~~(A) The individual is a physical therapist licensed pursuant to the Business and Professions Code, occupational therapist licensed~~

~~pursuant to the Business and Professions Code, or other qualified health care professional approved by the department.~~

~~(B) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers (NRRTS), or other credentialing organization recognized by the department.~~

~~(C) The individual has successfully passed one of the following credentialing examinations administered by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).~~

~~(i) The Assistive Technology Supplier examination.~~

~~(ii) The Assistive Technology Practitioner examination.~~

~~(iii) The Rehabilitation Engineering Technologist examination.~~

SEC. 3. Section 14105.485 is added to the Welfare and Institutions Code , to read:

14105.485. (a) For purposes of this section, the following definitions apply:

(1) "Complex rehabilitation technology" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Complex rehabilitation technology includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs, and seating systems that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.

(2) "Complex rehabilitation technology services" includes the application of enabling systems designed and assembled to meet the needs of a patient experiencing any permanent or long-term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate; the documentation of medical necessity; the selection, fit, customization, maintenance, assembly, repair, replacement, pick up and delivery, and testing of equipment and parts; and the training of an assistant caregiver and of the patient who will use the technology or individuals who will assist the complex needs patient in using the technology.

(3) "Complex rehabilitation technology provider" means a company or entity that complies with all of the following:

(A) Meets the supplier and quality standards established for a durable medical equipment supplier under the Medicare Program and is enrolled as a provider in the Medi-Cal program.

(B) Is accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology.

(C) Employs or contracts with at least one qualified rehabilitation technology professional for each distribution location.

(D) Has the qualified rehabilitation technology professional physically present for the evaluation and determination of the complex rehabilitation technology provided.

(E) Maintains a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians, and provides patients with prompt services and repair for all complex rehabilitation technology supplied.

(4) "Qualified rehabilitation technology professional" means an individual to whom any one of the following applies:

(A) The individual is a physical therapist licensed pursuant to Chapter 5.7 (commencing with Section 2600) of Division 2 of the Business and Professions Code, occupational therapist licensed pursuant to Chapter 5.6 (commencing with Section 2570) of Division 2 of the Business and Professions Code, or other qualified health care professional approved by the department.

(B) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers (NRRTS), and holds the designation of Certified Complex Rehabilitation Technology Specialist.

(C) The individual has successfully passed the credentialing examination and received the credential of Assistive Technology Professional (ATP) from the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(b) Complex rehabilitation technology shall be recognized as a separate benefit by the Medi-Cal program in both fee-for-service and managed care delivery systems.

(c) Any provider of complex rehabilitation technology to a Medi-Cal beneficiary shall have on staff, either as an employee or independent contractor, or have a contractual relationship with, a qualified rehabilitation technology professional who is directly involved in determining the specific complex rehabilitation technology needs of the patient and is directly involved with, or closely supervised, in the final fitting and delivery of the complex rehabilitation technology.

(d) A medical provider shall conduct a physical examination of a patient who is a Medi-Cal beneficiary before prescribing complex rehabilitation technology. The medical provider shall complete a certificate of medical necessity, developed by the department, that documents the medical condition that necessitates the technology and verifies that the patient is capable of using the technology safely.

(e) Notwithstanding Section 14133.05, complex rehabilitation technology shall be subject to a prior authorization process in which services are approved based on the medical, physical, and functional needs of the patient, as demonstrated in documents prescribed by the department. Prior authorization may be obtained through the treatment authorization request process set forth in Section 51321 of Title 22 of the California Code of Regulations. The department may adopt additional utilization controls for complex rehabilitation technology, as appropriate.

(f) (1) Subject to paragraph (2), complex rehabilitation technology shall be reimbursed through the methodology described in Section 14105.48.

(2) Notwithstanding Section 14105.48, the upper billing limit calculated pursuant to Section 51008.1 of Title 22 of the California Code of Regulations for complex rehabilitation technology shall reflect both net acquisition cost and labor cost attributable to the product or service, as determined from a labor index provided by a nationally recognized professional organization selected by the department based on the organization's expertise in the provision of complex rehabilitation technology. If a claim for an item of complex rehabilitation technology contains multiple claim lines or multiple Healthcare Common Procedure Coding System (HCPCS) codes, the upper billing limit calculation shall be based on the sum of multiple lines or multiple codes associated with the completed item, with the addition of labor costs calculated as described in this subdivision.

(g) Contracts initiated by the department with managed care plans shall be consistent with the requirements of this section.

~~SECTION 1. Section 14105.485 of the Welfare and~~

~~Institutions Code is amended to read:~~

~~14105.485. (a) Commencing July 1, 2006, any provider of custom rehabilitation equipment and custom rehabilitation technology services to a Medi-Cal beneficiary shall have on staff, either as an employee or independent contractor, or have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment.~~

~~(b) Commencing January 1, 2006, a medical provider shall conduct a physical examination of an individual before prescribing a motorized wheelchair or scooter for a Medi-Cal beneficiary. The medical provider shall complete a certificate of medical necessity, developed by the department, that documents the medical condition that necessitates the motorized wheelchair or scooter, and verifies that the patient is capable of using the wheelchair or scooter safely.~~

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

~~(1) "Custom rehabilitation equipment" means any item, piece of equipment, or product system, whether modified or customized, that is used to increase, maintain, or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, nonstandard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based on patient height, weight, and disability, specialized wheelchair electronics and cushions, custom bath equipment, standers, gait trainers, and specialized strollers.~~

~~(2) "Custom rehabilitation technology services" means the application of enabling technology systems designed and assembled to meet the needs of a specific person experiencing any permanent or long term loss or abnormality of physical or anatomical structure or function with respect to mobility. These services include, but are not limited to, the evaluation of the needs of a patient with a disability, including an assessment of the patient for the purpose of ensuring that the proposed equipment is appropriate, the documentation of medical necessity, the selection, fit, customization, maintenance, assembly, repair, replacement, pick up and delivery, and testing of equipment and parts, and the training of an assistant caregiver and of a patient who will use the equipment or individuals who will assist the client in using the equipment.~~

~~(3) "Qualified rehabilitation professional" means an individual to whom any one of the following applies:~~

~~(A) The individual is a physical therapist licensed pursuant to the Business and Professions Code, occupational therapist licensed pursuant to the Business and Professions Code, or other qualified health care professional approved by the department.~~

~~(B) The individual is a registered member in good standing of the National Registry of Rehabilitation Technology Suppliers (NRRTS), or other credentialing organization recognized by the department.~~

~~(C) The individual has successfully passed one of the following credentialing examinations administered by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA):~~

~~(i) The Assistive Technology Supplier examination.~~

~~(ii) The Assistive Technology Practitioner examination.~~

~~(iii) The Rehabilitation Engineering Technologist examination.~~

~~(d) Notwithstanding Section 14105.48 or any other law, and for~~

~~purposes of establishing reimbursement rates, the department shall recognize custom rehabilitation technology services, as defined in paragraph (2) of subdivision (c), as a separate benefit.~~

BILL NUMBER: AB 633 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 17, 2013
AMENDED IN ASSEMBLY MARCH 19, 2013

INTRODUCED BY Assembly Member Salas

FEBRUARY 20, 2013

An act to add Section 1799.103 to the Health and Safety Code, relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 633, as amended, Salas. Emergency medical services: civil liability.

Under existing law, a person who, in good faith and not for compensation, renders emergency medical or nonmedical care or assistance at the scene of an emergency is not liable for civil damages resulting from any act or omission, except as specified. Existing law further provides that a person who has completed a basic cardiopulmonary resuscitation course that complies with specified standards, and who in good faith renders emergency cardiopulmonary resuscitation at the scene of an emergency is not liable for any civil damages as a result of any act or omission, except as specified. Existing law provides that a health care provider, including any licensed clinic, health dispensary, or health facility, is not liable for professional negligence or malpractice for any occurrence or result solely on the basis that the occurrence or result was caused by the natural course of a disease or condition, or was the natural or expected result of reasonable treatment rendered for the disease or condition.

This bill would prohibit an employer from having a policy ~~precluding~~ *prohibiting* an employee from providing *voluntary* emergency medical services, including, but not limited to, cardiopulmonary resuscitation, in response to a medical emergency *, except as specified* . The bill would provide that an ~~employer~~ *employee* is not liable for any civil damages resulting from an act or omission ~~of its employee who,~~ *when he or she,* in good faith and not for compensation, renders emergency care at the scene of an emergency *, except as specified* .

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1799.103 is added to the Health and Safety Code, to read:

1799.103. (a) *(1)* An employer shall not adopt or enforce a policy ~~precluding~~ *prohibiting* an employee from *voluntarily* providing emergency medical services, including, but not limited to, cardiopulmonary resuscitation, in response to a medical emergency.

~~(b) An employer shall not be liable for any civil damages~~

~~resulting from an act or omission of its employee who, in good faith and not for compensation, renders emergency care at the scene of an emergency.~~

(2) Section 1799.102 applies to an employee providing resuscitation pursuant to paragraph (1).

(b) This section shall not apply to any of the following facilities if there is a "do not resuscitate" or a Physician Orders for Life Sustaining Treatment form as defined in Section 4780 of the Probate Code, or an advance health care directive that prohibits resuscitation pursuant to Chapter 1 (commencing with Section 4670) of Part 2 of Division 4.7 of the Probate Code, in effect for the person upon whom the resuscitation would otherwise be performed:

(1) A long-term health care facility, as defined in Section 1418.

(2) A community care facility, as defined in Section 1502.

(3) A residential care facility for the elderly, as defined in Section 1569.2.

(4) An adult day health care center, as defined in Section 1570.7.

BILL NUMBER: AB 809 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 3, 2013

INTRODUCED BY Assembly Member Logue

FEBRUARY 21, 2013

An act to amend Sections 1626.2, 2290.5, 4980.01, 4982, 4989.54, 4992.3, 4996, and 4999.90 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would ~~delete those provisions~~ *instead require the health care provider at the originating site to provide the patient with a waiver for the course of treatment involving telehealth services to obtain informed consent for the agreed upon course of treatment. The bill would require the signed waiver to be contained in the patient's medical record* . The bill would make additional conforming changes.

This bill would declare that it is to take effect immediately as an urgency statute.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1626.2 of the Business and Professions Code is amended to read:

1626.2. A dentist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

SEC. 2. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at

the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider at the originating site shall provide the patient with a waiver for the course of treatment involving telehealth services to obtain informed consent for the agreed upon course of treatment. The signed waiver shall be contained in the patient's medical record.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a course of treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

~~(b)~~

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

~~(c)~~

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

~~(d)~~

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

~~(e)~~

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 3. Section 4980.01 of the Business and Professions Code is amended to read:

4980.01. (a) Nothing in this chapter shall be construed to constrict, limit, or withdraw the Medical Practice Act, the Social

Work Licensing Law, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Act.

(b) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination when performing counseling services as part of his or her pastoral or professional duties, or to any person who is admitted to practice law in the state, or who is licensed to practice medicine, when providing counseling services as part of his or her professional practice.

(c) (1) This chapter shall not apply to an employee working in any of the following settings if his or her work is performed solely under the supervision of the employer:

(A) A governmental entity.

(B) A school, college, or university.

(C) An institution that is both nonprofit and charitable.

(2) This chapter shall not apply to a volunteer working in any of the settings described in paragraph (1) if his or her work is performed solely under the supervision of the entity, school, or institution.

(d) A marriage and family therapist licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

(e) Notwithstanding subdivisions (b) and (c), all persons registered as interns or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.

SEC. 4. Section 4982 of the Business and Professions Code is amended to read:

4982. The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or

of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) 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 marriage and family therapist.

(l) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that

collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of any registered intern, associate clinical social worker, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

(u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

SEC. 5. Section 4989.54 of the Business and Professions Code is amended to read:

4989.54. The board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) Conviction of a crime substantially related to the qualifications, functions, and duties of an educational psychologist.

(1) The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.
(2) The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee under this chapter.
(3) A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee under this chapter shall be deemed to be a conviction within the meaning of this section.
(4) The board may order a license suspended or revoked, or may 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 the person to withdraw a plea of guilty and enter a plea of not guilty or setting aside the verdict of guilty or dismissing the accusation, information, or indictment.
(b) Securing a license by fraud, deceit, or misrepresentation on an application for licensure submitted to the board, whether engaged in by an applicant for a license or by a licensee in support of an application for licensure.
(c) Administering to himself or herself a controlled substance or using any of the dangerous drugs specified in Section 4022 or an alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to himself or herself or to any other person or to the public or to the extent that the use impairs his or her ability to safely perform the functions authorized by the license. The board shall deny an application for a license or revoke the license of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing educational psychology.
(d) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.
(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.
(f) Commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee.
(g) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action imposed by another state or territory or possession of the United States or by any other governmental agency, on a license, certificate, or registration to practice educational psychology or any other healing art. A certified copy of the disciplinary action, decision, or judgment shall be conclusive evidence of that action.
(h) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as an educational psychologist, a clinical social worker, professional clinical counselor, or marriage and family therapist.
(i) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.
(j) Gross negligence or incompetence in the practice of

educational psychology.

(k) Misrepresentation as to the type or status of a license held by the licensee or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(l) Intentionally or recklessly causing physical or emotional harm to any client.

(m) Engaging in sexual relations with a client or a former client within two years following termination of professional services, 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 educational psychologist.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients.

(p) Failing to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(q) Performing, holding himself or herself out as being able to perform, or offering to perform any professional services beyond the scope of the license authorized by this chapter or beyond his or her field or fields of competence as established by his or her education, training, or experience.

(r) Reproducing or describing in public, or in any publication subject to general public distribution, any psychological test or other assessment device the value of which depends in whole or in part on the naivete of the subject in ways that might invalidate the test or device. An educational psychologist shall limit access to the test or device to persons with professional interests who can be expected to safeguard its use.

(s) Aiding or abetting an unlicensed person to engage in conduct requiring a license under this chapter.

(t) When employed by another person or agency, encouraging, either orally or in writing, the employer's or agency's clientele to utilize his or her private practice for further counseling without the approval of the employing agency or administration.

(u) Failing to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(v) Failing to comply with the elder and adult dependent abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(y) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

(z) Impersonation of another by any licensee or applicant for a license, or, in the case of a licensee, allowing any other person to use his or her license.

(aa) Permitting a person under his or her supervision or control to perform, or permitting that person to hold himself or herself out as competent to perform, professional services beyond the level of education, training, or experience of that person.

SEC. 6. Section 4992.3 of the Business and Professions Code is amended to read:

4992.3. The board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application

for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under his or her care.

(d) Incompetence in the performance of clinical social work.

(e) An act or omission that falls sufficiently below the standard of conduct of the profession as to constitute an act of gross negligence.

(f) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(g) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(h) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(i) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(j) Intentionally or recklessly causing physical or emotional harm to any client.

(k) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(l) Engaging in sexual relations with a client or with a former client within two years from the termination date of therapy with the client, 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 clinical social worker.

(m) Performing, or holding one's self out as being able to perform, or offering to perform or permitting, any registered associate clinical social worker or intern under supervision to perform any professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(n) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(o) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(p) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this

subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (o).

(q) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(r) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device. A licensee shall limit access to that test or device to persons with professional interest who are expected to safeguard its use.

(s) Any conduct in the supervision of any registered associate clinical social worker, intern, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(t) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(u) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(v) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(x) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(y) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

SEC. 7. Section 4996 of the Business and Professions Code is amended to read:

4996. (a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor.

(b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing that person holds a valid, unexpired, and unrevoked license under this article.

(c) A clinical social worker licensed under this chapter is a

licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.

SEC. 8. Section 4999.90 of the Business and Professions Code is amended to read:

4999.90. The board may refuse to issue any registration or license, or may suspend or revoke the registration or license of any intern or licensed professional clinical counselor, if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing licensed professional clinical counseling services.

(d) Gross negligence or incompetence in the performance of licensed professional clinical counseling services.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee or registrant, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) 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 professional clinical counselor.

(l) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee, applicant, or registrant under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional clinical counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of a registered intern, associate clinical social worker, or clinical counselor trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a clinical counselor trainee or intern under one's supervision or control to perform, or permitting the clinical

counselor trainee or intern to hold himself or herself out as competent to perform, professional services beyond the clinical counselor trainee's or intern's level of education, training, or experience.

(u) The violation of any statute or regulation of the standards of the profession, and the nature of the services being rendered, governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failing to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Repeated acts of negligence.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

(ab) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a professional clinical counselor, clinical social worker, educational psychologist, or marriage and family therapist.

(ac) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers expected to occur with the implementation of the federal Patient Protection and Affordable Care Act, and the assistance that further implementation of telehealth can provide to help relieve these burdens, it is necessary for this act to take effect immediately.

BILL NUMBER: AB 864 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 1, 2013

INTRODUCED BY Assembly Member Skinner

FEBRUARY 21, 2013

An act to add Chapter 5.8 (commencing with Section 2697.2) to Division 2 of, and to repeal Section 2697.8 of, the Business and Professions Code, relating to athletic trainers.

LEGISLATIVE COUNSEL'S DIGEST

AB 864, as amended, Skinner. Athletic trainers.

Existing law provides for the regulation of various professions and vocations, including those of an athlete agent.

This bill would *enact the Athletic Training Practice Act which would* provide for the licensure and regulation of athletic trainers, as ~~defined, by~~ *defined. The bill would establish, until January 1, 2019,* the Athletic Trainer Licensing Committee ~~, to be established by the bill~~ within the Physical Therapy Board of California *to implement these provisions, including issuing and renewing athletic training licenses and imposing disciplinary action* . Under the bill, the committee would be comprised of 7 members, to be appointed to 4-year terms as specified. Commencing July 1, 2014, the bill would prohibit a person from practicing as an athletic trainer or using certain titles without a license issued by the committee *, except as specified. The bill would prohibit, on and after January 1, 2017, a person from using the title "athletic trainer," unless licensed by the committee* . The bill would specify the requirements for licensure, including the payment of a license application fee established by the committee. The bill would define the practice of athletic training and prescribe supervision requirements on athletic trainers. The bill would establish the Athletic Trainers' Account within the Physical Therapy Fund for the deposit of license application and renewal fees, and would make those fees available to the committee for the purpose of implementing these provisions upon appropriation by the Legislature.

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. The Legislature finds and declares the following:

(a) California is one of only two states that does not currently regulate the practice of athletic training. This continued lack of regulation creates the risk that individuals who have lost or are unable to obtain licensure in another state will come to California to practice, thereby putting the public in danger and degrading the standards of the profession as a whole.

(b) There is a pressing and immediate need to regulate the profession of athletic training in order to protect the public health, safety, and welfare. This need is particularly important because athletic trainers often work with school-age children.

SEC. 2. Chapter 5.8 (commencing with Section 2697.2) is added to Division 2 of the Business and Professions Code, to read:

CHAPTER 5.8. ATHLETIC TRAINERS

2697.2. This chapter shall be known and may be cited as the Athletic ~~Trainers~~ *Training* Practice Act.

2697.4. For the purposes of this chapter, the following definitions shall apply:

(a) "Athletic trainer" means a person who meets the requirements of this chapter, is licensed by the committee, and practices under the direction of a licensed physician or surgeon.

(b) "Board" means the Physical Therapy Board of California.

(c) "Committee" means the Athletic Trainer Licensing Committee.

2697.6. (a) ~~No~~ *A* person shall *not* engage in the practice of athletic training unless licensed pursuant to this chapter.

(b) ~~No~~ *A* person shall *not* use the title "athletic trainer," "licensed athletic trainer," "certified athletic trainer," "athletic trainer certified," "a.t.," "a.t.l.," "c.a.t.," "a.t.c.," or any other variation of these terms, or any other similar terms indicating that the person is an athletic trainer unless that person is licensed pursuant to this chapter.

(c) Notwithstanding subdivisions (a) and (b), a person who practiced athletic training in California for a period of 15 consecutive years prior to July 1, 2014, and is not eligible for an athletic training license may use the title "athletic trainer" without being licensed by the committee, upon registration with the board. However, on and after January 1, 2017, no person may use the title "athletic trainer" unless he or she is licensed by the committee pursuant to this chapter.

(d) This section shall become operative on July 1, 2014.

2697.8. (a) There is established the Athletic Trainer Licensing Committee within the Physical Therapy Board of California. The committee shall consist of seven members.

(b) The seven committee members shall include the following:

(1) Four licensed athletic trainers. Initially, the committee shall include four athletic trainers who have satisfied the requirements of subdivision (a) of Section 2697.12 and who will satisfy the remainder of the licensure requirements described in Section 2697.12 as soon as it is practically possible.

(2) One public member.

(3) One physician and surgeon licensed by the Medical Board of California or one osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California.

(4) One physical therapist licensed by the Physical Therapy Board of California.

(c) Subject to confirmation by the Senate, the Governor shall appoint two of the licensed athletic trainers, the public member, and the physician and surgeon or osteopathic physician and surgeon. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a licensed athletic trainer. The Physical Therapy Board of California shall appoint the licensed physical therapist.

(d) (1) All appointments shall be for a term of four years and shall expire on June 30 of the year in which the term expires. Vacancies shall be filled for any unexpired term.

(2) Notwithstanding paragraph (1), for initial appointments made on or after January 1, 2014, the public member appointed by the Governor shall serve a term of one year. The athletic trainers

appointed by the Senate Committee on Rules and the Speaker of the Assembly shall serve terms of three years, and the remaining members shall serve terms of four years.

(e) Each member of the committee shall receive per diem and expenses as provided in Section 103.

(f) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date. The repeal of this section renders the committee subject to the review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code.

2697.10. (a) The committee shall adopt, repeal, and amend regulations as may be necessary to enable it to carry into effect the provisions of this chapter. All regulations shall be in accordance with this chapter.

(b) In promulgating regulations, the committee may consult the professional standards issued by the National Athletic Trainers' Association (NATA), the Board of Certification, Inc. (BOC), the Commission on Accreditation of Athletic Training Education (CAATE), or any other nationally recognized professional organization.

(c) The committee shall approve programs for the education and training of athletic trainers.

(d) The committee shall investigate each applicant, before a license is issued, in order to determine whether the applicant meets the qualifications required by this chapter.

(e) Protection of the public shall be the highest priority for the committee 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.

2697.12. Except as otherwise provided in this chapter, the committee shall issue an athletic ~~trainer~~ *training* license to an applicant who meets all of the following requirements:

(a) Has submitted an application developed by the committee that includes evidence that the applicant has graduated from a professional degree program in athletic training accredited by the Commission on Accreditation of Athletic Training Education, or its predecessors or successors, and approved by the committee, at an accredited post-secondary institution or institutions approved by the ~~committee.~~

~~(b) - Has completed a program of professional education that includes~~ *committee. The professional degree program shall consist of* didactic, clinical, and research experiences in athletic training using critical thinking and weighing of evidence.

~~(c)~~

(b) Has passed ~~a written~~ *an* athletic training certification examination offered by the Board of Certification, Inc., its predecessors or successors, or another nationally accredited athletic trainer certification agency approved and recognized by the committee.

~~(d)~~

(c) Possesses an emergency cardiac care certification from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

~~(e)~~

(d) Has paid the application fee established by the

committee.

2697.14. Notwithstanding Section 2697.12, the committee shall issue an athletic ~~trainer~~ *training* license to an applicant who did not graduate from an accredited athletic training education program as described in subdivision (a) of Section 2697.12, but who received athletic training via an internship, if the applicant meets all of the following requirements:

(a) Furnishes evidence satisfactory to the committee of completion of a degree at an accredited post-secondary institution that included instruction in basic sciences related to, and on the practice of, athletic training.

(b) Passes the ~~written~~ examination described in subdivision ~~(c)~~ *(b)* of Section 2697.12.

(c) Completes at least 1500 hours of clinical experience under an athletic trainer certified by the Board of Certification, Inc.

(d) Possesses an emergency cardiac care certification from a certification body, approved by the committee, that adheres to the most current international guidelines for cardiopulmonary resuscitation and emergency cardiac care.

(e) Has paid the application fee established by the committee.

2697.16. A license issued by the committee pursuant to Section 2697.12 or 2697.14 shall be valid for two years and thereafter shall be subject to the renewal requirements described in Sections 2697.18 and 2697.20.

2697.18. The committee shall establish license application and renewal fees in an amount sufficient to cover the reasonable regulatory costs of carrying out this chapter.

2697.20. The committee shall renew a license if an applicant meets all of the following requirements:

(a) Pays the renewal fee as established by the committee.

(b) Submits proof of all of the following:

(1) Satisfactory completion of continuing education, as determined by the committee.

(2) Current athletic training certification from a certification body approved by te committee, including, but not limited to, the Board of Certification, Inc., or its predecessors or successors.

(3) Current emergency cardiac care certification meeting the requirements of subdivision (d) of Section 2697.12.

2697.21. (a) The committee may deny a license or the renewal of a license for an applicant or licensee who is described by any of the following:

(1) Does not meet the requirements of this chapter.

(2) Has had an athletic training license, certification, or registration revoked or suspended by an accredited organization, state, or territory.

(3) Has been convicted of a felony or any other crime that substantially relates to the functions or duties of an athletic trainer.

(4) Has committed unprofessional conduct, as described in subdivision (b).

(b) The committee may order any of the following actions relative to an athletic training license after a hearing for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, any regulation adopted by the committee pursuant to this chapter, and revocation or suspension of an athletic training license, certification, or registration by an accredited organization, state, or territory:

(1) Issuance of the athletic training license subject to terms and

conditions.

(2) Suspension or revocation of the athletic training license.

(3) Imposition of probationary conditions upon the athletic training license.

2697.22. (a) The practice of athletic training includes all of the following:

(1) ~~The professional treatment of a patient for risk~~ *Risk* management and injury or illness prevention.

(2) The clinical evaluation and assessment of ~~a patient for~~ an injury or an illness sustained or exacerbated while participating in physical activity, or both.

(3) The immediate care and treatment of ~~a patient for~~ an injury or an illness sustained or exacerbated while participating in physical activity, or both.

(4) The rehabilitation and reconditioning ~~of a patient~~ from *an* injury or ~~from~~ an illness sustained or exacerbated while participating in physical activity, or both.

(b) The practice of athletic training does not include the practice of physical therapy, the practice of medicine, the practice of osteopathic medicine, the practice of chiropractic medicine, *the practice of nursing,* or medical diagnosis or treatment.

(c) An athletic trainer shall refer a patient to an appropriate licensed health care provider when the treatment or management of the injury, illness, or condition does not fall within the practice of athletic training.

(d) An athletic trainer shall not provide, offer to provide, or represent that he or she is qualified to provide any treatment that he or she is not qualified to perform by his or her education, training, or experience, or that he or she is otherwise prohibited by law from performing.

(e) For purposes of this section, "injury" or "illness" means an injury or illness sustained as a result of, or exacerbated by, participation in athletics or physical activity for which the athletic trainer has had formal training during his or her professional education program, including nationally recognized educational competencies and clinical proficiencies for the entry-level athletic trainer or advanced post-professional study, and falls within the practice of athletic training.

(f) This section shall become operative on July 1, 2014.

2697.24. (a) An athletic trainer shall render treatment within his or her scope of practice under the direction of a physician and surgeon licensed by the Medical Board of California or an osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California. This direction shall be provided by verbal order when the directing physician and surgeon or osteopathic physician and surgeon is present and by written order or by athletic training treatment plans or protocols, to be established by the physician and surgeon or osteopathic physician and surgeon, when the directing physician and surgeon or osteopathic physician and surgeon is not present.

(b) Notwithstanding any other law, and consistent with this chapter, the committee may establish other alternative mechanisms for the adequate direction of an athletic trainer.

(c) This section shall become operative on July 1, 2014.

2697.26. The requirements of this chapter do not apply to the following:

(a) An athletic trainer licensed, certified, or registered in another state or ~~county~~ *country* who is in California temporarily, traveling with a team or organization, to

engage in the practice of athletic training for, among other things, an athletic or sporting event.

(b) An athletic trainer licensed, certified, or registered in another state who is invited by a sponsoring organization, such as the United States Olympic Committee, to temporarily provide athletic training services under his or her state's scope of practice for athletic training.

(c) A student enrolled in an athletic training education program, while participating in educational activities during the course of his or her educational rotations under the supervision and guidance of an athletic trainer licensed under this chapter or other licensed health care provider.

(d) A member or employee of the United States Armed Forces, licensed, certified, or registered in another state, as part of his or her temporary federal deployment or employment in California for a limited time.

2697.28. ~~Nothing in this chapter shall be construed to~~ *This chapter does not* limit, impair, or otherwise apply to the practice of any person licensed and regulated under any other chapter of Division 2 (commencing with Section 500).

2697.30. ~~Nothing in this chapter shall~~ *This chapter does not* require new or additional third party reimbursement for services rendered by an individual licensed under this chapter.

~~2697.32. The committee may order any of the following actions relative to an athletic trainer's license after a hearing for unprofessional conduct that includes, but is not limited to, a violation of this chapter, any regulations adopted by the committee pursuant to this chapter, or revocation or suspension of an athletic training license, certification, or registration.~~

~~(a) Denial of an application for the athletic trainer's license.~~

~~(b) Issuance of the athletic trainer's license subject to terms and conditions.~~

~~(c) Suspension or revocation of the athletic trainer's license.~~

~~(d) Imposition of probationary conditions upon the athletic trainer's license.~~

~~2697.34.~~ *2697.32.* The Athletic Trainers' Account is hereby established in the Physical Therapy Fund. All fees collected pursuant to this chapter shall be paid into the account. These fees shall be available to the committee, upon appropriation by the Legislature, for the regulatory purpose of implementing this chapter.

BILL NUMBER: AB 894 INTRODUCED
BILL TEXT

INTRODUCED BY Assembly Member Mansoor

FEBRUARY 22, 2013

An act to amend Section 302 of the Business and Professions Code, relating to consumer affairs.

LEGISLATIVE COUNSEL'S DIGEST

AB 894, as introduced, Mansoor. Consumer affairs.

Under existing law, the Department of Consumer Affairs is comprised of boards that license and regulate various professions and vocations. Existing law provides that these boards are established to ensure that private businesses and professions are regulated to protect the people of this state. Under existing law, the department is under the control of the Director of Consumer Affairs. The term "director" is defined for the purposes of these provisions.

This bill would make a technical, nonsubstantive change to that provision.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 302 of the Business and Professions Code is amended to read:

302. As used in this chapter, the following terms have the following meanings:

(a) "Department" means the Department of Consumer Affairs.

(b) "Director" means the Director ~~of the Department~~ of Consumer Affairs.

(c) "Consumer" means any individual who seeks or acquires, by purchase or lease, any goods, services, money, or credit for personal, family, or household purposes.

(d) "Person" means an individual, partnership, corporation, limited liability company, association, or other group, however organized.

(e) "Individual" does not include a partnership, corporation, association, or other group, however organized.

(f) "Division" means the Division of Consumer Services.

(g) "Interests of consumers" is limited to the cost, quality, purity, safety, durability, performance, effectiveness, dependability, availability, and adequacy of choice of goods and services offered or furnished to consumers and the adequacy and accuracy of information relating to consumer goods, services, money, or credit (including labeling, packaging, and advertising of contents, qualities, and terms of sales).

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1000

Introduced by Assembly Member Wieckowski

February 22, 2013

An act to amend ~~Section 2630 of~~ *Sections 2620 and 2660 of, and to add Section 2620.1 to,* the Business and Professions Code, relating to physical therapy.

LEGISLATIVE COUNSEL'S DIGEST

AB 1000, as amended, Wieckowski. ~~Physical therapy.~~ *Physical therapists: direct access to services.*

Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act defines the term "physical therapy" for its purposes as, among other things, including physical therapy evaluation, treatment planning, instruction, and consultative services. The act makes it a crime to violate any of its provisions. The act authorizes the board to suspend, revoke, or impose probationary conditions on a license, certificate, or approval issued under the act for unprofessional conduct, as specified.

This bill would revise the definition of "physical therapy" to instead include examination and evaluation to determine a physical therapy diagnosis, as defined, prognosis, treatment plan, instruction, or consultative service.

This bill would specify that patients may access physical therapy treatment directly and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient

has a condition requiring treatment or services beyond that scope of practice, to disclose to the patient any financial interest he or she has in treating the patient, and, with the patient's written authorization, to notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient. The bill would provide that failure to comply with these provisions constitutes unprofessional conduct subject to disciplinary action by the board.

Because the bill would specify additional requirements under the Physical Therapy Practice Act, the violation of which would be a crime, it 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.

~~Existing law, until January 1, 2014, establishes the Physical Therapy Board of California, which oversees the licensing and regulation of physical therapists. Existing law prohibits any person or persons from practicing or offering to practice physical therapy in this state for compensation, or to hold himself or herself out as a physical therapist, unless he or she holds a valid license, as specified.~~

~~This bill would make a technical, nonsubstantive change to these provisions.~~

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

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

1 *SECTION 1. The Legislature finds and declares that an*
2 *individual's access to early intervention to physical therapy*
3 *treatment may decrease the duration of a disability, reduce pain,*
4 *and lead to a quicker recovery.*
5 *SEC. 2. Section 2620 of the Business and Professions Code is*
6 *amended to read:*
7 2620. (a) Physical therapy means the art and science of
8 physical or corrective rehabilitation or of physical or corrective
9 treatment of any bodily or mental condition of any person by the
10 use of the physical, chemical, and other properties of heat, light,
11 water, electricity, sound, massage, and active, passive, and resistive

exercise, and shall include *examination and evaluation to determine a* physical therapy ~~evaluation,~~ *diagnosis, prognosis,* treatment ~~planning, instruction and~~ *plan, instruction, or* consultative ~~services.~~ *service.* The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease.

(b) For the purposes of this section, "physical therapy diagnosis" means a systematic examination process that culminates in assigning a diagnostic label identifying the primary dysfunction toward which physical therapy treatment will be directed, but shall not include a medical diagnosis or a diagnosis of disease.

~~(b)~~

(c) Nothing in this section shall be construed to restrict or prohibit other healing arts practitioners licensed or registered under this division from practice within the scope of their license or registration.

SEC. 3. Section 2620.1 is added to the Business and Professions Code, to read:

2620.1. (a) In addition to receiving wellness and evaluation services from a physical therapist, a person may initiate physical therapy treatment directly from a licensed physical therapist if the treatment is within the scope of practice of physical therapists, as defined in Section 2620, and all of the following conditions are met:

(1) If, at any time, the physical therapist has reason to believe that the patient has signs or symptoms of a condition that requires treatment beyond the scope of practice of a physical therapist, the physical therapist shall refer the patient to a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.

(2) The physical therapist shall disclose to the patient any financial interest he or she has in treating the patient.

(3) With the patient's written authorization, the physical therapist shall notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient.

(b) The conditions in paragraphs (1), (2), and (3) of subdivision (a) do not apply to a physical therapist when providing evaluation or wellness physical therapy services to a patient as described in subdivision (a) of Section 2620.

(c) This section does not expand or modify the scope of practice for physical therapists set forth in Section 2620, including the prohibition on a physical therapist diagnosing a disease.

(d) This section does not require a health care service plan or insurer to provide coverage for direct access to treatment by a physical therapist.

SEC. 4. Section 2660 of the Business and Professions Code is amended to read:

2660. The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act, suspend for not more than 12 months, or revoke, or impose probationary conditions upon any license, certificate, or approval issued under this chapter for unprofessional conduct that includes, but is not limited to, one or any combination of the following causes:

(a) Advertising in violation of Section 17500.

(b) Fraud in the procurement of any license under this chapter.

(c) Procuring or aiding or offering to procure or aid in criminal abortion.

(d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a physical therapist or physical therapist assistant. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(e) Habitual intemperance.

(f) Addiction to the excessive use of any habit-forming drug.

(g) Gross negligence in his or her practice as a physical therapist or physical therapist assistant.

(h) Conviction of a violation of any of the provisions of this chapter or of the Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the Medical Practice Act.

(i) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

(j) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(k) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant.

(l) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.

(m) The commission of verbal abuse or sexual harassment.

(n) Failure to comply with the provisions of Section 2620.1.

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.

~~SECTION 1. Section 2630 of the Business and Professions Code is amended to read:~~

~~2630. It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing he or she holds a valid, unexpired, and unrevoked license issued under this chapter.~~

~~Nothing in this section shall restrict the activities authorized by their licenses on the part of any persons licensed under this code or any initiative act, or the activities authorized to be performed pursuant to Article 4.5 (commencing with Section 2655) or Chapter 7.7 (commencing with Section 3500).~~

~~A physical therapist licensed pursuant to this chapter may utilize the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record.~~

~~The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment shall not be prohibited by this section.~~

BILL NUMBER: AB 1003 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 1, 2013

INTRODUCED BY Assembly Member Maienschein

FEBRUARY 22, 2013

An act to amend 13401.5 of the Corporations Code, relating to professional corporations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1003, as amended, Maienschein. Professional corporations: healing arts practitioners.

The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act defines a professional corporation as a corporation organized under the General Corporation Law or pursuant to specified law that is engaged in rendering professional services in a single profession, except as otherwise authorized in the act, pursuant to a certificate of registration issued by the governmental agency regulating the profession and that in its practice or business designates itself as a professional or other corporation as may be required by statute. The act authorizes specified listed types of healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating to ownership of shares.

This bill would ~~delete professional employees from that authorization, and, instead, would provide that those provisions do not limit the employment of persons duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render professional services, by a designated professional corporation, to the listed licensed professionals specified in the provisions~~ *specify that those provisions do not limit the employment by a professional corporation to only those specified licensed professionals. The bill would authorize any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to be employed to render professional services by a professional corporation* .

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 13401.5 of the Corporations Code is amended to read:

13401.5. Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, directors, or professional employees of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed

persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation ~~:~~ *. This section does not limit the employment by a professional corporation designated in this section to only those licensed profe ssionals listed under each subdivision. Any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed to render professional services by a professional corporation designated in this section.*

(a) Medical corporation.
(1) Licensed doctors of podiatric medicine.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(b) Podiatric medical corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(c) Psychological corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed chiropractors.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(d) Speech-language pathology corporation.
(1) Licensed audiologists.
(e) Audiology corporation.
(1) Licensed speech-language pathologists.
(f) Nursing corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(g) Marriage and family therapist corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.

(3) Licensed clinical social workers.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(h) Licensed clinical social worker corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed marriage and family therapists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(i) Physician assistants corporation.
(1) Licensed physicians and surgeons.
(2) Registered nurses.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(j) Optometric corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(k) Chiropractic corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(*l*) Acupuncture corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Registered nurses.
(5) Licensed optometrists.
(6) Licensed marriage and family therapists.
(7) Licensed clinical social workers.
(8) Licensed physician assistants.
(9) Licensed chiropractors.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.

(9) Licensed marriage and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.
(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.
(7) Licensed acupuncturists.
(8) Naturopathic doctors.

~~SECTION 1. Section 13401.5 of the Corporations Code is amended to read:~~

~~13401.5. (a) Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, or directors of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation:~~

~~(1) Medical corporation.~~
~~(A) Licensed doctors of podiatric medicine.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed physician assistants.~~
~~(H) Licensed chiropractors.~~
~~(I) Licensed acupuncturists.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(2) Podiatric medical corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(3) Psychological corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Registered nurses.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~

~~(G) Licensed chiropractors.~~
~~(H) Licensed acupuncturists.~~
~~(I) Naturopathic doctors.~~
~~(J) Licensed professional clinical counselors.~~
~~(4) Speech language pathology corporation.~~
~~(A) Licensed audiologists.~~
~~(5) Audiology corporation.~~
~~(A) Licensed speech-language pathologists.~~
~~(6) Nursing corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Licensed optometrists.~~
~~(E) Licensed marriage and family therapists.~~
~~(F) Licensed clinical social workers.~~
~~(G) Licensed physician assistants.~~
~~(H) Licensed chiropractors.~~
~~(I) Licensed acupuncturists.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(7) Marriage and family therapist corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed clinical social workers.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(H) Licensed professional clinical counselors.~~
~~(8) Licensed clinical social worker corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed marriage and family therapists.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(H) Licensed professional clinical counselors.~~
~~(9) Physician assistants corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Registered nurses.~~
~~(C) Licensed acupuncturists.~~
~~(D) Naturopathic doctors.~~
~~(10) Optometric corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Naturopathic doctors.~~
~~(11) Chiropractic corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed optometrists.~~
~~(F) Licensed marriage and family therapists.~~
~~(G) Licensed clinical social workers.~~
~~(H) Licensed acupuncturists.~~

~~(I) Naturopathic doctors.~~
~~(J) Licensed professional clinical counselors.~~
~~(12) Acupuncture corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed doctors of podiatric medicine.~~
~~(C) Licensed psychologists.~~
~~(D) Registered nurses.~~
~~(E) Licensed optometrists.~~
~~(F) Licensed marriage and family therapists.~~
~~(G) Licensed clinical social workers.~~
~~(H) Licensed physician assistants.~~
~~(I) Licensed chiropractors.~~
~~(J) Naturopathic doctors.~~
~~(K) Licensed professional clinical counselors.~~
~~(13) Naturopathic doctor corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Registered nurses.~~
~~(D) Licensed physician assistants.~~
~~(E) Licensed chiropractors.~~
~~(F) Licensed acupuncturists.~~
~~(G) Licensed physical therapists.~~
~~(H) Licensed doctors of podiatric medicine.~~
~~(I) Licensed marriage and family therapists.~~
~~(J) Licensed clinical social workers.~~
~~(K) Licensed optometrists.~~
~~(L) Licensed professional clinical counselors.~~
~~(14) Dental corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Dental assistants.~~
~~(C) Registered dental assistants.~~
~~(D) Registered dental assistants in extended functions.~~
~~(E) Registered dental hygienists.~~
~~(F) Registered dental hygienists in extended functions.~~
~~(G) Registered dental hygienists in alternative practice.~~
~~(15) Professional clinical counselor corporation.~~
~~(A) Licensed physicians and surgeons.~~
~~(B) Licensed psychologists.~~
~~(C) Licensed clinical social workers.~~
~~(D) Licensed marriage and family therapists.~~
~~(E) Registered nurses.~~
~~(F) Licensed chiropractors.~~
~~(G) Licensed acupuncturists.~~
~~(H) Naturopathic doctors.~~
~~(b) This section does not limit the employment of persons duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render professional services, by a professional corporation designated in the section, to the licensed professionals listed under each paragraph of subdivision (a).~~

BILL NUMBER: AB 1013 INTRODUCED
BILL TEXT

INTRODUCED BY Assembly Member Gomez

FEBRUARY 22, 2013

An act to amend Section 320 of the Business and Professions Code, relating to consumer affairs.

LEGISLATIVE COUNSEL'S DIGEST

AB 1013, as introduced, Gomez. Consumer affairs.

Under existing law, the Department of Consumer Affairs is comprised of boards that license and regulate various professions and vocations. Existing law provides that these boards are established to ensure that private businesses and professions are regulated to protect the people of this state. Existing law authorizes the director or the Attorney General to intervene in a matter or proceeding pending before any state commission, regulatory agency, department, or agency, or any court, which the director finds may affect substantially the interests of consumers within California, in any appropriate manner to represent the interests of consumers. Existing law also authorizes the director, or any officer or employee designated by the director for that purpose, or the Attorney General to thereafter present evidence and argument to the agency, court of department, as specified, for the effective protection of the interests of consumers.

This bill would additionally authorize any employee designated by the Attorney General to make those presentations.

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

320. Whenever there is pending before any state commission, regulatory agency, department, or other state agency, or any state or federal court or agency, any matter or proceeding which the director finds may affect substantially the interests of consumers within California, the director, or the Attorney General, may intervene in such matter or proceeding in any appropriate manner to represent the interests of consumers. The director, or any officer or employee designated by the director for that purpose, or the Attorney General *, or any employee designated by the Attorney General for that purpose* , may thereafter present to ~~such~~ *that* agency, court, or department, in conformity with the rules of practice and procedure thereof, ~~such~~ *the* evidence and argument as he *or she* shall determine to be necessary, for the effective protection of the interests of consumers.

BILL NUMBER: AB 1017 INTRODUCED
BILL TEXT

INTRODUCED BY Assembly Member Gomez

FEBRUARY 22, 2013

An act to amend Section 11022 of the Government Code, relating to state agencies.

LEGISLATIVE COUNSEL'S DIGEST

AB 1017, as introduced, Gomez. Incoming telephone calls: messages.

Existing law requires each state agency to establish a procedure pursuant to which incoming telephone calls on any public line are answered within 10 rings during regular business hours, except as specified. For purposes of this provision, "state agency" includes every state office, officer, department, division, bureau, board, and commission.

This bill would require, in addition, that the procedure established by the state agency enable a caller to leave a message, as specified, and that the message be returned within 3 business days, or 72 hours, whichever is earlier.

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 11022 of the Government Code is amended to read:

11022. Each state agency shall establish a procedure pursuant to which incoming telephone calls on any public line shall be answered within 10 rings during regular business hours as set forth in Section 11020, except where emergency or illness require adjustments to normal staffing levels. This requirement shall be met in every office where staff is available, unless compliance would require overtime or compensating time off. *This procedure also shall enable a caller to leave a message, either person-to-person, or via voice mai l or other method of 24-hour telecommunications . Each call shall be returned within three business days or 72 hours after the message is left, whichever is earlier.*

BILL NUMBER: AB 1147 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 15, 2013

INTRODUCED BY Assembly Member Gomez

FEBRUARY 22, 2013

An act to amend ~~Section~~ *Sections* 4601 *and 4612* of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1147, as amended, Gomez. Massage therapy.

Existing law, until January 1, 2015, provides for the voluntary certification of *massage practitioners and* massage therapists by the California Massage Therapy Council. ~~Existing law specifies the requirements for the council to issue to an applicant a certificate as a massage therapist, including, but not limited to, successfully completing curricula in massage and related subjects totaling a minimum of 500 hours, or the credit unit equivalent, a minimum of 250 hours of which shall be from a school approved by the council, and the other 250 hours may be secured as specified.~~

~~This bill would instead increase that minimum of hours to 505 hours, or the credit unit equivalent, a minimum of 250 hours of which would be required to be from a school approved by the council, and the other 255 hours secured as specified.~~

Existing law specifies the requirements for the council to issue to an applicant a certificate as a massage practitioner, including, but not limited to, successfully completing curricula in massage and related subjects totaling a minimum of 250 hours or the credit unit equivalent, as specified.

This bill would additionally require an applicant for a certificate as a massage practitioner to pass a massage and bodywork competency assessment examination that meets generally recognized psychometric principles and standards, and that is approved by the council.

Existing law specifies the requirements for the council to issue to an applicant a certificate as a massage therapist, including, but not limited to, (1) successfully completing curricula in massage and related subjects totaling a minimum of 500 hours or the credit unit equivalent, as specified, or (2) successfully completing curricula in massage and related subjects totaling a minimum of 250 hours, as specified, and passing a massage and bodywork competency assessment examination that meets generally recognized psychometric principles and standards, and that is approved by the council.

This bill would instead require an applicant for a certificate as a massage therapist to successfully complete curricula in massage and related subjects totaling a minimum of 500 hours or the credit unit equivalent, as specified, and to pass the massage and bodywork competency assessment examination as described above.

Existing law authorizes a city, county, or city and county to impose certain requirements on massage establishments or businesses that are the sole proprietorship of an individual certified pursuant

to existing state law or that employ or use only persons who are so certified. Existing law authorizes a city, county, or city and county to, among other things, adopt reasonable health and safety requirements, as specified, pertaining to those massage establishments or businesses, and to require an applicant for a business license to operate a massage business or establishment to fill out an application that requests relevant information, as specified.

This bill would authorize a city, county, or city and county to require a massage establishment or business described above to apply for and receive a revocable certificate of registration. The bill would authorize a city, county, or city and county to require from an applicant, among other things, copies of specified identification and a statement that the applicant will only employ or use certified persons to provide massage services and that failure to comply with this provision may result in revocation of the certificate of registration. The bill would authorize a city, county, or city and county to require a massage establishment or business to comply with specified local ordinances, regulations, rules, requirements, or restrictions as a condition granting or maintaining a revocable certificate of registration and would authorize a city, county, or city and county to revoke a certificate of registration for cause.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4601 of the Business and Professions Code is amended to read:

4601. (a) The council shall issue a certificate under this chapter to an applicant who satisfies the requirements of this chapter.

(b) (1) In order to obtain certification as a massage practitioner, an applicant shall submit a written application and provide the council with satisfactory evidence that he or she meets all of the following requirements:

(A) The applicant is 18 years of age or older.

(B) The applicant has successfully completed, at an approved school, curricula in massage and related subjects, totaling a minimum of 250 hours or the credit unit equivalent, that incorporates appropriate school assessment of student knowledge and skills. Included in the hours shall be instruction addressing anatomy and physiology, contraindications, health and hygiene, and business and ethics, with at least 100 hours of the required minimum 250 hours devoted to these curriculum areas.

(C) The applicant has passed a massage and bodywork competency assessment examination that meets generally recognized psychometric principles and standards, and that is approved by the council. The successful completion of this examination may have been accomplished before the date the council is authorized by this chapter to begin issuing certificates.

~~(C)~~

(D) All fees required by the council have been paid.

(2) New certificates shall not be issued pursuant to this subdivision after December 31, 2015. Certificates issued pursuant to this section or subdivision (a) or (c) of Section 4604 on or before December 31, 2015, shall, after December 31, 2015, be renewed without any additional educational requirements, provided that the

certificate holder continues to be qualified pursuant to this chapter.

(c) In order to obtain certification as a massage therapist, an applicant shall submit a written application and provide the council with satisfactory evidence that he or she meets all of the following requirements:

(1) The applicant is 18 years of age or older.

~~(2) The applicant satisfies at least one of the following requirements:~~

~~(A) He or she~~

(2) The applicant has successfully completed the curricula in massage and related subjects totaling a minimum of ~~505~~ *500* hours or the credit unit equivalent. Of this ~~505~~ *500* hours, a minimum of 250 hours shall be from approved schools. The remaining ~~255~~ *250* hours required may be secured either from approved or registered schools, or from continuing education providers approved by, or registered with, the council or the Department of Consumer Affairs. After December 31, 2015, applicants may only satisfy the curricula in massage and related subjects from approved schools.

~~(B) The applicant has done both of the following:~~

~~(i) Successfully completed, at an approved school, curricula in massage and related subjects totaling a minimum of 250 hours that incorporates appropriate school assessment of student knowledge and skills. Included in the hours shall be instruction addressing anatomy and physiology, contraindications, health and hygiene, and business and ethics, with at least 100 hours of the required minimum 250 hours devoted to these curriculum areas.~~

~~(ii) Passed~~

(3) The applicant has passed a massage and bodywork competency assessment examination that meets generally recognized psychometric principles and standards, and that is approved by the ~~board~~ *council* . The successful completion of this examination may have been accomplished before the date the council is authorized by this chapter to begin issuing certificates.

~~(3)~~

(4) All fees required by the council have been paid.

(d) The council shall issue a certificate to an applicant who meets the other qualifications of this chapter and holds a current and valid registration, certification, or license from any other state whose licensure requirements meet or exceed those defined within this chapter. The council shall have discretion to give credit for comparable academic work completed by an applicant in a program outside of California.

(e) An applicant applying for a massage therapist certificate shall file with the council a written application provided by the council, showing to the satisfaction of the council that he or she meets all of the requirements of this chapter.

(f) Any certification issued under this chapter shall be subject to renewal every two years in a manner prescribed by the council, and shall expire unless renewed in that manner. The council may provide for the late renewal of a ~~license~~ *certificate*

.

(g) (1) The council shall have the responsibility to determine that the school or schools from which an applicant has obtained the education required by this chapter meet the requirements of this chapter. If the council has any reason to question whether or not the

applicant received the education that is required by this chapter from the school or schools that the applicant is claiming, the council shall investigate the facts to determine that the applicant received the required education prior to issuing a certificate.

(2) For purposes of paragraph (1) and any other provision of this chapter for which the council is authorized to receive factual information as a condition of taking any action, the council shall have the authority to conduct oral interviews of the applicant and others or to make any investigation deemed necessary to establish that the information received is accurate and satisfies any criteria established by this chapter.

(h) The certificate issued pursuant to this chapter, as well as any identification card issued by the council, shall be surrendered to the council by any certificate holder whose certificate has been suspended or revoked.

SEC. 2. Section 4612 of the Business and Professions Code is amended to read:

4612. (a) (1) The holder of a certificate issued pursuant to this chapter shall have the right to practice massage, consistent with this chapter and the qualifications established by his or her certification, in any city, county, or city and county in this state and shall not be required to obtain any other license, permit, or other authorization, except as provided in this section, to engage in that practice.

(2) Notwithstanding any other provision of law, a city, county, or city and county shall not enact an ordinance that requires a license, permit, or other authorization to provide massage for compensation by an individual who is certified pursuant to this chapter and who is practicing consistent with the qualifications established by his or her certification, or by a massage business or massage establishment that employs or uses only persons who are certified pursuant to this chapter to provide massage for compensation. No provision of any ordinance enacted by a city, county, or city and county that is in effect before the effective date of this chapter, and that requires a license, permit, or other authorization to provide massage for compensation, may be enforced against an individual who is certified pursuant to this chapter or against a massage business or massage establishment that employs or uses only persons who are certified pursuant to this chapter to provide massage for compensation.

(3) Except as provided in subdivision (b), nothing in this section shall be interpreted to prevent a city, county, or city and county from adopting or enforcing any local ordinance that provides for reasonable health and safety requirements for massage establishments or businesses. Subdivision (b) shall not apply to any massage establishment or business that employs or uses persons to provide massage services who are not certified pursuant to this chapter.

(b) (1) This subdivision shall apply only to massage establishments or businesses that are sole proprietorships, where the sole proprietor is certified pursuant to this chapter, and to massage establishments or businesses that employ or use only persons certified pursuant to this chapter to provide massage services. For purposes of this subdivision, a sole proprietorship is a business where the owner is the only person employed by that business to provide massage services.

(2) (A) Any massage establishment or business described in paragraph (1) shall maintain on its premises evidence for review by local authorities that demonstrates that all persons providing massage services are certified.

(B) Nothing in this section shall preclude a city, county, or city

and county from including in a local ordinance a provision that requires a business described in paragraph (1) to file copies or provide other evidence of the certificates held by the persons who are providing massage services at the business.

(3) A city, county, or city and county may charge a massage business or establishment a business licensing fee, provided that the fee shall be no higher than the lowest fee that is applied to other individuals and businesses providing professional services, as defined in subdivision (a) of Section 13401 of the Corporations Code.

(4) Nothing in this section shall prohibit a city, county, or city and county from enacting ordinances, regulations, rules, requirements, restrictions, land use regulations, moratoria, conditional use permits, or zoning requirements applicable to an individual certified pursuant to this chapter or to a massage establishment or business that uses only individuals who are certified pursuant to this chapter to provide massage for compensation, provided that, unless otherwise exempted by this chapter, these ordinances, regulations, rules, requirements, restrictions, land use regulations, moratoria, conditional use permits, and zoning requirements shall be no different than the requirements that are uniformly applied to all other individuals and businesses providing professional services, as defined in subdivision (a) of Section 13401 of the Corporations Code. No provision of any ordinance, regulation, rule, requirement, restriction, land use regulation, moratoria, conditional use permit, or zoning requirement enacted by a city, county, or city and county that is in effect before the effective date of this chapter, and that is inconsistent with this paragraph, may be enforced against an individual who is certified pursuant to this chapter or against a massage business or massage establishment that uses only individuals who are certified pursuant to this chapter to provide massage for compensation.

(5) Local building code or physical facility requirements applicable to massage establishments or businesses shall not require additional restroom, shower, or other facilities that are not uniformly applicable to other professional or personal service businesses, nor shall building or facility requirements be adopted that (A) require unlocked doors when there is no staff available to ensure security for clients and massage staff who are behind closed doors, or (B) require windows that provide a view into massage rooms that interfere with the privacy of clients of the massage business.

(6) A city, county, or city and county may adopt reasonable health and safety requirements with respect to massage establishments or businesses, including, but not limited to, requirements for cleanliness of massage rooms, towels and linens, and reasonable attire and personal hygiene requirements for persons providing massage services, provided that nothing in this paragraph shall be interpreted to authorize adoption of local ordinances that impose additional qualifications, such as medical examinations, background checks, or other criteria, upon any person certified pursuant to this chapter.

(7) Nothing in this section shall preclude a city, county, or city and county from doing any of the following:

(A) Requiring an applicant for a business license to operate a massage business or establishment to fill out an application that requests the applicant to provide relevant information, as long as the information requested is the same as that required of other individuals and professionals providing professional services as defined in subdivision (a) of Section 13401 of the Corporations Code.

(B) Making reasonable investigations into the information so provided.

(C) Denying or restricting a business license if the applicant has provided materially false information.

(c) An owner or operator of a massage business or establishment who is certified pursuant to this chapter shall be responsible for the conduct of all employees or independent contractors working on the premises of the business. Failure to comply with this chapter may result in revocation of the owner's or operator's certificate in accordance with Section 4603. Nothing in this section shall preclude a local ordinance from authorizing suspension, revocation, or other restriction of a license or permit issued to a massage establishment or business if violations of this chapter, or of the local ordinance, occur on the business premises.

(d) Nothing in this section shall preclude a city, county, or city and county from adopting a local ordinance that is applicable to massage businesses or establishments described in paragraph (1) of subdivision (b) and that does either of the following:

(1) Provides that duly authorized officials of the city, county, or city and county have the right to conduct reasonable inspections, during regular business hours, to ensure compliance with this chapter, the local ordinance, or other applicable fire and health and safety requirements.

(2) Requires an owner or operator to notify the city, county, or city and county of any intention to rename, change management, or convey the business to another person.

(e) Nothing in this chapter shall be construed to preclude a city, county, or city and county from requiring a background check of an owner or operator of a massage establishment who owns 5 percent or more of a massage business or massage establishment and who is not certified pursuant to this chapter. The background check may include, but is not limited to, a criminal background check, including requiring submission of fingerprints for a state and federal criminal background check, submission of an application that requires the applicant to state information, including, but not limited to, the applicant's business, occupation, and employment history for the 10 years preceding the date of application, the inclusive dates of same, and the name and address of any massage business or other like establishment owned or operated by any person who is subject to the background check requirement of this subdivision. If a noncertified owner's or operator's background check results in a finding that the city, county, or city and county determines is relevant to owning or operating a massage establishment, then the provisions of subdivisions (a) and (b) shall not apply to that establishment and the city, county, or city and county may regulate that establishment in any manner it deems proper that is in accordance with the law.

(f) (1) Nothing in this chapter shall preclude a city, county, or city and county from including a provision in a local ordinance that requires the owner or owners of a massage establishment or business described in paragraph (1) of subdivision (b) to apply for and receive a revocable certificate of registration.

(2) As part of the application for a certificate of registration, a city, county, or city and county may require the following from an applicant:

(A) The full true name under which the massage establishment or business will be conducted.

(B) The present or proposed address where the massage establishment or business will be conducted.

(C) The full true legal name and mailing address of the owner or

owners of the massage establishment or business.

(D) A copy of a certificate, or any other evidence of certification, issued to each person pursuant to this chapter who will be providing massage services at the massage establishment or business.

(E) A copy of a photographic government-issued identification card of the owner or owners of the massage establishment or business.

(F) A statement that the applicant will only employ or use persons certified pursuant to this chapter to provide massage services and that failure to comply with this provision may result in revocation of the certificate of registration.

(G) A statement that the applicant will provide written notification of any changes to the original application within 10 days of that change occurring.

(H) Authorization for the city, county, or city and county to investigate the truth of the information contained in the application.

(I) The payment of a fee to conduct a background check pursuant to subdivision (e) if the owner or owners of the massage establishment or business applying for the certificate of registration are not certified pursuant to this chapter and own 5 percent or more of the massage establishment or business.

(3) A city, county, or city and county may require a massage establishment or business to comply with any applicable local ordinance, regulation, rule, requirement, or restriction passed pursuant to subdivision (b) as a condition granting or maintaining a revocable certificate of registration, including, but not limited to, those provisions pertaining to health and safety or zoning.

(4) A city, county, or city and county may exempt certain classes of persons or businesses from compliance with the requirements for a certificate of registration.

(5) A city, county, or city and county may make the certificate of registration nontransferable.

(6) A city, county, or city and county may revoke a certificate of registration for cause.

BILL NUMBER: AB 1231AMENDED
BILL TEXT

AMENDED IN ASSEMBLY APRIL 24, 2013
AMENDED IN ASSEMBLY MARCH 21, 2013

INTRODUCED BY Assembly Member V. Manuel Pérez

FEBRUARY 22, 2013

An act to add and repeal Section 4686.21 of the Welfare and Institutions Code, relating to regional center services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1231, as amended, V. Manuel Pérez. Regional centers: telehealth and teledentistry.

The Lanterman Developmental Disabilities Services Act authorizes the State Department of Developmental Services to contract with regional centers to provide services and support to individuals with developmental disabilities, including autism.

This bill would, until January 1, 2019, require the department to inform all regional centers that behavioral health treatment to treat pervasive developmental disorder or autism may be provided through the use of telehealth, as defined, and that dentistry may be provided through the use of teledentistry, as defined. The bill would require the department to provide technical assistance to regional centers on the use of telehealth and teledentistry and to request those centers to include a consideration of telehealth and teledentistry in individual program plans and individualized family services plans, as specified.

The bill would require providers of telehealth and teledentistry services to maintain the privacy and security of all confidential consumer information. The bill would provide ~~that a consumer may receive behavioral health treatment and dentistry services through the use of telehealth or teledentistry on a provisional basis not to exceed 12 months, as specified,~~ that the provision of a service through the use of telehealth and teledentistry shall be voluntary and may be discontinued at the request of the consumer, ~~and that the consumer may return to his or her preexisting services,~~ as specified. The bill would require the department, on or before December 1, 2017, to forward to the fiscal and appropriate policy committees of the Legislature information provided by the regional centers to assess the effectiveness and appropriateness of providing telehealth and teledentistry services to regional center consumers, as specified.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Autism spectrum disorders (ASD) now affect one in every 88 children of all ethnic, racial, and socioeconomic backgrounds.

(2) ASD is now the fastest growing developmental disability in California and the nation and is more common than childhood cancer, juvenile diabetes, and pediatric AIDS combined.

(3) Approximately two-thirds of all new consumers who are entering the regional center system are now diagnosed with ASD.

(4) Behavioral health treatment (BHT), also known as early intervention therapy or applied behavior analysis, is established to improve brain function, cognitive abilities, and activities of daily living for a significant number of individuals with ASD, but may not be accessible or available in underserved communities.

(5) A significant number of individuals with ASD suffer from inadequate dental care.

(b) It is the intent of the Legislature to do all of the following:

(1) Improve access to treatments and intervention services for individuals with ASD or other developmental disabilities and their families in underserved populations.

(2) Provide more cost-effective treatments and intervention services for individuals with ASD or other developmental disabilities and their families.

(3) Maximize the effectiveness of the interpersonal and face-to-face interactions that are utilized for the treatment of individuals with ASD or other developmental disabilities.

(4) Continue maintenance and support of the existing service workforce for individuals with ASD or other developmental disabilities.

(5) Utilize telehealth and teledentistry to improve services for individuals with ASD and other developmental disabilities.

SEC. 2. Section 4686.21 is added to the Welfare and Institutions Code, to read:

4686.21. (a) The department shall do all of the following:

(1) Inform all regional centers that behavioral health treatment may be provided through the use of telehealth.

(2) Inform all regional centers that dentistry may be provided through the use of teledentistry.

(3) Request regional centers to include a consideration of telehealth and teledentistry in each individual program plan (IPP) and individualized family service plan (IFSP) that includes a discussion of behavioral health treatment or dental health care.

(4) Provide, using existing resources, and in partnership with other organizations, resources, and stakeholders, technical assistance to regional centers regarding the use of telehealth and teledentistry.

(b) The use of telehealth and teledentistry services shall be considered for inclusion in training programs for parents, including, but not limited to, group training programs as described in clause

(i) of subparagraph (B) of paragraph (3) of subdivision (c) of Section 4685.

(c) The department may implement appropriate vendorization subcodes for telehealth and teledentistry services and programs.

(d) Providers of telehealth and teledentistry services shall maintain the privacy and security of all confidential consumer information.

~~(e) A consumer may receive behavioral health treatment and dentistry services through the use of telehealth or teledentistry on a provisional basis with the consent of the consumer or, as appropriate, the consumer's parent, legal guardian, or conservator, as set forth in the consumer's IPP or IFSP. The provisional period for receiving services through the use of telehealth or teledentistry shall not exceed 12 months. During the provisional period, any consumer who receives services through the use of telehealth or teledentistry may return to his or her preexisting services, as defined by the consumer's IPP or IFSP, that were in place prior to the commencement of the telehealth or teledentistry services, subject to subdivision (f).~~

~~(f)~~

(e) The provision of a service through the use of telehealth and teledentistry shall be voluntary and may be discontinued at the request of the consumer or, as appropriate, the consumer's parent, legal guardian, or conservator. If, at any time, a consumer or, as appropriate, the consumer's parent, legal guardian, or conservator requests to discontinue the provision of a service through the use of telehealth or teledentistry, the regional center shall convene a review to determine alternative, appropriate means for providing the service.

~~(g)~~

(f) On or before December 1, 2017, the department shall forward to the fiscal and appropriate policy committees of the Legislature any information provided by the regional centers to the department to assess the effectiveness and appropriateness of providing telehealth and teledentistry services to regional center consumers through the IPP and IFSP ~~process~~ *processes* .

~~(h)~~

(g) A provider of telehealth or teledentistry services shall be responsible for all expenses and costs related to the equipment, transmission, storage, infrastructure, and other expenses related to telehealth and teledentistry.

~~(i)~~

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

(1) "Behavioral health treatment" has the same meaning as set forth in paragraph (1) of subdivision (c) of Section 1374.73 of the Health and Safety Code.

(2) "Department" means the State Department of Developmental Services.

(3) "Teledentistry" is the use of information technology and

telecommunications for dental care, consultation, education, and public awareness in the same manner as described in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

(4) "Telehealth" has the same meaning as set forth in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

~~(j)~~

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

BILL NUMBER: SB 138 AMENDED
BILL TEXT

AMENDED IN SENATE APRIL 8, 2013
AMENDED IN SENATE MARCH 13, 2013

INTRODUCED BY Senator Hernandez
(Coauthors: Senators DeSaulnier and Leno)

JANUARY 28, 2013

An act to amend Sections 56.05, 56.104, and 56.16 of, and to add Section 56.107 to, the Civil Code, to amend Sections 1280.15, 1627, 117928, 120985, 121010, and 130201 of the Health and Safety Code, *to add Section 791.29 to the Insurance Code,* and to amend Section 3208.05 of the Labor Code, relating to medical information.

LEGISLATIVE COUNSEL'S DIGEST

SB 138, as amended, Hernandez. Confidentiality of medical information.

Existing federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), establishes certain requirements relating to the provision of health insurance, and the protection of privacy of individually identifiable health information.

Existing state law, the Confidentiality of Medical Information Act, provides that medical information, as defined, may not be disclosed by providers of health care, health care service plans, or contractors, as defined, without the patient's written authorization, subject to certain exceptions, including disclosure to a probate court investigator, as specified. A violation of the act resulting in economic loss or personal injury to a patient is a misdemeanor and subjects the violating party to liability for specified damages and administrative fines and penalties. The act defines various terms relevant to its implementation.

This bill would declare the intent of the Legislature to incorporate HIPAA standards into state law and to clarify standards for protecting the confidentiality of medical information in insurance transactions. The bill would define additional terms in connection with maintaining the confidentiality of this information, including an "authorization for insurance communications," which an insured individual may submit for the purpose of specifying disclosable medical information and insurance transactions, and permissible recipients.

This bill would specify the manner in which a health care service plan or health insurer would be required to maintain confidentiality of information regarding the treatment of insured individuals less than 26 years of age who are insured as dependents on another person's policy, the treatment of an insured individual involving sensitive services, as defined, or situations in which disclosure would endanger the insured individual, as defined.

This bill would specifically authorize a provider of health care to communicate information regarding benefit cost-sharing arrangements to the health care service plan or health insurer, as specified.

This bill would also prohibit the health care service plan or health insurer from conditioning enrollment in the plan or

eligibility for benefits on the provision of an authorization for insurance communications. The bill also would make conforming technical changes. By expanding the scope of a crime, the bill would create a state-mandated local program.

Existing state law, the Insurance Information and Privacy Protection Act, generally regulates how insurers collect, use, and disclose information gathered in connection with insurance transactions.

This bill would specify that a health insurer, as defined, shall comply with the requirements of the Confidentiality of Medical Information Act, if that act conflicts with the Insurance Information and Privacy Protection Act.

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) Privacy is a fundamental right of all Californians, protected by the California Constitution, the federal Health Insurance Portability and Accountability Act (HIPAA; Public Law 104-191), and the Confidentiality of Medical Information Act, Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(b) Implementation of the recently enacted federal Patient Protection and Affordable Care Act (Public Law 111-148) will expand the number of individuals insured as dependents on a health insurance policy held in another person's name, including adult children under 26 years of age insured on a parent's insurance policy.

(c) HIPAA explicitly protects the confidentiality of medical care obtained by dependents insured under a health insurance policy held by another person.

(d) Therefore, it is the intent of the Legislature in enacting this act to incorporate HIPAA standards into state law and to clarify the standards for protecting the confidentiality of medical information in insurance transactions.

SEC. 2. Section 56.05 of the Civil Code is amended to read:

56.05. For purposes of this part:

(a) "Authorization" means permission granted in accordance with Section 56.11 or 56.21 for the disclosure of medical information.

(b) "Authorization for insurance communications" means permission from the individual, that meets the requirements of subdivisions (a) to (c), inclusive, of Section 56.11, specifying the medical information and insurance transactions that may be disclosed and the identity of the people to whom disclosures are permitted as part of an insurance communication.

(c) "Authorized recipient" means any person who is authorized to receive medical information pursuant to Section 56.10 or 56.20.

(d) "Confidential communications request" means a request by an insured individual that insurance communications be communicated by a specific method, such as by telephone, email, or in a covered envelope rather than postcard, or to a specific mail or email address or specific telephone number, as designated by the insured

individual.

(e) "Contractor" means any person or entity that is a medical group, independent practice association, pharmaceutical benefits manager, or a medical service organization and is not a health care service plan or provider of health care. "Contractor" does not include insurance institutions as defined in subdivision (k) of Section 791.02 of the Insurance Code or pharmaceutical benefits managers licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(f) "Endanger" means that the insured individual fears harassment or abuse resulting from an insurance communication sufficient to deter the patient from obtaining health care absent confidentiality.

(g) "Health care service plan" means any entity regulated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(h) "Health insurer" means an entity *that issues health insurance, as* defined in *subdivision (b) of* Section 106 of the Insurance Code.

(i) "Insured individual" means a person entitled to coverage under a health care service plan or health insurer, including the policyholder and dependents.

(j) "Insurance communication" means any communication from the health care service plan or health insurer to policyholders or insured individuals that discloses individually identifiable medical information. Insurance communication includes, but is not limited to, explanation of benefits forms, scheduling information, notices of denial, and notices of contested claims.

(k) "Licensed health care professional" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act or the Chiropractic Initiative Act, or Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(l) "Marketing" means to make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service.

"Marketing" does not include any of the following:

(1) Communications made orally or in writing for which the communicator does not receive direct or indirect remuneration, including, but not limited to, gifts, fees, payments, subsidies, or other economic benefits, from a third party for making the communication.

(2) Communications made to current enrollees solely for the purpose of describing a provider's participation in an existing health care provider network or health plan network of a Knox-Keene licensed health plan to which the enrollees already subscribe; communications made to current enrollees solely for the purpose of describing if, and the extent to which, a product or service, or payment for a product or service, is provided by a provider, contractor, or plan or included in a plan of benefits of a Knox-Keene licensed health plan to which the enrollees already subscribe; or communications made to plan enrollees describing the availability of more cost-effective pharmaceuticals.

(3) Communications that are tailored to the circumstances of a particular individual to educate or advise the individual about treatment options, and otherwise maintain the individual's adherence to a prescribed course of medical treatment, as provided in Section 1399.901 of the Health and Safety Code, for a chronic and seriously debilitating or life-threatening condition as defined in subdivisions

(d) and (e) of Section 1367.21 of the Health and Safety Code, if the health care provider, contractor, or health plan receives direct or indirect remuneration, including, but not limited to, gifts, fees, payments, subsidies, or other economic benefits, from a third party for making the communication, if all of the following apply:

(A) The individual receiving the communication is notified in the communication in typeface no smaller than 14-point type of the fact that the provider, contractor, or health plan has been remunerated and the source of the remuneration.

(B) The individual is provided the opportunity to opt out of receiving future remunerated communications.

(C) The communication contains instructions in typeface no smaller than 14-point type describing how the individual can opt out of receiving further communications by calling a toll-free number of the health care provider, contractor, or health plan making the remunerated communications. No further communication may be made to an individual who has opted out after 30 calendar days from the date the individual makes the opt out request.

(m) "Medical information" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

(n) "Nondisclosure request" means a written request to withhold insurance communications that includes the insured individual's name and address, description of the medical or other information that should not be disclosed, identity of the persons from whom information shall be withheld, and contact information for the individual for additional information or clarification necessary to satisfy the request.

(o) "Patient" means any natural person, whether or not still living, who received health care services from a provider of health care and to whom medical information pertains.

(p) "Pharmaceutical company" means any company or business, or an agent or representative thereof, that manufactures, sells, or distributes pharmaceuticals, medications, or prescription drugs. "Pharmaceutical company" does not include a pharmaceutical benefits manager, as included in subdivision (c), or a provider of health care.

(q) "Provider of health care" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Provider of health care" does not include insurance institutions as defined in subdivision (k) of Section 791.02 of the Insurance Code.

(r) "Sensitive services" means all health care services described in Sections 6924, 6925, 6926, 6927, 6928, and 6929 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by any patient who has reached the minimum age specified for

consenting to the service specified in the section, including patients 18 years of age and older.

SEC. 3. Section 56.104 of the Civil Code is amended to read:

56.104. (a) Notwithstanding subdivision (c) of Section 56.10, except as provided in subdivision (e), no provider of health care, health care service plan, or contractor may release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to subdivision (c) of Section 56.10, if the requested information specifically relates to the patient's participation in outpatient treatment with a psychotherapist, unless the person or entity requesting that information submits to the patient pursuant to subdivision (b) and to the provider of health care, health care service plan, or contractor a written request, signed by the person requesting the information or an authorized agent of the entity requesting the information, that includes all of the following:

(1) The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses.

(2) The length of time during which the information will be kept before being destroyed or disposed of. A person or entity may extend that timeframe, provided that the person or entity notifies the provider, plan, or contractor of the extension. Any notification of an extension shall include the specific reason for the extension, the intended use or uses of the information during the extended time, and the expected date of the destruction of the information.

(3) A statement that the information will not be used for any purpose other than its intended use.

(4) A statement that the person or entity requesting the information will destroy the information and all copies in the person's or entity's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified in paragraph (2) has expired.

(b) The person or entity requesting the information shall submit a copy of the written request required by this section to the patient within 30 days of receipt of the information requested, unless the patient has signed a written waiver in the form of a letter signed and submitted by the patient to the provider of health care or health care service plan waiving notification.

(c) For purposes of this section, "psychotherapist" means a person who is both a "psychotherapist" as defined in Section 1010 of the Evidence Code and a "provider of health care" as defined in Section 56.05.

(d) This section does not apply to the disclosure or use of medical information by a law enforcement agency or a regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes, unless the disclosure is otherwise prohibited by law.

(e) This section shall not apply to any of the following:

(1) Information authorized to be disclosed pursuant to paragraph (1) of subdivision (c) of Section 56.10.

(2) Information requested from a psychotherapist by law enforcement or by the target of the threat subsequent to a disclosure by that psychotherapist authorized by paragraph (19) of subdivision (c) of Section 56.10, in which the additional information is clearly necessary to prevent the serious and imminent threat disclosed under that paragraph.

(3) Information disclosed by a psychotherapist pursuant to paragraphs (14) and (22) of subdivision (c) of Section 56.10 and

requested by an agency investigating the abuse reported pursuant to those paragraphs.

(f) Nothing in this section shall be construed to grant any additional authority to a provider of health care, health care service plan, or contractor to disclose information to a person or entity without the patient's consent.

SEC. 4. Section 56.107 is added to the Civil Code, to read:

56.107. (a) Notwithstanding any other law, and to the extent permitted by federal law, a health care service plan or health insurer shall take the following steps to protect the confidentiality of an insured individual's medical information as follows:

(1) A health care service plan or health insurer shall not send insurance communications relating to sensitive services:

(A) Unless the health care service plan or health insurer has received an authorization for insurance communications from an insured individual who is under 26 years of age and insured as a dependent on another person's insurance policy.

(B) For an insured individual to whom subparagraph (A) does not apply, if that insured individual has submitted a nondisclosure request.

(2) A health care service plan or health insurer shall comply with a confidential communications request regarding sensitive services from an insured individual.

(3) A health care service plan or health insurer shall comply with a nondisclosure request or a confidential communications request from an insured individual who states that disclosure of ~~health~~ *medical* information will endanger the individual, and shall not require an explanation as to the basis for the insured individual's statement that disclosure will endanger the individual.

(b) Notwithstanding subdivision (a), the provider of health care may make arrangements with the insured individual for the payment of benefit cost sharing and communicate that arrangement with the health care service plan or health insurer.

(c) A health care service plan or health insurer shall not condition enrollment or coverage in the health plan or health insurance policy or eligibility for benefits on the provision of an authorization for insurance communications.

SEC. 5. Section 56.16 of the Civil Code is amended to read:

56.16. For disclosures not addressed by Section 56.1007, unless there is a specific written request by the patient to the contrary, nothing in this part shall be construed to prevent a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, upon an inquiry concerning a specific patient, from releasing at its discretion any of the following information: the patient's name, address, age, and sex; a general description of the reason for treatment (whether an injury, a burn, poisoning, or some unrelated condition); the general nature of the injury, burn, poisoning, or other condition; the general condition of the patient; and any information that is not medical information as defined in Section 56.05.

SEC. 6. Section 1280.15 of the Health and Safety Code is amended to read:

1280.15. (a) A clinic, health facility, home health agency, or hospice licensed pursuant to Section 1204, 1250, 1725, or 1745 shall prevent unlawful or unauthorized access to, and use or disclosure of, patients' medical information, as defined in Section 56.05 of the Civil Code and consistent with Section 130203. For purposes of this section, internal paper records, electronic mail, or facsimile transmissions inadvertently misdirected within the same facility or

health care system within the course of coordinating care or delivering services shall not constitute unauthorized access to, or use or disclosure of, a patient's medical information. The department, after investigation, may assess an administrative penalty for a violation of this section of up to twenty-five thousand dollars ($25,000) per patient whose medical information was unlawfully or without authorization accessed, used, or disclosed, and up to seventeen thousand five hundred dollars ($17,500) per subsequent occurrence of unlawful or unauthorized access, use, or disclosure of that ~~patients'~~ *patient's* medical information. For purposes of the investigation, the department shall consider the clinic's, health facility's, agency's, or hospice's history of compliance with this section and other related state and federal statutes and regulations, the extent to which the facility detected violations and took preventative action to immediately correct and prevent past violations from recurring, and factors outside its control that restricted the facility's ability to comply with this section. The department shall have full discretion to consider all factors when determining the amount of an administrative penalty pursuant to this section.

(b) (1) A clinic, health facility, home health agency, or hospice to which subdivision (a) applies shall report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the department no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice.

(2) Subject to subdivision (c), a clinic, health facility, home health agency, or hospice shall also report any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information to the affected patient or the patient's representative at the last known address, no later than five business days after the unlawful or unauthorized access, use, or disclosure has been detected by the clinic, health facility, home health agency, or hospice.

(c) (1) A clinic, health facility, home health agency, or hospice shall delay the reporting, as required pursuant to paragraph (2) of subdivision (b), of any unlawful or unauthorized access to, or use or disclosure of, a patient's medical information beyond five business days if a law enforcement agency or official provides the clinic, health facility, home health agency, or hospice with a written or oral statement that compliance with the reporting requirements of paragraph (2) of subdivision (b) would likely impede the law enforcement agency's investigation that relates to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information and specifies a date upon which the delay shall end, not to exceed 60 days after a written request is made, or 30 days after an oral request is made. A law enforcement agency or official may request an extension of a delay based upon a written declaration that there exists a bona fide, ongoing, significant criminal investigation of serious wrongdoing relating to the unlawful or unauthorized access to, and use or disclosure of, a patient's medical information, that notification of patients will undermine the law enforcement agency's investigation, and that specifies a date upon which the delay shall end, not to exceed 60 days after the end of the original delay period.

(2) If the statement of the law enforcement agency or official is made orally, then the clinic, health facility, home health agency, or hospice shall do both of the following:

(A) Document the oral statement, including, but not limited to,

the identity of the law enforcement agency or official making the oral statement and the date upon which the oral statement was made.

(B) Limit the delay in reporting the unlawful or unauthorized access to, or use or disclosure of, the patient's medical information to the date specified in the oral statement, not to exceed 30 calendar days from the date that the oral statement is made, unless a written statement that complies with the requirements of this subdivision is received during that time.

(3) A clinic, health facility, home health agency, or hospice shall submit a report that is delayed pursuant to this subdivision not later than five business days after the date designated as the end of the delay.

(d) If a clinic, health facility, home health agency, or hospice to which subdivision (a) applies violates subdivision (b), the department may assess the licensee a penalty in the amount of one hundred dollars ($100) for each day that the unlawful or unauthorized access, use, or disclosure is not reported to the department or the affected patient, following the initial five-day period specified in subdivision (b). However, the total combined penalty assessed by the department under subdivision (a) and this subdivision shall not exceed two hundred fifty thousand dollars ($250,000) per reported event. For enforcement purposes, it shall be presumed that the facility did not notify the affected patient if the notification was not documented. This presumption may be rebutted by a licensee only if the licensee demonstrates, by a preponderance of the evidence, that the notification was made.

(e) In enforcing subdivisions (a) and (d), the department shall take into consideration the special circumstances of small and rural hospitals, as defined in Section 124840, and primary care clinics, as defined in subdivision (a) of Section 1204, in order to protect access to quality care in those hospitals and clinics. When assessing a penalty on a skilled nursing facility or other facility subject to Section 1423, 1424, 1424.1, or 1424.5, the department shall issue only the higher of either a penalty for the violation of this section or a penalty for violation of Section 1423, 1424, 1424.1, or 1424.5, not both.

(f) All penalties collected by the department pursuant to this section, Sections 1280.1, 1280.3, and 1280.4, shall be deposited into the Internal Departmental Quality Improvement Account, which is hereby created within the Special Deposit Fund under Section 16370 of the Government Code. Upon appropriation by the Legislature, moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program.

(g) If the licensee disputes a determination by the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, or the imposition of a penalty under this section, the licensee may, within 10 days of receipt of the penalty assessment, request a hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and the penalty has been upheld.

(h) In lieu of disputing the determination of the department regarding a failure to prevent or failure to timely report unlawful or unauthorized access to, or use or disclosure of, patients' medical information, transmit to the department 75 percent of the total amount of the administrative penalty, for each violation, within 30 business days of receipt of the administrative penalty.

(i) Notwithstanding any other law, the department may refer violations of this section to the Office of Health Information Integrity for enforcement pursuant to Section 130303.

(j) For purposes of this section, the following definitions shall

apply:

(1) "Reported event" means all breaches included in any single report that is made pursuant to subdivision (b), regardless of the number of breach events contained in the report.

(2) "Unauthorized" means the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or any other statute or regulation governing the lawful access, use, or disclosure of medical information.

SEC. 7. Section 1627 of the Health and Safety Code is amended to read:

1627. (a) (1) On or before July 1, 2011, the University of California is requested to develop a plan to establish and administer the Umbilical Cord Blood Collection Program for the purpose of collecting units of umbilical cord blood for public use in transplantation and providing nonclinical units for research pertaining to biology and new clinical utilization of stem cells derived from the blood and tissue of the placenta and umbilical cord. The program shall conclude no later than January 1, 2018.

(2) For purposes of this article, "public use" means both of the following:

(A) The collection of umbilical cord blood units from genetically diverse donors that will be owned by the University of California. This inventory shall be accessible by the National Registry and by qualified California-based and other United States and international registries and transplant centers to increase the likelihood of providing suitably matched donor cord blood units to patients or research participants who are in need of a transplant.

(B) Cord blood units with a lower number of cells than deemed necessary for clinical transplantation and units that meet clinical requirements, but for other reasons are unsuitable, unlikely to be transplanted, or otherwise unnecessary for clinical use, may be made available for research.

(b) (1) In order to implement the collection goals of this program, the University of California may, commensurate with available funds appropriated to the University of California for this program, contract with one or more selected applicant entities that have demonstrated the competence to collect and ship cord blood units in compliance with federal guidelines and regulations.

(2) It is the intent of the Legislature that, if the University of California contracts with another entity pursuant to this subdivision, the following shall apply:

(A) The University of California may use a competitive process to identify the best proposals submitted by applicant entities to administer the collection and research objectives of the program, to the extent that the University of California chooses not to undertake these activities itself.

(B) In order to qualify for selection under this section to receive, process, cryopreserve, or bank cord blood units, the entity shall, at a minimum, have obtained an investigational new drug (IND) exemption from the FDA or a biologic license from the FDA, as appropriate, to manufacture clinical grade cord blood stem cell units for clinical indications.

(C) In order to qualify to receive appropriate cord blood units and placental tissue to advance the research goals of this program, an entity shall, at a minimum, be a laboratory recognized as having performed peer-reviewed research on stem and progenitor cells,

including those derived from placental or umbilical cord blood and postnatal tissue.

(3) A medical provider or research facility shall comply with, and shall be subject to, existing penalties for violations of all applicable state and federal laws with respect to the protection of any medical information, as defined in Section 56.05 of the Civil Code, and any personally identifiable information contained in the umbilical cord blood inventory.

(c) The University of California is encouraged to make every effort to avoid duplication or conflicts with existing and ongoing programs and to leverage existing resources.

(d) (1) All information collected pursuant to the program shall be confidential, and shall be used solely for the purposes of the program, including research. Access to confidential information shall be limited to authorized persons who are bound by appropriate institutional policies or who otherwise agree, in writing, to maintain the confidentiality of that information.

(2) Any person who, in violation of applicable institutional policies or a written agreement to maintain confidentiality, discloses any information provided pursuant to this section, or who uses information provided pursuant to this section in a manner other than as approved pursuant to this section, may be denied further access to any confidential information maintained by the University of California, and shall be subject to a civil penalty not exceeding one thousand dollars ($1,000). The penalty provided for in this section shall not be construed to limit or otherwise restrict any remedy, provisional or otherwise, provided by law for the benefit of the University of California or any other person covered by this section.

(3) Notwithstanding the restrictions of this section, an individual to whom the confidential information pertains shall have access to his or her own personal information.

(e) It is the intent of the Legislature that the plan and implementation of the program provide for both of the following:

(1) Limit fees for access to cord blood units to the reasonable and actual costs of storage, handling, and providing units, as well as for related services such as donor matching and testing of cord blood and other programs and services typically provided by cord blood banks and public use programs.

(2) The submittal of the plan developed pursuant to subdivision (a) to the health and fiscal committees of the Legislature.

(f) It is additionally the intent of the Legislature that the plan and implementation of the program attempt to provide for all of the following:

(1) Development of a strategy to increase voluntary participation by hospitals in the collection and storage of umbilical cord blood and identify funding sources to offset the financial impact on hospitals.

(2) Consideration of a medical contingency response program to prepare for and respond effectively to biological, chemical, or radiological attacks, accidents, and other public health emergencies where victims potentially benefit from treatment.

(3) Exploration of the feasibility of operating the program as a self-funding program, including the potential for charging users a reimbursement fee.

SEC. 8. Section 117928 of the Health and Safety Code is amended to read:

117928. (a) Any common storage facility for the collection of medical waste produced by small quantity generators operating independently, but sharing common storage facilities, shall have a

permit issued by the enforcement agency.

(b) A permit for any common storage facility specified in subdivision (a) may be obtained by any one of the following:

(1) A provider of health care as defined in Section 56.05 of the Civil Code.

(2) The registered hazardous waste transporter.

(3) The property owner.

(4) The property management firm responsible for providing tenant services to the medical waste generators.

SEC. 9. Section 120985 of the Health and Safety Code is amended to read:

120985. (a) Notwithstanding Section 120980, the results of an HIV test that identifies or provides identifying characteristics of the person to whom the test results apply may be recorded by the physician who ordered the test in the test subject's medical record or otherwise disclosed without written authorization of the subject of the test, or the subject's representative as set forth in Section 121020, to the test subject's providers of health care, as defined in Section 56.05 of the Civil Code, for purposes of diagnosis, care, or treatment of the patient, except that for purposes of this section , "providers of health care" does not include a health care service plan regulated pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2.

(b) Recording or disclosure of HIV test results pursuant to subdivision (a) does not authorize further disclosure unless otherwise permitted by law.

SEC. 10. Section 121010 of the Health and Safety Code is amended to read:

121010. Notwithstanding Section 120975 or 120980, the results of a blood test to detect antibodies to the probable causative agent of AIDS may be disclosed to any of the following persons without written authorization of the subject of the test:

(a) To the subject of the test or the subject's legal representative, conservator, or to any person authorized to consent to the test pursuant to subdivision (b) of Section 120990.

(b) To a test subject's provider of health care, as defined in Section 56.05 of the Civil Code, except that for purposes of this section, "provider of health care" does not include a health care service plan regulated pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2.

(c) To an agent or employee of the test subject's provider of health care who provides direct patient care and treatment.

(d) To a provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7).

(e) (1) To the designated officer of an emergency response employee, and from that designated officer to an emergency response employee regarding possible exposure to HIV or AIDS, but only to the extent necessary to comply with provisions of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

(2) For purposes of this subdivision, "designated officer" and "emergency response employee" have the same meaning as these terms are used in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

(3) The designated officer shall be subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV results. Further, the designated officer shall inform the

exposed emergency response employee that the employee is also subject to the confidentiality requirements specified in Section 120980, and may be personally liable for unauthorized release of any identifying information about the HIV test results.

SEC. 11. Section 130201 of the Health and Safety Code is amended to read:

130201. For purposes of this division, the following definitions apply:

(a) "Director" means the Director of the Office of Health Information Integrity.

(b) "Medical information" means the term as defined in Section 56.05 of the Civil Code.

(c) "Office" means the Office of Health Information Integrity.

(d) "Provider of health care" means the term as defined in Sections 56.05 and 56.06 of the Civil Code.

(e) "Unauthorized access" means the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or by other statutes or regulations governing the lawful access, use, or disclosure of medical information.

SEC. 12. Section 791.29 is added to the Insurance Code , to read:

791.29. A health insurer, as defined in subdivision (h) of Section 56.05 of the Civil Code, shall comply with the provisions of Section 56.107 of the Civil Code to the extent required by that section. To the extent this article conflicts with Section 56.107 of the Civil Code, the provisions of Section 56.107 of the Civil Code shall control.

~~SEC. 12.~~ *SEC. 13.* Section 3208.05 of the Labor Code is amended to read:

3208.05. (a) "Injury" includes a reaction to or a side effect arising from health care provided by an employer to a health care worker, which health care is intended to prevent the development or manifestation of any bloodborne disease, illness, syndrome, or condition recognized as occupationally incurred by Cal-OSHA, the federal Centers for Disease Control and Prevention, or other appropriate governmental entities. This section shall apply only to preventive health care that the employer provided to a health care worker under the following circumstances: (1) prior to an exposure because of risk of occupational exposure to such a disease, illness, syndrome, or condition, or (2) where the preventive care is provided as a consequence of a documented exposure to blood or bodily fluid containing blood that arose out of and in the course of employment. Such a disease, illness, syndrome, or condition includes, but is not limited to, hepatitis, and the human immunodeficiency virus. Such preventive health care, and any disability indemnity or other benefits required as a result of the preventive health care provided by the employer, shall be compensable under the workers' compensation system. The employer may require the health care worker to document that the employer provided the preventive health care and that the reaction or side effects arising from the preventive health care resulted in lost work time, health care costs, or other costs normally compensable under workers' compensation.

(b) The benefits of this section shall not be provided to a health care worker for a reaction to or side effect from health care intended to prevent the development of the human immunodeficiency virus if the worker claims a work-related exposure and if the worker tests positive within 48 hours of that exposure to a test to

determine the presence of the human immunodeficiency virus.

(c) For purposes of this section, "health care worker" includes any person who is an employee of a provider of health care as defined in Section 56.05 of the Civil Code, and who is exposed to human blood or other bodily fluids contaminated with blood in the course of employment, including, but not limited to, a registered nurse, a licensed vocational nurse, a certified nurse aide, clinical laboratory technologist, dental hygienist, physician, janitor, and housekeeping worker. "Health care worker" does not include an employee who provides employee health services for an employer primarily engaged in a business other than providing health care.

~~SEC. 13.~~ *SEC. 14.* 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.

BILL NUMBER: SB 158 AMENDED
BILL TEXT

AMENDED IN SENATE MARCH 21, 2013

INTRODUCED BY Senator Correa
(*Coauthor: Senator Beall*
)

FEBRUARY 1, 2013

An act *to add and repeal Section 4639.8 of the Welfare and Institutions Code,* relating to autism *services* .

LEGISLATIVE COUNSEL'S DIGEST

SB 158, as amended, Correa. Autism services: demonstration program.

The Lanterman Developmental Disabilities Services Act authorizes the State Department of Developmental Services to contract with regional centers to provide services and support to individuals with developmental disabilities, including autism.

This bill would ~~declare the intent of the Legislature to enact legislation that would~~ establish *, until January 1, 2019,* a demonstration program ~~that will provide technical assistance and best practices related to linguistic and cultural competency for autism services that are provided by regional centers to consumers and their families~~ *that would be known as the Regional Center Excellence in Community Autism Partnerships (RE CAP) program to implement measures in underserved communities to promote awareness and reduce the stigma associated with autism or pervasive developmental spectrum disorders, improve the early screening, diagnosis, and assessment of those disorders, and increase access to evidence-based interventions and treatments, as specified. The bill would require the department to contract with a University of California or California State University campus to serve as the coordinating center for the program. The bill would also require the departm ent to define the responsibilities of the coordinating center and to establish criteria for participation in, and guidelines for the implementation of, the program. The bill would require, on or before January 1, 2018, the center, or its designee, to provide information to the appropriate committees of the Legislature, the department, the Governor's office, and participating regional centers information regarding the efficacy and outcomes of the RE CAP program* .

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 4639.8 is added to the Welfare and Institutions Code , to read:

4639.8. (a) A demonstration program that shall provide improved services, supports, interventions, and other resources to assist individuals with autism spectrum disorders (ASD), and their families, who are regional center consumers and who reside in underserved communities is hereby established pursuant to this section.

(b) The demonstration program shall be known as the Regional Center Excellence in Community Autism Partnerships (RE CAP) program.

(c) The department shall contract with a University of California or California State University campus that shall serve as a coordinating center to implement the RE CAP program. In collaboration with the participating regional centers, the coordinating center shall identify and coordinate the activities and resources of other participating entities and organizations.

(d) The department shall do all of the following:

(1) Define the responsibilities of the coordinating center.

(2) Establish appropriate criteria and parameters by which regional centers may participate in the RE CAP program.

(3) Establish criteria and parameters by which specific geographic areas in catchment areas of participating regional centers shall be designated as underserved communities.

(4) Establish guidelines, best practices, and technical assistance by which regional centers participating in the RE CAP program shall implement measures in underserved communities to accomplish any of the following:

(A) Promote awareness and reduce the stigma associated with ASD.

(B) Improve the early screening for ASD.

(C) Improve the diagnosis and assessment of ASD.

(D) Increase access to evidence-based interventions and treatments for ASD.

(5) Establish indicators and outcome measures that may be utilized to evaluate the efficacy of the RE CAP program.

(e) Participation of the regional centers shall be on a voluntary basis or as deemed necessary by the department.

(f) (1) Funding for the RE CAP program shall be from existing regional center resources in combination with additional resources provided by foundations, federal funding, and other sources and as allocated by the coordinating center for each of the RE CAP programs. No additional state funds shall be allocated for these purposes.

(2) The coordinating center shall implement the demonstration project described in this section only to the extent that adequate funding and resources are made available for the project.

(g) On or before January 1, 2018, the coordinating center, or its designee, shall provide information to the appropriate committees of the Legislature, the department, the Governor's office, and participating regional centers regarding the efficacy and outcomes of the RE CAP program.

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

~~SECTION 1. It is the intent of the Legislature to enact legislation that would establish a demonstration program that will provide technical assistance and best practices related to linguistic and cultural competency for autism services that are provided by regional centers to consumers and their families.~~

BILL NUMBER: SB 305 AMENDED
BILL TEXT

AMENDED IN SENATE APRIL 15, 2013

INTRODUCED BY Senator Price
(*Principal coauthor: Assembly Member Gordon*)

FEBRUARY 15, 2013

An act to amend Sections 2450, 2450.3, *2569, 3010.5, 3014.6,* 3685, 3686, 3710, ~~and~~ 3716 *, and 3765* of *, and to add Section 144.5 to,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 305, as amended, Price. Healing arts: boards.

Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation and would authorize a local or state agency to provide those records to the board upon request.

Existing law, the Osteopathic Act, ~~establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons.~~ *provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California.*

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that *the* review be performed as if ~~those~~ *these* provisions were scheduled to be repealed as of January 1, 2018.

Existing law, the Naturopathic Doctors Act, *until January 1, 2014,* provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. ~~Existing law repeals these provisions on January 1, 2014.~~ Existing law also specifies that the *repeal of the* committee ~~is subject~~ *subjects it* to review by the appropriate policy committees of the Legislature.

This bill would ~~instead repeal those provisions on January 1, 2018,~~ *extend the operation of these provisions until January 1, 2018,* and make conforming changes.

Existing law provides for the regulation of dispensing opticians, as defined, by the Medical Board of California.

This bill would require that the powers and duties of the board,

as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.

Existing law *, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act* provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. ~~Existing law~~ *Each of those acts* authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014 and subjects the ~~board~~ *boards* to review by the Joint ~~Sunset Review Committee~~ *Committee on Boards, Commissions, and Consumer Protection* .

This bill would ~~instead repeal those provisions on January 1, 2018,~~ *extend the operation of these provisions until January 1, 2018,* and provide that the ~~committee is subject to~~ *repeal of these provisions subjects the boards to* review by the appropriate policy committees of the Legislature.

The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified acts, including, among others, the performance of respiratory care services in case of an emergency or self-care by a patient.

This bill would additionally authorize 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.

This bill would make legislative findings and declarations as to the necessity of a special statute for the persons described above.

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 144.5 is added to the Business and Professions Code , to read:

144.5. Notwithstanding any other law, a board described in Section 144 may request, and is authorized to receive, from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. A local or state agency may provide those records to the board upon request.

~~SECTION 1.~~ *SEC. 2.* Section 2450 of the Business and Professions Code is amended to read:

2450. There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.

Persons who elect to practice using the term of suffix "M.D.," as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election.

Notwithstanding any other law, the powers and duties of the Osteopathic Medical Board of California, as set forth in this article and under the Osteopathic Act, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

~~SEC. 2.~~ *SEC. 3.* Section 2450.3 of the Business and Professions Code is amended to read:

2450.3. There is within the jurisdiction of the Osteopathic Medical Board of California a Naturopathic Medicine Committee authorized under the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)). This section shall become inoperative on January 1, 2018, and, as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the Naturopathic Medicine Committee subject to review by the appropriate policy committees of the Legislature.

SEC. 4. Section 2569 of the Business and Professions Code is amended to read:

2569. ~~The~~ *Notwithstanding any other law, the* powers and duties of the board, as set forth in this chapter, shall be subject to ~~the~~ review ~~required by Division 1.2 (commencing with Section 473).~~ *by the appropriate policy committees of the Legislature.* The review shall be performed as if this chapter were scheduled to be repealed as of January 1, ~~2014, as described in Section 473.1.~~ *2018.*

SEC. 5. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date. ~~The~~ *Notwithstanding any other law, the* repeal of this section renders the board subject to ~~the~~ review ~~required by Division 1.2 (commencing with Section 473).~~ *by the appropriate policy committees of the Legislature.*

SEC. 6. Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (a) 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 him or her by this chapter.

(b) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date.

~~SEC. 3.~~ *SEC. 7.* Section 3685 of the Business and Professions Code is amended to read:

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

~~SEC. 4.~~ *SEC. 8.* Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

~~SEC. 5.~~ *SEC. 9.* Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

~~SEC. 6.~~ *SEC. 10.* Section 3716 of the Business and Professions Code is amended to read:

3716. The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 11. 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 himself or herself 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 speciality.

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.

(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 Health Services of specific, limited, and basic respiratory care or respiratory care related services that have been

authorized by the board.

(i) 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. 12. The Legislature finds and declares that a special law, as set forth in Section 11 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by Los Angeles county hospitals and have performed pulmonary function testing for at least 15 years.

BILL NUMBER: SB 306 AMENDED
BILL TEXT

AMENDED IN SENATE APRIL 18, 2013

INTRODUCED BY Senator Price
(*Principal coauthor: Assembly Member Gordon*)

FEBRUARY 15, 2013

An act to amend Sections 1000, *2530.2,* 2531, 2531.75, ~~and~~ *2533,* 2570.19 *, 2602, and 2607.5* of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 306, as amended, Price. Healing arts: boards.

The Chiropractic Act, *enacted by* an initiative ~~measure approved by the electors on November 7, 1922,~~ *measure,* provides for the regulation and licensing of chiropractors in this state by the State Board of Chiropractic Examiners. Existing law specifies that the law governing chiropractors is found in the act.

This bill would ~~provide~~ *require* that the powers and duties of the ~~State Board of Chiropractic Examiners,~~ *board,* as provided, ~~shall~~ be subject to review by the appropriate policy committees of the ~~Legislature~~ *Legislature. The bill would require that the review of the board be performed* as if ~~those~~ *these* provisions were scheduled to be repealed on January 1, 2018.

~~Existing law establishes the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board in the Department of Consumer Affairs and makes the board responsible for the licensure of speech-language pathologists, audiologists, and hearing aid dispensers.~~ Existing law *, the Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act, provides for the licensure and regulation of speech-language pathologists, audiologists, and hearing aid dispensers by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. The act* authorizes the board to appoint an executive officer. Existing law repeals these provisions on January 1, 2014, and subjects the board to review by the Joint ~~Sunset Review and Committee prior to that repeal.~~ *Committee on Boards, Commissions, and Consumer Protection.*

This bill would ~~instead repeal those provisions on~~ *extend the operation of these provisions until* January 1, 2018, and ~~would subject~~ *provide*

that the repeal of these provisions subjects the board to review by the appropriate policy committees of the Legislature. *The bill would also rename the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board as the California Speech and Hearing Board. The bill would make conforming changes.*

The Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act also authorizes the board to refuse to issue, or issue subject to terms and conditions, a license on specified grounds, including, among others, securing a license by fraud or deceit.

This bill would additionally authorize the board to refuse to issue, or issue subject to terms and conditions, a license for a violation of a term or condition of a probationary order of a license issued by the board, as provided.

Existing law *, the Occupational Therapy Practice Act,* provides for the licensure and regulation of occupational therapists, as defined, by the California Board of Occupational Therapy ~~within the Department of Consumer Affairs~~ . Existing law repeals those provisions on January 1, 2014, and subjects the board to review by the Joint ~~Sunset Review Committee prior to that repeal.~~ *Committee on Boards, Commissions, and Consumer Protection.*

This bill would ~~instead repeal those provisions on~~ *extend the operation of these provisions until* January 1, 2018, ~~would subject~~ *and provide that the repeal of these provisions subjects* the board to review by the appropriate policy committees of the Legislature.

Existing law, the Physical Therapy Practice Act, provides for the licensure and regulation of physical therapists by the Physical Therapy Board of California. The act authorizes the board to appoint an executive officer. Existing law repeals these provisions on January 1, 2014.

This bill would extend the operation of these provisions until January 1, 2018.

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 1000 of the Business and Professions Code is amended to read:

1000. The law governing practitioners of chiropractic is found in an initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," adopted by the electors November 7, 1922. Notwithstanding any other law, the powers and duties of the State Board of Chiropractic Examiners, as set forth in this article and under the act creating the board, shall be

subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 2. Section 2530.2 of the Business and Professions Code is amended to read:

2530.2. As used in this chapter, unless the context otherwise requires:

(a) "Board" means the ~~Speech-Language Pathology and Audiology and Hearing Aid Dispensers~~ *California Speech and Hearing* Board. As used in this chapter or any other provision of law, *"Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board" or* "Speech-Language Pathology and Audiology Board" shall be deemed to refer to the ~~Speech-Language Pathology and Audiology and Hearing Aid Dispensers~~ *California Speech and Hearing* Board or any successor.

(b) "Person" means any individual, partnership, corporation, limited liability company, or other organization or combination thereof, except that only individuals can be licensed under this chapter.

(c) A "speech-language pathologist" is a person who practices speech-language pathology.

(d) The practice of speech-language pathology means all of the following:

(1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing.

(2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals.

(3) Conducting hearing screenings.

(4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures.

(e) (1) Instrumental procedures referred to in subdivision (d) are the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing as well as to guide communication and swallowing assessment and therapy.

(2) Nothing in this subdivision shall be construed as a diagnosis. Any observation of an abnormality shall be referred to a physician and surgeon.

(f) A licensed speech-language pathologist shall not perform a flexible fiberoptic nasendoscopic procedure unless he or she has received written verification from an otolaryngologist certified by the American Board of Otolaryngology that the speech-language pathologist has performed a minimum of 25 flexible fiberoptic nasendoscopic procedures and is competent to perform these

procedures. The speech-language pathologist shall have this written verification on file and readily available for inspection upon request by the board. A speech-language pathologist shall pass a flexible fiberoptic nasendoscopic instrument only under the direct authorization of an otolaryngologist certified by the American Board of Otolaryngology and the supervision of a physician and surgeon.

(g) A licensed speech-language pathologist shall only perform flexible endoscopic procedures described in subdivision (e) in a setting that requires the facility to have protocols for emergency medical backup procedures, including a physician and surgeon or other appropriate medical professionals being readily available.

(h) "Speech-language pathology aide" means any person meeting the minimum requirements established by the board, who works directly under the supervision of a speech-language pathologist.

(i) (1) "Speech-language pathology assistant" means a person who meets the academic and supervised training requirements set forth by the board and who is approved by the board to assist in the provision of speech-language pathology under the direction and supervision of a speech-language pathologist who shall be responsible for the extent, kind, and quality of the services provided by the speech-language pathology assistant.

(2) The supervising speech-language pathologist employed or contracted for by a public school may hold a valid and current license issued by the board, a valid, current, and professional clear clinical or rehabilitative services credential in language, speech, and hearing issued by the Commission on Teacher Credentialing, or other credential authorizing service in language, speech, and hearing issued by the Commission on Teacher Credentialing that is not issued on the basis of an emergency permit or waiver of requirements. For purposes of this paragraph, a "clear" credential is a credential that is not issued pursuant to a waiver or emergency permit and is as otherwise defined by the Commission on Teacher Credentialing. Nothing in this section referring to credentialed supervising speech-language pathologists expands existing exemptions from licensing pursuant to Section 2530.5.

(j) An "audiologist" is one who practices audiology.

(k) "The practice of audiology" means the application of principles, methods, and procedures of measurement, testing, appraisal, prediction, consultation, counseling, instruction related to auditory, vestibular, and related functions and the modification of communicative disorders involving speech, language, auditory behavior or other aberrant behavior resulting from auditory dysfunction; and the planning, directing, conducting, supervising, or participating in programs of identification of auditory disorders, hearing conservation, cerumen removal, aural habilitation, and rehabilitation, including, hearing aid recommendation and evaluation procedures including, but not limited to, specifying amplification requirements and evaluation of the results thereof, auditory training, and speech reading, and the selling of hearing aids.

(l) A "dispensing audiologist" is a person who is authorized to sell hearing aids pursuant to his or her audiology license.

(m) "Audiology aide" means any person meeting the minimum

requirements established by the board. An audiology aid may not perform any function that constitutes the practice of audiology unless he or she is under the supervision of an audiologist. The board may by regulation exempt certain functions performed by an industrial audiology aide from supervision provided that his or her employer has established a set of procedures or protocols that the aide shall follow in performing these functions.

(n) "Medical board" means the Medical Board of California.

(o) A "hearing screening" performed by a speech-language pathologist means a binary puretone screening at a preset intensity level for the purpose of determining if the screened individuals are in need of further medical or audiological evaluation.

(p) "Cerumen removal" means the nonroutine removal of cerumen within the cartilaginous ear canal necessary for access in performance of audiological procedures that shall occur under physician and surgeon supervision. Cerumen removal, as provided by this section, shall only be performed by a licensed audiologist. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but shall include all of the following:

(1) Collaboration on the development of written standardized protocols. The protocols shall include a requirement that the supervised audiologist immediately refer to an appropriate physician any trauma, including skin tears, bleeding, or other pathology of the ear discovered in the process of cerumen removal as defined in this subdivision.

(2) Approval by the supervising physician of the written standardized protocol.

(3) The supervising physician shall be within the general vicinity, as provided by the physician-audiologist protocol, of the supervised audiologist and available by telephone contact at the time of cerumen removal.

(4) A licensed physician and surgeon may not simultaneously supervise more than two audiologists for purposes of cerumen removal.

~~SEC. 2.~~ *SEC. 3.* Section 2531 of the Business and Professions Code is amended to read:

2531. (a) There is in the Department of Consumer Affairs ~~a Speech-Language Pathology and Audiology and Hearing Aid Dispensers~~ *the California Speech and Hearing* Board in which the enforcement and administration of this chapter are vested. The ~~Speech-Language Pathology and Audiology and Hearing Aid Dispensers~~ *California Speech and Hearing* Board shall consist of nine members, three of whom shall be public members.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

~~SEC. 3.~~ *SEC. 4.* Section 2531.75 of

the Business and Professions Code is amended to read:

2531.75. (a) 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 him or her by this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 5. Section 2533 of the Business and Professions Code is amended to read:

2533. The board may refuse to issue, or issue subject to terms and conditions, a license on the grounds specified in Section 480, or may suspend, revoke, or impose terms and conditions upon the license of any licensee for any of the following:

(a) Conviction of a crime substantially related to the qualifications, functions, and duties of a speech-language pathologist or audiologist or hearing aid dispenser, as the case may be. The record of the conviction shall be conclusive evidence thereof.

(b) Securing a license by fraud or deceit.

(c) (1) The use or administering to himself or herself, of any controlled substance; (2) the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in a manner as to be dangerous or injurious to the licensee, to any other person, or to the public, or to the extent that the use impairs the ability of the licensee to practice speech-language pathology or audiology safely; (3) more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section; or (4) any combination of paragraph (1), (2), or (3). The record of the conviction shall be conclusive evidence of unprofessional conduct.

(d) Advertising in violation of Section 17500. Advertising an academic degree that was not validly awarded or earned under the laws of this state or the applicable jurisdiction in which it was issued is deemed to constitute a violation of Section 17500.

(e) Committing a dishonest or fraudulent act that is substantially related to the qualifications, functions, or duties of a licensee.

(f) Incompetence, gross negligence, or repeated negligent acts.

(g) Other acts that have endangered or are likely to endanger the health, welfare, and safety of the public.

(h) Use by a hearing aid dispenser of the term "doctor" or "physician" or "clinic" or "audiologist," or any derivation thereof, except as authorized by law.

(i) The use, or causing the use, of any advertising or promotional literature in a manner that has the capacity or tendency to mislead or deceive purchasers or prospective purchasers.

(j) Any cause that would be grounds for denial of an application for a license.

(k) Violation of Section 1689.6 or 1793.02 of the Civil Code.

(l) Violation of a term or condition of a probationary order of a

license issued by the board pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

~~SEC. 4.~~ *SEC. 6.* Section 2570.19 of the Business and Professions Code is amended to read:

2570.19. (a) There is hereby created a California Board of Occupational Therapy, hereafter referred to as the board. The board shall enforce and administer this chapter.

(b) The members of the board shall consist of the following:

(1) Three occupational therapists who shall have practiced occupational therapy for five years.

(2) One occupational therapy assistant who shall have assisted in the practice of occupational therapy for five years.

(3) Three public members who shall not be licentiates of the board, of any other board under this division, or of any board referred to in Section 1000 or 3600.

(c) The Governor shall appoint the three occupational therapists and one occupational therapy assistant to be members of the board. The Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall each appoint a public member. Not more than one member of the board shall be appointed from the full-time faculty of any university, college, or other educational institution.

(d) All members shall be residents of California at the time of their appointment. The occupational therapist and occupational therapy assistant members shall have been engaged in rendering occupational therapy services to the public, teaching, or research in occupational therapy for at least five years preceding their appointments.

(e) The public members may not be or have ever been occupational therapists or occupational therapy assistants or in training to become occupational therapists or occupational therapy assistants. The public members may not be related to, or have a household member who is, an occupational therapist or an occupational therapy assistant, and may not have had, within two years of the appointment, a substantial financial interest in a person regulated by the board.

(f) The Governor shall appoint two board members for a term of one year, two board members for a term of two years, and one board member for a term of three years. Appointments made thereafter shall be for four-year terms, but no person shall be appointed to serve more than two consecutive terms. Terms shall begin on the first day of the calendar year and end on the last day of the calendar year or until successors are appointed, except for the first appointed members who shall serve through the last calendar day of the year in which they are appointed, before commencing the terms prescribed by this section. Vacancies shall be filled by appointment for the unexpired term. The board shall annually elect one of its members as president.

(g) The board shall meet and hold at least one regular meeting annually in the Cities of Sacramento, Los Angeles, and San Francisco. The board may convene from time to time until its business is concluded. Special meetings of the board may be held at any time and

place designated by the board.

(h) Notice of each meeting of the board shall be given in accordance with 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).

(i) Members of the board shall receive no compensation for their services, but shall be entitled to reasonable travel and other expenses incurred in the execution of their powers and duties in accordance with Section 103.

(j) The appointing power shall have the power to remove any member of the board from office for neglect of any duty imposed by state law, for incompetency, or for unprofessional or dishonorable conduct.

(k) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 7. Section 2602 of the Business and Professions Code is amended to read:

2602. The Physical Therapy Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date.

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

SEC. 8. Section 2607.5 of the Business and Professions Code is amended to read:

2607.5. (a) 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 him or her by this chapter.

(b) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date.

BILL NUMBER: SB 381 INTRODUCED
BILL TEXT

INTRODUCED BY Senator Yee

FEBRUARY 20, 2013

An act to add Section 734 to the Business and Professions Code, relating to chiropractic practice.

LEGISLATIVE COUNSEL'S DIGEST

SB 381, as introduced, Yee. Healing arts: chiropractic practice.

Existing law, the Chiropractic Act, enacted by an initiative measure, provides for the licensure and regulation of chiropractors by the State Board of Chiropractic Examiners. Under the act, a license authorizes its holder to practice chiropractic as taught in chiropractic schools or colleges but does not authorize its holder to practice medicine, surgery, osteopathy, dentistry, or optometry.

Existing law provides for the licensure and regulation of physicians and surgeons and osteopathic physicians and surgeons by the Medical Board of California and the Osteopathic Medical Board of California, respectively.

This bill would prohibit a health care practitioner from performing a joint manipulation or joint adjustment, as defined, unless he or she is a licensed chiropractor, physician and surgeon, or osteopathic physician and surgeon. The bill would provide that a health care practitioner who performs a joint manipulation or joint adjustment in violation of these provisions engages in the unlawful practice of chiropractic, which shall constitute, among other things, good cause for the revocation or suspension of the health care practitioner's license, as specified.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 734 is added to the Business and Professions Code, to read:

734. (a) Notwithstanding any other law, a health care practitioner subject to regulation pursuant to this division shall not be authorized to perform a joint manipulation or joint adjustment except for the following individuals:

(1) A chiropractor licensed by the State Board of Chiropractic Examiners.

(2) A physician and surgeon licensed by the Medical Board of California.

(3) An osteopathic physician and surgeon licensed by the Osteopathic Medical Board of California.

(b) A health care practitioner who performs a joint manipulation or joint adjustment in violation of this section engages in the unlawful practice of chiropractic, which shall constitute good cause for the revocation or suspension of the health care practitioner's license, or any other disciplinary action deemed appropriate by the health care practitioner's licensing board.

(c) For purposes of this section, "joint manipulation" and "joint

adjustment" are synonymous terms that describe a method of skillful and beneficial treatment where a person uses a direct thrust to move the joint of a patient beyond its normal range of motion, but without exceeding the limits of anatomical integrity, as taught in chiropractic schools or colleges.

BILL NUMBER: SB 555 AMENDED
BILL TEXT

AMENDED IN SENATE APRIL 1, 2013

INTRODUCED BY Senator Correa
(*Principal coauthor: Senator Padilla*)

FEBRUARY 22, 2013

An act *to amend Section 95020 of the Government Code, and to amend Sections 4512, 4641, 4642, 4643, 4646, 4646.5, 4648, and 4685 of the Welfare and Institutions Code,* relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

SB 555, as amended, Correa. Developmental services: *regional centers:* individual program plans and ~~individual~~ *individualized* family service plans.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is authorized to contract with regional centers to provide services and supports to individuals with developmental disabilities. The services and supports to be provided to a regional center consumer are contained in an individual program plan (IPP) or ~~individual~~ *individualized* family service plan (IFSP), developed in accordance with prescribed requirements. Existing law states that it is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, as specified.

~~This bill would state the intent of the Legislature to enact legislation that would require an IPP or IFSP to consider the needs of the consumer, and his or her family, in order to provide services and supports in a culturally and linguistically appropriate manner.~~

This bill would require those provisions to be implemented in a manner that meets the cultural preferences, values, lifestyle, and native language of the consumer and the consumer's family, and require the IPP or IFSP, and the services and supports provided under the IPP or IFSP, to be designed to meet the cultural preferences, values, and lifestyle of the consumer and the consumer's family, and provided in their native language, as defined.

Under existing law, regional centers are required to conduct casefinding activities, including notification of the availability of

services in English and other languages that are appropriate to the service area.

This bill would require the department and the regional centers to ensure that consumers and their families receive culturally and linguistically competent information, including written documents, about the IPP and the IFSP, and related processes and procedures, as prescribed. This bill would require each regional center to make this information available to the public, and require the department and the regional centers to make this information available on the department's and regional center's Internet Web sites.

Under existing law, a person believed to have a developmental disability or to have a high risk of parenting a developmentally disabled infant is eligible for initial intake and assessment in the regional centers, as specified.

This bill would require all communication with the consumer and his or her family pursuant to those provisions to be in their native language.

This bill would make other conforming changes.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) California's diverse language and ethnic communities account for about 60 percent of its population. The number of people in the United States who do not speak English as their native language has grown 140 percent over the past three decades. In California, about 40 percent of Californians speak a language other than English at home, and the number of individuals whose first language is not English is rapidly growing.

(b) Health disparities can result in significant health, social, and economic consequences. Culturally and linguistically competent health care services can assist in achieving health equity. Health literacy plays a central role in promoting quality of life, health development, and health behaviors across all groups and life stages.

(c) To address any disparities in the regional center system, it is the intent of the Legislature that the State Department of Developmental Services and regional centers ensure that all consumers and their families receive culturally and linguistically competent information, including written documents, about the individual program plan and individualized family service plan processes and procedures. It is also the intent of the Legislature that each regional center make available culturally and linguistically competent information to individuals living in its geographic catchment area about regional center services, processes, and procedures.

SEC. 2. Section 95020 of the Government Code is amended to read:

95020. (a) An eligible infant or toddler shall have an individualized family service plan. The individualized family service plan shall be used in place of an individualized education program required pursuant to Sections 4646 and 4646.5 of the Welfare and Institutions Code, the individualized program plan required pursuant to Section 56340 of the Education Code, or any other applicable service plan.

(b) For an infant or toddler who has been evaluated for the first time, a meeting to share the results of the evaluation, to determine eligibility and, for children who are eligible, to develop the initial individualized family service plan shall be conducted within 45 calendar days of receipt of the written referral. Evaluation results and determination of eligibility may be shared in a meeting with the family prior to the individualized family service plan. Written parent consent to evaluate and assess shall be obtained within the 45-day timeline. A regional center, local educational agency, or the designee of one of those entities shall initiate and conduct this meeting. Families shall be afforded the opportunity to participate in all decisions regarding eligibility and services. During intake and assessment, but no later than the ~~IFSP~~ *individualized family service plan* meeting, the parents, legal guardian, or conservator shall provide copies of any health benefit cards under which the consumer is eligible to receive health benefits, including, but not limited to, private health insurance, a health care service plan, Medi-Cal, Medicare, and TRICARE. If the individual, or, where appropriate, the parents, legal guardians, or conservators, have no such benefits, the regional center shall not use that fact to negatively impact the services that the individual may or may not receive from the regional center.

(c) Parents shall be fully informed of their rights, including the right to invite another person, including a family member or an advocate or peer parent, or any or all of them, to accompany them to any or all individualized family service plan meetings. With parental consent, a referral shall be made to the local family resource center or network.

(d) The individualized family service plan shall be in writing and shall address all of the following:

(1) A statement of the infant's or toddler's present levels of physical development including vision, hearing, and health status, cognitive development, communication development, social and emotional development, and adaptive developments.

(2) With the concurrence of the family, a statement of the family's concerns, priorities, and resources related to meeting the special developmental needs of the eligible infant or toddler.

(3) A statement of the major outcomes expected to be achieved for the infant or toddler and family where services for the family are related to meeting the special developmental needs of the eligible infant or toddler.

(4) The criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions are necessary.

(5) (A) A statement of the specific early intervention services

necessary to meet the unique needs of the infant or toddler as identified in paragraph (3), including, but not limited to, the frequency, intensity, location, duration, and method of delivering the services, and ways of providing services in natural generic environments, including group training for parents on behavioral intervention techniques in lieu of some or all of the in-home parent training component of the behavior intervention services, and purchase of neighborhood preschool services and needed qualified personnel in lieu of infant development programs.

(B) Effective July 1, 2009, at the time of development, review, or modification of an infant's or toddler's individualized family service plan, the regional center shall consider both of the following:

(i) The use of group training for parents on behavior intervention techniques, in lieu of some or all of the in-home parent training component of the behavior intervention services.

(ii) The purchase of neighborhood preschool services and needed qualified personnel, in lieu of infant development programs.

(6) A statement of the agency responsible for providing the identified services.

(7) The name of the service coordinator who shall be responsible for facilitating implementation of the plan and coordinating with other agencies and persons.

(8) The steps to be taken to ensure transition of the infant or toddler upon reaching three years of age to other appropriate services. These may include, as appropriate, special education or other services offered in natural environments.

(9) The projected dates for the initiation of services in paragraph (5) and the anticipated duration of those services.

(e) Each service identified on the individualized family service plan shall be designated as one of three types:

(1) An early intervention service, as defined in subsection (4) of Section 1432 of Title 20 of the United States Code, and applicable regulations, that is provided or purchased through the regional center, local educational agency, or other participating agency. The State Department of Health Care Services, State Department of Social Services, and State Department of Alcohol and Drug Programs shall provide services in accordance with state and federal law and applicable regulations, and up to the level of funding as appropriated by the Legislature. Early intervention services identified on an individualized family service plan that exceed the funding, statutory, and regulatory requirements of these departments shall be provided or purchased by regional centers or local educational agencies under subdivisions (b) and (c) of Section 95014. The State Department of Health Care Services, State Department of Social Services, and State Department of Alcohol and Drug Programs shall not be required to provide early intervention services over their existing funding, statutory, and regulatory requirements.

(2) Another service, other than those specified in paragraph (1), which the eligible infant or toddler or his or her family may receive from other state programs, subject to the eligibility standards of those programs.

(3) A referral to a nonrequired service that may be provided to an eligible infant or toddler or his or her family. Nonrequired services are those services that are not defined as early intervention services or do not relate to meeting the special developmental needs of an eligible infant or toddler related to the disability, but that may be helpful to the family. The granting or denial of nonrequired services by a public or private agency is not subject to appeal under this title. Notwithstanding any other provision of law or regulation to the contrary, effective July 1, 2009, with the exception of durable medical equipment, regional centers shall not purchase nonrequired services, but may refer a family to a nonrequired service that may be available to an eligible infant or toddler or his or her family.

(f) An annual review, and other periodic reviews, of the individualized family service plan for an infant or toddler and the infant's or toddler's family shall be conducted to determine the degree of progress that is being made in achieving the outcomes specified in the plan and whether modification or revision of the outcomes or services is necessary. The frequency, participants, purpose, and required processes for annual and periodic reviews shall be consistent with the statutes and regulations under Part C of the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1431 et seq.) and this title, and shall be specified in regulations adopted pursuant to Section 95028. At the time of the review, the parents, legal guardian, or conservator shall provide copies of any health benefit cards under which the consumer is eligible to receive health benefits, including, but not limited to, private health insurance, a health care service plan, Medi-Cal, Medicare, and TRICARE. If the parents, legal guardian, or conservator have no such benefit cards, the regional center shall not use that fact to negatively impact the services that the individual may or may not receive from the regional center.

(g) Individualized family service plans and the provision of services and supports shall be designed to meet the cultural preferences, values, and lifestyle of the infant or toddler and his or her family, and shall be provided in their native language. A copy of the individualized family service plan shall be provided in their native language.

SEC. 3. Section 4512 of the Welfare and Institutions Code is amended to read:

4512. As used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

(b) "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills training, specialized medical and dental care, supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan.

(c) Notwithstanding subdivisions (a) and (b), for any organization or agency receiving federal financial participation under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, as amended, "developmental disability" and "services for persons with developmental disabilities" mean the terms as defined in the federal act to the extent required by federal law.

(d) "Consumer" means a person who has a disability that meets the definition of developmental disability set forth in subdivision (a).

(e) "Natural supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships, friendships reflecting the diversity of the

neighborhood and the community, associations with fellow students or employees in regular classrooms and workplaces, and associations developed through participation in clubs, organizations, and other civic activities.

(f) "Circle of support" means a committed group of community members, who may include family members, meeting regularly with an individual with developmental disabilities in order to share experiences, promote autonomy and community involvement, and assist the individual in establishing and maintaining natural supports. A circle of support generally includes a plurality of members who neither provide nor receive services or supports for persons with developmental disabilities and who do not receive payment for participation in the circle of support.

(g) "Facilitation" means the use of modified or adapted materials, special instructions, equipment, or personal assistance by an individual, such as assistance with communications, that will enable a consumer to understand and participate to the maximum extent possible in the decisions and choices that effect his or her life.

(h) "Family support services" means services and supports that are provided to a child with developmental disabilities or his or her family and that contribute to the ability of the family to reside together.

(i) "Voucher" means any authorized alternative form of service delivery in which the consumer or family member is provided with a payment, coupon, chit, or other form of authorization that enables the consumer or family member to choose his or her own service provider.

(j) "Planning team" means the individual with developmental disabilities, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, one or more regional center representatives, including the designated regional center service coordinator pursuant to subdivision (b) of Section 4640.7, any individual, including a service provider, invited by the consumer, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, and including a minor's, dependent's, or ward's court-appointed developmental services decisionmaker appointed pursuant to Section 319, 361, or 726.

(k) "Stakeholder organizations" means statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations.

(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

(m) "Native language" means the language normally used by the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative.

SEC. 4. Section 4641 of the Welfare and Institutions Code is amended to read:

4641. *(a)* All regional centers shall conduct casefinding activities, including notification of availability of service in English and such other languages as may be appropriate to the service area, outreach services in areas with a high incidence of developmental disabilities, and identification of persons who may need service.

(b) The department and the regional centers shall ensure that consumers and their families receive culturally and linguistically competent information, including written documents, about the individual program plan required by Section 4646, and the individualized family service plan required by Section 95020 of the Government Code, and related processes and procedures. Each regional center shall make available to the public information about regional center services, processes, and procedures. The department and the regional centers shall fulfill these obligations in a manner that meets the standards set forth in Sections 7295.2 and 7296.2 of the Government Code, and ensure that its materials are written in plain, straightforward language and in an easily readable style. The materials provided by the department and the regional centers shall also be available on the department's and the regional centers' Internet Web sites.

SEC. 5. Section 4642 of the Welfare and Institutions Code is amended to read:

4642. *(a) (1)* Any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant shall be eligible for initial intake and assessment services in the regional centers. In addition, any infant having a high risk of becoming developmentally disabled may be eligible for initial intake and assessment services in the regional centers. For purposes of this section, "high-risk infant" means a child less than 36 months of age whose genetic, medical, or environmental history is predictive of a substantially greater risk for developmental disability than that for the general population. The department, in consultation with the State Department of *Public* Health ~~Services~~ , shall develop specific risk and service criteria for the high-risk infant program on or before July 1, 1983. These criteria may be modified in subsequent years based on analysis of actual clinical experience.

~~Initial~~

(2) Initial intake shall be performed within 15 working days following request for assistance. Initial intake shall include, but need not be limited to, information and advice about the nature and availability of services provided by the regional center and by other agencies in the community, including guardianship, conservatorship, income maintenance, mental health, housing, education, work activity and vocational training, medical, dental, recreational, and other services or programs that may be useful to persons with developmental disabilities or their families. Intake shall also include a decision to provide assessment.

(b) All communication with the consumer and his or her family pursuant to this section shall be in their native language.

SEC. 6. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b).

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

(c) At the time of assessment, the individual, or, where appropriate, the parents, legal guardian, or conservator, shall provide copies of any health benefit cards under which the consumer is eligible to receive health benefits, including, but not limited to, private health insurance, a health care service plan, Medi-Cal, Medicare, and TRICARE. If the individual, or where appropriate, the parents, legal guardians, or conservators, have no such benefits, the regional center shall not use that fact to negatively impact the services that the individual may or may not receive from the regional center.

(d) All communication with the consumer and his or her family pursuant to this section shall be in their native language.

SEC. 7. Section 4646 of the Welfare and Institutions Code is amended to read:

4646. (a) It is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family

of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, where appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and healthy environments. It is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.

(b) The individual program plan is developed through a process of individualized needs determination. The individual with developmental disabilities and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, shall have the opportunity to actively participate in the development of the plan.

(c) An individual program plan shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment. At the time of intake, the regional center shall inform the consumer and, where appropriate, his or her parents, legal guardian or conservator, or authorized representative, of the services available through the local area board and the protection and advocacy agency designated by the Governor pursuant to federal law, and shall provide the address and telephone numbers of those agencies.

(d) Individual program plans shall be prepared jointly by the planning team. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the consumer's individual program plan and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative at the program plan meeting.

(e) Regional centers shall comply with the request of a consumer, or where appropriate, the request of his or her parents, legal guardian, conservator, or authorized representative, that a designated representative receive written notice of all meetings to develop or revise his or her individual program plan and of all notices sent to the consumer pursuant to Section 4710. The designated representative may be a parent or family member.

(f) If a final agreement regarding the services and supports to be provided to the consumer cannot be reached at a program plan meeting, then a subsequent program plan meeting shall be convened within 15 days, or later at the request of the consumer or, when appropriate, the parents, legal guardian, conservator, or authorized representative or when agreed to by the planning team. Additional program plan meetings may be held with the agreement of the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative.

(g) An authorized representative of the regional center and the consumer or, where appropriate, his or her parents, legal guardian, conservator, or authorized representative shall sign the individual

program plan prior to its implementation. If the consumer or, where appropriate, his or her parents, legal guardian, conservator, or authorized representative, does not agree with all components of the plan, he or she may indicate that disagreement on the plan. Disagreement with specific plan components shall not prohibit the implementation of services and supports agreed to by the consumer or, where appropriate, his or her parents, legal guardian, conservator, or authorized representative. If the consumer or, where appropriate, his or her parents, legal guardian, conservator, or authorized representative, does not agree with the plan in whole or in part, he or she shall be sent written notice of the fair hearing rights, as required by Section 4701.

(h) Individual program plans and the provision of services and supports shall be designed to meet the cultural preferences, values, and lifestyle of the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative, and shall be provided in their native language. A copy of the individual program plan shall be provided in their native language.

SEC. 8. Section 4646.5 of the Welfare and Institutions Code is amended to read:

4646.5. (a) The planning process for the individual program plan described in Section 4646 shall include all of the following:

(1) Gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers, and concerns or problems of the person with developmental disabilities. For children with developmental disabilities, this process should include a review of the strengths, preferences, and needs of the child and the family unit as a whole. Assessments shall be conducted by qualified individuals and performed in natural environments whenever possible. Information shall be taken from the consumer, his or her parents and other family members, his or her friends, advocates, authorized representative, if applicable, providers of services and supports, and other agencies. The assessment process shall reflect awareness of, and sensitivity to, the lifestyle and cultural background of the consumer and the family.

(2) A statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities, and a statement of specific, time-limited objectives for implementing the person's goals and addressing his or her needs. These objectives shall be stated in terms that allow measurement of progress or monitoring of service delivery. These goals and objectives should maximize opportunities for the consumer to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over his or her life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals.

(3) When developing individual program plans for children, regional centers shall be guided by the principles, process, and services and support parameters set forth in Section 4685.

(4) A schedule of the type and amount of services and supports to

be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the individual program plan goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. The individual program plan shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services.

(5) When agreed to by the consumer, the parents, legally appointed guardian, or authorized representative of a minor consumer, or the legally appointed conservator of an adult consumer or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548, subdivision (b) of Section 4701.6, and subdivision (e) of Section 4705, a review of the general health status of the adult or child, including medical, dental, and mental health needs, shall be conducted. This review shall include a discussion of current medications, any observed side effects, and the date of last review of the medication. Service providers shall cooperate with the planning team to provide any information necessary to complete the health status review. If any concerns are noted during the review, referrals shall be made to regional center clinicians or to the consumer's physician, as appropriate. Documentation of health status and referrals shall be made in the consumer's record by the service coordinator.

(6) (A) The development of a transportation access plan for a consumer when all of the following conditions are met:

(i) The regional center is purchasing private, specialized transportation services or services from a residential, day, or other provider, excluding vouchered service providers, to transport the consumer to and from day or work services.

(ii) The planning team has determined that a consumer's community integration and participation could be safe and enhanced through the use of public transportation services.

(iii) The planning team has determined that generic transportation services are available and accessible.

(B) To maximize independence and community integration and participation, the transportation access plan shall identify the services and supports necessary to assist the consumer in accessing public transportation and shall comply with Section 4648.35. These services and supports may include, but are not limited to, mobility training services and the use of transportation aides. Regional centers are encouraged to coordinate with local public transportation agencies.

(7) A schedule of regular periodic review and reevaluation to ascertain that planned services have been provided, that objectives have been fulfilled within the times specified, and that consumers and families are satisfied with the individual program plan and its implementation.

(b) For all active cases, individual program plans shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's

achievement or changing needs, and no less often than once every parents, legal guardian, authorized representative, or conservator requests an individual program plan review, the individual program shall be reviewed within 30 days after the request is submitted.

(c) (1) The department, with the participation of representatives of a statewide consumer organization, the Association of Regional Center Agencies, an organized labor organization representing service coordination staff, and the Organization of Area Boards shall prepare training material and a standard format and instructions for the preparation of individual program plans, which embodies an approach centered on the person and family.

(2) Each regional center shall use the training materials and format prepared by the department pursuant to paragraph (1).

(3) The department shall biennially review a random sample of individual program plans at each regional center to ensure that these plans are being developed and modified in compliance with Section 4646 and this section.

(d) This section shall be implemented in a manner that meets the cultural preferences, values, lifestyle, and native language of the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative.

SEC. 9. Section 4648 of the Welfare and Institutions Code is amended to read:

4648. In order to achieve the stated objectives of a consumer's individual program plan, the regional center shall conduct activities, including, but not limited to, all of the following:

(a) Securing needed services and supports.

(1) It is the intent of the Legislature that services and supports assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible and in exercising personal choices. The regional center shall secure services and supports that meet the needs of the consumer, as determined in the consumer's individual program plan, and within the context of the individual program plan, the planning team shall give highest preference to those services and supports which would allow minors with developmental disabilities to live with their families, adult persons with developmental disabilities to live as independently as possible in the community, and that allow all consumers to interact with persons without disabilities in positive, meaningful ways.

(2) In implementing individual program plans, regional centers, through the planning team, shall first consider services and supports in natural community, home, work, and recreational settings. Services and supports shall be flexible and individually tailored to the consumer and, where appropriate, his or her family.

(3) A regional center may, pursuant to vendorization or a contract, purchase services or supports for a consumer from any individual or agency which the regional center and consumer or, where appropriate, his or her parents, legal guardian, or conservator, or authorized representatives, determines will best accomplish all or any part of that consumer's program plan.

(A) Vendorization or contracting is the process for

identification, selection, and utilization of service vendors or contractors, based on the qualifications and other requirements necessary in order to provide the service.

(B) A regional center may reimburse an individual or agency for services or supports provided to a regional center consumer if the individual or agency has a rate of payment for vendored or contracted services established by the department, pursuant to this division, and is providing services pursuant to an emergency vendorization or has completed the vendorization procedures or has entered into a contract with the regional center and continues to comply with the vendorization or contracting requirements. The director shall adopt regulations governing the vendorization process to be utilized by the department, regional centers, vendors and the individual or agency requesting vendorization.

(C) Regulations shall include, but not be limited to: the vendor application process, and the basis for accepting or denying an application; the qualification and requirements for each category of services that may be provided to a regional center consumer through a vendor; requirements for emergency vendorization; procedures for termination of vendorization; the procedure for an individual or an agency to appeal any vendorization decision made by the department or regional center.

(D) A regional center may vendorize a licensed facility for exclusive services to persons with developmental disabilities at a capacity equal to or less than the facility's licensed capacity. A facility already licensed on January 1, 1999, shall continue to be vendorized at their full licensed capacity until the facility agrees to vendorization at a reduced capacity.

(E) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not newly vendor a State Department of Social Services licensed 24-hour residential care facility with a licensed capacity of 16 or more beds, unless the facility qualifies for receipt of federal funds under the Medicaid Program.

(4) Notwithstanding subparagraph (B), a regional center may contract or issue a voucher for services and supports provided to a consumer or family at a cost not to exceed the maximum rate of payment for that service or support established by the department. If a rate has not been established by the department, the regional center may, for an interim period, contract for a specified service or support with, and establish a rate of payment for, any provider of the service or support necessary to implement a consumer's individual program plan. Contracts may be negotiated for a period of up to three years, with annual review and subject to the availability of funds.

(5) In order to ensure the maximum flexibility and availability of appropriate services and supports for persons with developmental disabilities, the department shall establish and maintain an equitable system of payment to providers of services and supports identified as necessary to the implementation of a consumers' individual program plan. The system of payment shall include provision for a rate to ensure that the provider can meet the special

needs of consumers and provide quality services and supports in the least restrictive setting as required by law.

(6) The regional center and the consumer, or where appropriate, his or her parents, legal guardian, conservator, or authorized representative, including those appointed pursuant to subdivision (d) of Section 4548, subdivision (b) of Section 4701.6, or subdivision (e) of Section 4705, shall, pursuant to the individual program plan, consider all of the following when selecting a provider of consumer services and supports:

(A) A provider's ability to deliver quality services or supports which can accomplish all or part of the consumer's individual program plan.

(B) A provider's success in achieving the objectives set forth in the individual program plan.

(C) Where appropriate, the existence of licensing, accreditation, or professional certification.

(D) The cost of providing services or supports of comparable quality by different providers, if available, shall be reviewed, and the least costly available provider of comparable service, including the cost of transportation, who is able to accomplish all or part of the consumer's individual program plan, consistent with the particular needs of the consumer and family as identified in the individual program plan, shall be selected. In determining the least costly provider, the availability of federal financial participation shall be considered. The consumer shall not be required to use the least costly provider if it will result in the consumer moving from an existing provider of services or supports to more restrictive or less integrated services or supports.

(E) The consumer's choice of providers, or, where appropriate, the consumer's parent's, legal guardian's, authorized representative's, or conservator's choice of providers.

(7) No service or support provided by any agency or individual shall be continued unless the consumer or, where appropriate, his or her parents, legal guardian, or conservator, or authorized representative, including those appointed pursuant to subdivision (d) of Section 4548, subdivision (b) of Section 4701.6, or subdivision (e) of Section 4705, is satisfied and the regional center and the consumer or, when appropriate, the person's parents or legal guardian or conservator agree that planned services and supports have been provided, and reasonable progress toward objectives have been made.

(8) Regional center funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services.

(9) (A) A regional center may, directly or through an agency acting on behalf of the center, provide placement in, purchase of, or follow-along services to persons with developmental disabilities in, appropriate community living arrangements, including, but not limited to, support service for consumers in homes they own or lease, foster family placements, health care facilities, and licensed community care facilities. In considering appropriate placement alternatives for children with developmental disabilities, approval

by the child's parent or guardian shall be obtained before placement is made.

(B) Effective July 1, 2012, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase residential services from a State Department of Social Services licensed 24-hour residential care facility with a licensed capacity of 16 or more beds. This prohibition on regional center purchase of residential services shall not apply to any of the following:

(i) A residential facility with a licensed capacity of 16 or more beds that has been approved to participate in the department's Home and Community Based Services Waiver or another existing waiver program or certified to participate in the Medi-Cal program.

(ii) A residential facility service provider that has a written agreement and specific plan prior to July 1, 2012, with the vendoring regional center to downsize the existing facility by transitioning its residential services to living arrangements of 15 beds or less or restructure the large facility to meet federal Medicaid eligibility requirements on or before June 30, 2013.

(iii) A residential facility licensed as a mental health rehabilitation center by the State Department of Mental Health or successor agency under any of the following circumstances:

(I) The facility is eligible for Medicaid reimbursement.

(II) The facility has a department-approved plan in place by June 30, 2013, to transition to a program structure eligible for federal Medicaid funding, and this transition will be completed by June 30, 2014. The department may grant an extension for the date by which the transition will be completed if the facility demonstrates that it has made significant progress toward transition, and states with specificity the timeframe by which the transition will be completed and the specified steps that will be taken to accomplish the transition. A regional center may pay for the costs of care and treatment of a consumer residing in the facility on June 30, 2012, until June 30, 2013, inclusive, and, if the facility has a department-approved plan in place by June 30, 2013, may continue to pay the costs under this subparagraph until June 30, 2014, or until the end of any period during which the department has granted an extension.

(III) There is an emergency circumstance in which the regional center determines that it cannot locate alternate federally eligible services to meet the consumer's needs. Under such an emergency circumstance, an assessment shall be completed by the regional center as soon as possible and within 30 days of admission. An individual program plan meeting shall be convened immediately following the assessment to determine the services and supports needed for stabilization and to develop a plan to transition the consumer from the facility into the community. If transition is not expected within 90 days of admission, an individual program plan meeting shall be held to discuss the status of transition and to determine if the consumer is still in need of placement in the facility. Commencing October 1, 2012, this determination shall be made after also considering resource options identified by the statewide specialized

resource service. If it is determined that emergency services continue to be necessary, the regional center shall submit an updated transition plan that can cover a period of up to 90 days. In no event shall placements under these emergency circumstances exceed 180 days.

(C) (i) Effective July 1, 2012, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase new residential services from institutions for mental disease, as described in Part 5 (commencing with Section 5900) of Division 5, for which federal Medicaid funding is not available.

(ii) The prohibition described in clause (i) shall not apply to emergencies, as determined by the regional center, when a regional center cannot locate alternate federally eligible services to meet the consumer's needs. As soon as possible within 30 days of admission due to an emergency, an assessment shall be completed by the regional center. An individual program plan meeting shall be convened immediately following the assessment, to determine the services and supports needed for stabilization and to develop a plan to transition the consumer from the facility to the community. If transition is not expected within 90 days of admission, an emergency, program plan meeting shall be held to discuss the status of transition and to determine if the consumer is still in need of placement in the facility. If emergency services continue to be necessary, the regional center shall submit an updated transition plan to the department for an extension of up to 90 days. Placement shall not exceed 180 days.

(iii) Regional centers shall complete a comprehensive assessment of any consumer residing in an institution for mental disease as of July 1, 2012, for which federal Medicaid funding is not available. The comprehensive assessment shall be completed prior to the consumer's next scheduled individual program plan meeting and shall include identification of the services and supports needed and the timeline for identifying or developing those services needed to transition the consumer back to the community. Effective October 1, 2012, the regional center shall also consider resource options identified by the statewide specialized resource service. For each individual program plan meeting convened pursuant to this subparagraph, the clients' rights advocate for the regional center shall be notified of the meeting and may participate in the meeting unless the consumer objects on his or her own behalf.

(D) Each person with developmental disabilities placed by the regional center in a community living arrangement shall have the rights specified in this division. These rights shall be brought to the person's attention by any means necessary to reasonably communicate these rights to each resident, provided that, at a minimum, the Director of Developmental Services prepare, provide, and require to be clearly posted in all residential facilities and day programs a poster using simplified language and pictures that is designed to be more understandable by persons with cognitive disabilities and that the rights information shall also be available through the regional center to each residential facility and day program in alternative formats, including, but not limited to, other

languages, braille, and audio tapes, when necessary to meet the communication needs of consumers.

(E) Consumers are eligible to receive supplemental services including, but not limited to, additional staffing, pursuant to the process described in subdivision (d) of Section 4646. Necessary additional staffing that is not specifically included in the rates paid to the service provider may be purchased by the regional center if the additional staff are in excess of the amount required by regulation and the individual's planning team determines the additional services are consistent with the provisions of the individual program plan. Additional staff should be periodically reviewed by the planning team for consistency with the individual program plan objectives in order to determine if continued use of the additional staff is necessary and appropriate and if the service is producing outcomes consistent with the individual program plan. Regional centers shall monitor programs to ensure that the additional staff is being provided and utilized appropriately.

(10) Emergency and crisis intervention services including, but not limited to, mental health services and behavior modification services, may be provided, as needed, to maintain persons with developmental disabilities in the living arrangement of their own choice. Crisis services shall first be provided without disrupting a person's living arrangement. If crisis intervention services are unsuccessful, emergency housing shall be available in the person's home community. If dislocation cannot be avoided, every effort shall be made to return the person to his or her living arrangement of choice, with all necessary supports, as soon as possible.

(11) Among other service and support options, planning teams shall consider the use of paid roommates or neighbors, personal assistance, technical and financial assistance, and all other service and support options which would result in greater self-sufficiency for the consumer and cost-effectiveness to the state.

(12) When facilitation as specified in an individual program plan requires the services of an individual, the facilitator shall be of the consumer's choosing.

(13) The community support may be provided to assist individuals with developmental disabilities to fully participate in community and civic life, including, but not limited to, programs, services, work opportunities, business, and activities available to persons without disabilities. This facilitation shall include, but not be limited to, any of the following:

(A) Outreach and education to programs and services within the community.

(B) Direct support to individuals which would enable them to more fully participate in their community.

(C) Developing unpaid natural supports when possible.

(14) When feasible and recommended by the individual program planning team, for purposes of facilitating better and cost-effective services for consumers or family members, technology, including telecommunication technology, may be used in conjunction with other services and supports. Technology in lieu of a consumer's in-person appearances at judicial proceedings or administrative due process

hearings may be used only if the consumer or, when appropriate, the consumer's parent, legal guardian, conservator, or authorized representative, gives informed consent. Technology may be used in lieu of, or in conjunction with, in-person training for providers, as appropriate.

(15) Other services and supports may be provided as set forth in Sections 4685, 4686, 4687, 4688, and 4689, when necessary.

(16) Notwithstanding any other provision of law or regulation to the contrary, effective July 1, 2009, regional centers shall not purchase experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown. Experimental treatments or therapeutic services include experimental medical or nutritional therapy when the use of the product for that purpose is not a general physician practice. For regional center consumers receiving these services as part of their individual program plan (IPP) or individualized family service plan (IFSP) on July 1, 2009, this prohibition shall apply on August 1, 2009.

(b) (1) Advocacy for, and protection of, the civil, legal, and service rights of persons with developmental disabilities as established in this division.

(2) Whenever the advocacy efforts of a regional center to secure or protect the civil, legal, or service rights of any of its consumers prove ineffective, the regional center or the person with developmental disabilities or his or her parents, legal guardian, or other representative may request the area board to initiate action under the provisions defining area board advocacy functions established in this division.

(c) The regional center may assist consumers and families directly, or through a provider, in identifying and building circles of support within the community.

(d) In order to increase the quality of community services and protect consumers, the regional center shall, when appropriate, take either of the following actions:

(1) Identify services and supports that are ineffective or of poor quality and provide or secure consultation, training, or technical assistance services for any agency or individual provider to assist that agency or individual provider in upgrading the quality of services or supports.

(2) Identify providers of services or supports that may not be in compliance with local, state, and federal statutes and regulations and notify the appropriate licensing or regulatory authority, or request the area board to investigate the possible noncompliance.

(e) When necessary to expand the availability of needed services of good quality, a regional center may take actions that include, but are not limited to, the following:

(1) Soliciting an individual or agency by requests for proposals or other means, to provide needed services or supports not presently available.

(2) Requesting funds from the Program Development Fund, pursuant

to Section 4677, or community placement plan funds designated from that fund, to reimburse the startup costs needed to initiate a new program of services and supports.

(3) Using creative and innovative service delivery models, including, but not limited to, natural supports.

(f) Except in emergency situations, a regional center shall not provide direct treatment and therapeutic services, but shall utilize appropriate public and private community agencies and service providers to obtain those services for its consumers.

(g) Where there are identified gaps in the system of services and supports or where there are identified consumers for whom no provider will provide services and supports contained in his or her individual program plan, the department may provide the services and supports directly.

(h) At least annually, regional centers shall provide the consumer, his or her parents, legal guardian, conservator, or authorized representative a statement of services and supports the regional center purchased for the purpose of ensuring that they are delivered. The statement shall include the type, unit, month, and cost of services and supports purchased.

(i) Ensuring that individual program plans and the provision of services and supports shall be designed to meet the cultural preferences, values, and lifestyle of the individual and, when appropriate, his or her parent, legal guardian or conservator, or authorized representative, and shall be provided in their native language.

SEC. 10. Section 4685 of the Welfare and Institutions Code is amended to read:

4685. (a) Consistent with state and federal law, the Legislature finds and declares that children with developmental disabilities most often have greater opportunities for educational and social growth when they live with their families. The Legislature further finds and declares that the cost of providing necessary services and supports which enable a child with developmental disabilities to live at home is typically equal to or lower than the cost of providing out-of-home placement. The Legislature places a high priority on providing opportunities for children with developmental disabilities to live with their families, when living at home is the preferred objective in the child's individual program plan.

(b) It is the intent of the Legislature that regional centers provide or secure family support services that do all of the following:

(1) Respect and support the decisionmaking authority of the family.

(2) Be flexible and creative in meeting the unique and individual needs of families as they evolve over time.

(3) Recognize and build on family strengths, natural supports, and existing community resources.

(4) Be designed to meet the cultural preferences, *native language,* values, and lifestyles of families.

(5) Focus on the entire family and promote the inclusion of children with disabilities in all aspects of school and community.

(c) In order to provide opportunities for children to live with their families, the following procedures shall be adopted:

(1) The department and regional centers shall give a very high priority to the development and expansion of services and supports designed to assist families that are caring for their children at home, when that is the preferred objective in the individual program plan. This assistance may include, but is not limited to specialized medical and dental care, special training for parents, infant stimulation programs, respite for parents, homemaker services, camping, day care, short-term out-of-home care, child care, counseling, mental health services, behavior modification programs, special adaptive equipment such as wheelchairs, hospital beds, communication devices, and other necessary appliances and supplies, and advocacy to assist persons in securing income maintenance, educational services, and other benefits to which they are entitled.

(2) When children with developmental disabilities live with their families, the individual program plan shall include a family plan component which describes those services and supports necessary to successfully maintain the child at home. Regional centers shall consider every possible way to assist families in maintaining their children at home, when living at home will be in the best interest of the child, before considering out-of-home placement alternatives. When the regional center first becomes aware that a family may consider an out-of-home placement, or is in need of additional specialized services to assist in caring for the child in the home, the regional center shall meet with the family to discuss the situation and the family's current needs, solicit from the family what supports would be necessary to maintain the child in the home, and utilize creative and innovative ways of meeting the family's needs and providing adequate supports to keep the family together, if possible.

(3) (A) To ensure that these services and supports are provided in the most cost-effective and beneficial manner, regional centers may utilize innovative service-delivery mechanisms, including, but not limited to, vouchers; alternative respite options such as foster families, vacant community facility beds, crisis child care facilities; group training for parents on behavioral intervention techniques in lieu of some or all of the in-home parent training component of the behavioral intervention services; purchase of neighborhood preschool services and needed qualified personnel in lieu of infant development programs; and alternative child care options such as supplemental support to generic child care facilities and parent child care cooperatives.

(B) Effective July 1, 2009, at the time of development, review, or modification of a child's individualized family service plan or individual program plan, the regional center shall consider both of the following:

(i) The use of group training for parents on behavioral intervention techniques in lieu of some or all of the in-home parent training component of the behavioral intervention services.

(ii) The purchase of neighborhood preschool services and needed qualified personnel in lieu of infant development programs.

(4) If the parent of any child receiving services and supports from a regional center believes that the regional center is not offering adequate assistance to enable the family to keep the child at home, the parent may initiate a request for fair hearing as established in this division. A family shall not be required to start a placement process or to commit to placing a child in order to receive requested services.

(5) Nothing in this section shall be construed to encourage the continued residency of adult children in the home of their parents when that residency is not in the best interests of the person.

(6) When purchasing or providing a voucher for day care services for parents who are caring for children at home, the regional center may pay only the cost of the day care service that exceeds the cost of providing day care services to a child without disabilities. The regional center may pay in excess of this amount when a family can demonstrate a financial need and when doing so will enable the child to remain in the family home.

(7) A regional center may purchase or provide a voucher for diapers for children three years of age or older. A regional center may purchase or provide vouchers for diapers under three years of age when a family can demonstrate a financial need and when doing so will enable the child to remain in the family home.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would require an individual program plan, or individual family services plan, to consider the needs of the consumer, and his or her family, in order to provide services and supports in a culturally and linguistically appropriate manner.~~

BILL NUMBER: SB 626 AMENDED
BILL TEXT

AMENDED IN SENATE APRIL 18, 2013

INTRODUCED BY Senator Beall

FEBRUARY 22, 2013

An act to amend Sections *75,* 4600, *4604.5,* 4610, 4610.6, 4616, and 4660.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 626, as amended, Beall. Workers' compensation.

Existing law establishes a worker's compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law creates the Commission on Health and Safety and Workers' Compensation consisting of 8 voting members, that includes 4 voting members representing organized labor and 4 voting members representing employers.

This bill would increase the number of commission voting members to 10 by adding one voting member representing injured workers and one additional voting member representing employers, appointed by the Governor.

Existing ~~law establishes a worker's compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing~~ law generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury. Existing law authorizes, with some exceptions, the employee to be treated by a physician of his or her own choice or at a facility of his or her own choice after 30 days from the date the injury is reported. Existing law prohibits a chiropractor from being the treating physician after the employee has received the maximum number of chiropractic visits.

This bill would delete that ~~provision and would instead provide that a physician, as defined, may remain the patient's primary treating physician even if additional treatment has been denied as long as the physician complies with specified reporting requirements~~ *prohibition* .

Existing law requires that the recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director be presumptively correct on the issue of extent and scope of medical treatment. Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an employee is entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

This bill would delete the limitation on chiropractic, occupational therapy, and physical therapy visits per industrial injury.

Existing law requires an employer to establish a medical treatment

utilization review process and, in this regard, prohibits any person other than a licensed physician from modifying, delaying, or denying requests for authorization of medical treatment for reasons of medical necessity to cure and relieve. Existing law also provides for an independent medical review process to resolve disputes over a utilization review decision for injuries occurring on or after January 1, 2013, and for any decision that is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

This bill would revise these provisions to require that medical treatment utilization reviews and independent medical reviews be conducted by physicians or medical professionals, as applicable, who hold the same California license as the requesting physician. The bill would delete the requirement that *an* independent medical review organization keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization.

Existing law prohibits a workers' compensation administrative law judge, the appeals board, or any higher court from making a determination of medical necessity contrary to the determination of the independent medical review organization.

This bill would delete that provision.

Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of permanent partial disability and permanent total disability for injuries occurring on or after January 1, 2013. Existing law requires that the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of injury be taken into account in determining the percentages of permanent partial disability or permanent total disability. Existing law, with some exceptions, prohibits increases in impairment ratings for sleep dysfunction, sexual dysfunction, or psychiatric disorder, or any combination thereof, as specified.

This bill would delete the prohibition on increases in impairment ratings for psychiatric disorder and would make related changes.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 75 of the Labor Code is amended to read:

75. (a) There is in the department the Commission on Health and Safety and Workers' Compensation. The commission shall be composed of ~~eight~~ *10* voting members. Four voting members shall represent organized labor, *one voting member shall represent injured workers,* and ~~four~~ *five* voting members shall represent employers. Not more than one employer member shall represent public agencies. ~~Two~~ *Three* of the employer ~~and~~ *members,* two of the labor members *, and the member representing injured workers* shall be appointed by the Governor. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one employer and one labor representative. The public employer representative shall be appointed by the Governor. No action of the commission shall be valid unless agreed to by a majority of the membership and by not less than two members representing organized labor and two members representing employers.

(b) The commission shall select one of the members representing organized labor to chair the commission during the 1994 calendar year, and thereafter the commission shall alternatively select an employer and organized labor representative to chair the commission for one-year terms.

(c) The initial terms of the members of the commission shall be four years, and they shall hold office until the appointment of a successor. However, the initial terms of one employer and one labor member appointed by the Governor shall expire on December 31, 1995; the initial terms of the members appointed by the Senate Committee on Rules shall expire December 31, 1996; the initial terms of the members appointed by the Speaker of the Assembly shall expire on December 31, 1997; and the initial term of one employer and one labor member appointed by the Governor shall expire on December 31, 1998. Any vacancy shall be filled by appointment to the unexpired term.

(d) The commission shall meet every other month and upon the call of the chair. Meetings shall be open to the public. Members of the commission shall receive one hundred dollars ($100) for each day of their actual attendance at meetings of the commission and other official business of the commission and shall also receive their actual and necessary traveling expenses incurred in the performance of their duty as a member. Payment of per diem and traveling expenses shall be made from the Workers' Compensation Administration Revolving Fund, when appropriated by the Legislature.

~~SECTION 1.~~ *SEC. 2.* Section 4600 of the Labor Code is amended to read:

4600. (a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other provision of law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. ~~A physician, as defined in Section 3209.3, may remain the employee's primary treating physician even if additional medical treatment, as specified in the medical treatment utilization schedule adopted under Section 5307.27, has been denied, as long as the physician complies with the reporting requirements set forth by the administrative director.~~

(d) (1) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee shall be entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee shall be entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e) (1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

(f) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently

speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(g) If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services. An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or 5703.8. The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

SEC. 3. Section 4604.5 of the Labor Code is amended to read:

4604.5. (a) The recommended guidelines set forth in the medical treatment utilization schedule adopted by the administrative director pursuant to Section 5307.27 shall be presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines reasonably is required to cure or relieve the injured worker from the effects of his or her injury. The presumption created is one affecting the burden of proof.

(b) The recommended guidelines set forth in the schedule adopted pursuant to subdivision (a) shall reflect practices that are evidence and scientifically based, nationally recognized, and peer reviewed. The guidelines shall be designed to assist providers by offering an analytical framework for the evaluation and treatment of injured workers, and shall constitute care in accordance with Section 4600 for all injured workers diagnosed with industrial conditions.

~~(c) (1) Notwithstanding the medical treatment utilization schedule, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial~~

~~injury.~~

~~(2) (A) Paragraph (1) shall not apply when an employer authorizes, in writing, additional visits to a health care practitioner for physical medicine services. Payment or authorization for treatment beyond the limits set forth in paragraph (1) shall not be deemed a waiver of the limits set forth by paragraph (1) with respect to future requests for authorization.~~

~~(B) The Legislature finds and declares that the amendments made to subparagraph (A) by the act adding this subparagraph are declaratory of existing law.~~

~~(3) Paragraph (1) shall not apply to visits for postsurgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the administrative director pursuant to Section 5307.27.~~

~~(d)~~

(c) For all injuries not covered by the official utilization schedule adopted pursuant to Section 5307.27, authorized treatment shall be in accordance with other evidence-based medical treatment guidelines that are recognized generally by the national medical community and scientifically based.

~~SEC. 2.~~ *SEC. 4.* Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a physician who holds the same California

license as that held by the requesting physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be

communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from

the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

~~SEC. 3.~~ *SEC. 5.* Section 4610.6 of the Labor Code is amended to read:

4610.6. (a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the request for review and supporting documentation, or within less time as

prescribed by the administrative director. If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. Independent medical reviews shall be conducted by medical professionals who hold the same California license as the requesting physician. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars ($5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

~~SEC. 4.~~ *SEC. 6.* Section 4616 of the Labor Code is amended to read:

4616. (a) (1) On or after January 1, 2005, an insurer, employer, or entity that provides physician network services may establish or modify a medical provider network for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries. The administrative director shall encourage the integration of occupational and nonoccupational providers. The number of physicians in the medical provider network shall be sufficient to enable treatment for injuries or conditions to be provided in a timely manner. The provider network shall include an adequate number and

type of physicians, as described in Section 3209.3, or other providers, as described in Section 3209.5, to treat common injuries experienced by injured employees based on the type of occupation or industry in which the employee is engaged, and the geographic area where the employees are employed.

(2) Medical treatment for injuries shall be readily available at reasonable times to all employees. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees. With respect to availability and accessibility of treatment, the administrative director shall consider the needs of rural areas, specifically those in which health facilities are located at least 30 miles apart and areas in which there is a health care shortage.

(3) Commencing January 1, 2014, a treating physician shall be included in the network only if, at the time of entering into or renewing an agreement by which the physician would be in the network, the physician, or an authorized employee of the physician or the physician's office, provides a separate written acknowledgment in which the physician affirmatively elects to be a member of the network. Copies of the written acknowledgment shall be provided to the administrative director upon the administrative director's request. This paragraph shall not apply to a physician who is a shareholder, partner, or employee of a medical group that elects to be part of the network.

(4) Commencing January 1, 2014, every medical provider network shall post on its Internet Web site a roster of all treating physicians in the medical provider network and shall update the roster at least quarterly. Every network shall provide to the administrative director the Internet Web site address of the network and of its roster of treating physicians. The administrative director shall post, on the division's Internet Web site, the Internet Web site address of every approved medical provider network.

(5) Commencing January 1, 2014, every medical provider network shall provide one or more persons within the United States to serve as medical access assistants to help an injured employee find an available physician of the employee's choice, and subsequent physicians if necessary, under Section 4616.3. Medical access assistants shall have a toll-free telephone number that injured employees may use and shall be available at least from 7 a.m. to 8 p.m. Pacific Standard Time, Monday through Saturday, inclusive, to respond to injured employees, contact physicians' offices during regular business hours, and schedule appointments. The administrative director shall promulgate regulations on or before July 1, 2013, governing the provision of medical access assistants.

(b) (1) An insurer, employer, or entity that provides physician network services shall submit a plan for the medical provider network to the administrative director for approval. The administrative director shall approve the plan for a period of four years if he or she determines that the plan meets the requirements of this section. If the administrative director does not act on the plan within 60 days of submitting the plan, it shall be deemed approved. Commencing January 1, 2014, existing approved plans shall be deemed approved for a period of four years from the most recent application or modification approval date. Plans for reapproval for medical provider networks shall be submitted at least six months before the expiration of the four-year approval period. Upon a showing that the medical provider network was approved or deemed approved by the administrative director, there shall be a conclusive presumption on the part of the appeals board that the medical provider network was validly formed.

(2) Every medical provider network shall establish and follow procedures to continuously review the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

(3) Every medical provider network shall submit geocoding of its network for reapproval to establish that the number and geographic location of physicians in the network meets the required access standards.

(4) The administrative director shall at any time have the discretion to investigate complaints and to conduct random reviews of approved medical provider networks.

(5) Approval of a plan may be denied, revoked, or suspended if the medical provider network fails to meet the requirements of this article. Any person contending that a medical provider network is not validly constituted may petition the administrative director to suspend or revoke the approval of the medical provider network. The administrative director may adopt regulations establishing a schedule of administrative penalties not to exceed five thousand dollars ($5,000) per violation, or probation, or both, in lieu of revocation or suspension for less severe violations of the requirements of this article. Penalties, probation, suspension, or revocation shall be ordered by the administrative director only after notice and opportunity to be heard. Unless suspended or revoked by the administrative director, the administrative director's approval of a medical provider network shall be binding on all persons and all courts. A determination of the administrative director may be reviewed only by an appeal of the determination of the administrative director filed as an original proceeding before the reconsideration unit of the workers' compensation appeals board on the same grounds and within the same time limits after issuance of the determination as would be applicable to a petition for reconsideration of a decision of a workers' compensation administrative law judge.

(c) Physician compensation may not be structured in order to achieve the goal of reducing, delaying, or denying medical treatment or restricting access to medical treatment.

(d) If the employer or insurer meets the requirements of this section, the administrative director may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing a medical provider network, an employer or insurer shall have the exclusive right to determine the members of their network.

(e) All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to Section 5307.27.

(f) No person other than a physician who holds the same California license as the requesting physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, when these services are within the scope of the physician's practice, may modify, delay, or deny requests for authorization of medical treatment.

(g) Commencing January 1, 2013, every contracting agent that sells, leases, assigns, transfers, or conveys its medical provider networks and their contracted reimbursement rates to an insurer, employer, entity that provides physician network services, or another contracting agent shall, upon entering or renewing a provider contract, disclose to the provider whether the medical provider network may be sold, leased, transferred, or conveyed to other insurers, employers, entities that provide physician network services, or another contracting agent, and specify whether those insurers, employers, entities that provide physician network

services, or contracting agents include workers' compensation insurers.

(h) On or before November 1, 2004, the administrative director, in consultation with the Department of Managed Health Care, shall adopt regulations implementing this article. The administrative director shall develop regulations that establish procedures for purposes of making medical provider network modifications.

~~SEC. 5.~~ *SEC. 7.* Section 4660.1 of the Labor Code is amended to read:

4660.1. This section shall apply to injuries occurring on or after January 1, 2013.

(a) In determining the percentages of permanent partial or permanent total disability, account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his or her age at the time of injury.

(b) For purposes of this section, the "nature of the physical injury or disfigurement" shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th edition) with the employee's whole person impairment, as provided in the guides, multiplied by an adjustment factor of 1.4.

(c) There shall be no increases in impairment ratings for sleep dysfunction or sexual dysfunction, or both, arising out of a compensable physical injury. Nothing in this section shall limit the ability of an injured employee to obtain treatment for sleep dysfunction or sexual dysfunction, if any, that are a consequence of an industrial injury.

(d) The administrative director may formulate a schedule of age and occupational modifiers and may amend the schedule for the determination of the age and occupational modifiers in accordance with this section. The Schedule for Rating Permanent Disabilities pursuant to the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th edition) and the schedule of age and occupational modifiers shall be available for public inspection and, without formal introduction in evidence, shall be prima facie evidence of the percentage of permanent disability to be attributed to each injury covered by the schedule. Until the schedule of age and occupational modifiers is amended, for injuries occurring on or after January 1, 2013, permanent disabilities shall be rated using the age and occupational modifiers in the permanent disability rating schedule adopted as of January 1, 2005.

(e) The schedule of age and occupational modifiers shall promote consistency, uniformity, and objectivity.

(f) The schedule of age and occupational modifiers and any amendment thereto or revision thereof shall apply prospectively and shall apply to and govern only those permanent disabilities that result from compensable injuries received or occurring on and after the effective date of the adoption of the schedule, amendment, or revision, as the case may be.

(g) Nothing in this section shall preclude a finding of permanent total disability in accordance with Section 4662.

(h) In enacting the act adding this section, it is not the intent of the Legislature to overrule the holding in Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman) (2010) 187 Cal.App.4th 808.

(i) The Commission on Health and Safety and Workers' Compensation shall conduct a study to compare average loss of earnings for employees who sustained work-related injuries with permanent disability ratings under the schedule, and shall report the results

of the study to the appropriate policy and fiscal committees of the Legislature no later than January 1, 2016.

BILL NUMBER: SB 809 INTRODUCED
BILL TEXT

INTRODUCED BY Senators DeSaulnier and Steinberg
(Coauthors: Senators Hancock, Lieu, Pavley, and Price)
(Coauthor: Assembly Member Blumenfield)

FEBRUARY 22, 2013

An act to add Section 805.8 to the Business and Professions Code, to amend Sections 11165 and 11165.1 of the Health and Safety Code, and to add Part 21 (commencing with Section 42001) to Division 2 of the Revenue and Taxation Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as introduced, DeSaulnier. Controlled substances: reporting.

(1) Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill would establish the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill would require the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized to prescribe or dispense controlled substances, by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified. This bill would also require the California State Board of Pharmacy to increase the licensure, certification, and renewal fees charged to wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

(2) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or

both, providing care or services to the individual.

This bill would require licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care, and, upon the happening of specified events, to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Existing law imposes various taxes, including taxes on the privilege of engaging in certain activities. The Fee Collection Procedures Law, the violation of which is a crime, provides procedures for the collection of certain fees and surcharges.

This bill would impose a tax upon qualified manufacturers, as defined, for the privilege of doing business in this state, as specified. This bill would also impose a tax upon specified insurers, as defined, for the privilege of doing business in this state, as specified. The tax would be administered by the State Board of Equalization and would be collected pursuant to the procedures set forth in the Fee Collection Procedures Law. The bill would require the board to deposit all taxes, penalties, and interest collected pursuant to these provisions in the CURES Fund, as provided. Because this bill would expand application of the Fee Collection Procedures Law, the violation of which is a crime, it would impose a state-mandated local program.

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

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

(5) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. 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) The Controlled Substance Utilization Review and Evaluation System (CURES) is a valuable investigative, preventive, and educational tool for law enforcement, regulatory boards, educational researchers, and the health care community. Recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support the CURES Prescription Drug Monitoring Program (PDMP). The PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs. Without a dedicated funding source, the CURES PDMP is not sustainable.

(b) Each year CURES responds to more than 60,000 requests from practitioners and pharmacists regarding all of the following:

(1) Helping identify and deter drug abuse and diversion of prescription drugs through accurate and rapid tracking of Schedule II, Schedule III, and Schedule IV controlled substances.

(2) Helping practitioners make better prescribing decisions.

(3) Helping reduce misuse, abuse, and trafficking of those drugs.

(c) Schedule II, Schedule III, and Schedule IV controlled substances have had deleterious effects on private and public

interests, including the misuse, abuse, and trafficking in dangerous prescription medications resulting in injury and death. It is the intent of the Legislature to work with stakeholders to fully fund the operation of CURES which seeks to mitigate those deleterious effects, and which has proven to be a cost-effective tool to help reduce the misuse, abuse, and trafficking of those drugs.

SEC. 2. Section 805.8 is added to the Business and Professions Code, to read:

805.8. (a) (1) The Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized pursuant to Section 11150 of the Health and Safety Code to prescribe or dispense Schedule II, Schedule III, or Schedule IV controlled substances by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

(2) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.

(3) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating veterinary food-animal drug retailers licensed or certificated by that board.

(b) The funds collected pursuant to subdivision (a) shall be deposited in the CURES accounts, which are hereby created, within the Contingent Fund of the Medical Board of California, the State Dentistry Fund, the Pharmacy Board Contingent Fund, the Veterinary Medical Board Contingent Fund, the Board of Registered Nursing Fund, the Osteopathic Medical Board of California Contingent Fund, the Optometry Fund, and the Board of Podiatric Medicine Fund. Moneys in the CURES accounts of each of those funds shall, upon appropriation by the Legislature, be available to the Department of Justice solely for maintaining CURES for the purposes of regulating prescribers and dispensers of controlled substances. All moneys received by the Department of Justice pursuant to this section shall be deposited in the CURES Fund described in Section 11165 of the Health and Safety Code.

SEC. 3. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds ~~from~~ *in the CURES accounts within* the

Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, ~~and~~ the Osteopathic Medical Board of California Contingent Fund, *the Veterinary Medical Board Contingent Fund, the Optometry Fund, the Board of Podiatric Medicine Fund, and the CURES Fund,* maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds ~~from~~ *for* the Department of Justice *for the purpose of finding CURES*. The department may seek and use grant funds to pay the costs incurred from the reporting of controlled substance prescriptions to CURES. ~~Funds~~ *The department shall make information about the amount and the source of all private grant funds it receives for support of CURES available to the public. Grant funds* shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, or the Osteopathic Medical Board of California Contingent Fund to pay the costs of reporting Schedule III and Schedule IV controlled substance prescriptions to CURES.

(c) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal persons or public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or ~~agency~~ *agency,* as described in this ~~subdivision~~ *subdivision,* shall not be disclosed, sold, or transferred to any third party.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy or clinic shall provide the following information to the Department of Justice on a weekly basis and in a format specified by the Department of Justice:

(1) Full name, address, and ~~the~~ telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure and license ~~number;~~ *number, the* federal controlled substance registration ~~number;~~ *number,* and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, and federal controlled substance registration number.

(4) ~~NDC (National Drug Code)~~ *National Drug Code (NDC)* number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) ~~ICD-9 (diagnosis code),~~ *International Statistical Classification of Diseases, 9th revision (ICD-9) Code,* if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) ~~This section shall become operative on January 1, 2005.~~ *The CURES Fund is hereby established within the State Treasury. The CURES Fund shall consist of all funds made available to the Department of Justice for the purpose of funding CURES. Money in the CURES Fund shall, upon appropriation by the Legislature, be available for allocation to the Department of Justice for the purpose of funding CURES.*

SEC. 4. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) A licensed health care practitioner eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances or a pharmacist ~~may~~ *shall* provide a notarized application developed by the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient maintained within the Department of Justice, ~~and~~ *and, upon approval,* the department ~~may~~ *shall* release to that practitioner or pharmacist, the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(A) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal Drug Enforcement Administration (DEA) registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(B) Any authorized subscriber shall notify the Department of Justice within 10 days of any changes to the subscriber account.

(2) To allow sufficient time for licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and a pharmacist to apply and receive access to PDMP, a written request may be made, until July 1, 2012, and the Department of Justice may release to that practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care based on data contained in CURES.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines

developed by the Department of Justice.

(c) ~~In~~ *(1) Until the Department of Justice has issued the notification described in paragraph (3), in* order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(2) Upon the Department of Justice issuing the notification described in paragraph (3) and approval of the application required pursuant to subdivision (a), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substance.

(3) The Department of Justice shall notify licensed health care practitioners and pharmacists who have submitted the application required pursuant to subdivision (a) when the department determines that CURES is capable of accommodating the mandate contained in paragraph (2). The department shall provide a copy of the notification to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the notification on the department's Internet Web site.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

SEC. 5. Part 21 (commencing with Section 42001) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 21. Controlled Substance Utilization Review and Evaluation System (CURES) Tax Law

42001. For purposes of this part, the following definitions apply:

(a) "Controlled substance " means a drug, substance, or immediate precursor listed in any schedule in Section 11055, 11056, or 11057 of the Health and Safety Code.

(b) "Insurer" means a health insurer licensed pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and a workers' compensation insurer licensed pursuant to Part 3 (commencing with Section 11550) of Division 2 of the Insurance Code.

(c) "Qualified manufacturer" means a manufacturer of a controlled

substance doing business in this state, as defined in Section 23101, but does not mean a wholesaler or nonresident wholesaler of dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section 4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

42003. (a) For the privilege of doing business in this state, an annual tax is hereby imposed on all qualified manufacturers in an amount of ____ dollars ($____), for the purpose of establishing and maintaining enforcement of the Controlled Substance Utilization Review and Evaluation System (CURES), established pursuant to Section 11165 of the Health and Safety Code.

(b) For the privilege of doing business in this state, a tax is hereby imposed on a one time basis on all insurers in an amount of ____ dollars ($____), for the purpose of upgrading CURES.

42005. Each qualified manufacturer and insurer shall prepare and file with the board a return, in the form prescribed by the board, containing information as the board deems necessary or appropriate for the proper administration of this part. The return shall be filed on or before the last day of the calendar month following the calendar quarter to which it relates, together with a remittance payable to the board for the amount of tax due for that period.

42007. The board shall administer and collect the tax imposed by this part pursuant to the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)). For purposes of this part, the references in the Fee Collection Procedures Law (Part 30 (commencing with Section 55001)) to "fee" shall include the tax imposed by this part and references to "feepayer" shall include a person required to pay the tax imposed by this part.

42009. All taxes, interest, penalties, and other amounts collected pursuant to this part, less refunds and costs of administration, shall be deposited into the CURES Fund.

42011. The board shall prescribe, adopt, and enforce rules and regulations relating to the administration and enforcement of this part.

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

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the public from the continuing threat of prescription drug abuse at the earliest possible time, it is necessary this act take effect immediately.

BILL NUMBER: SB 816 INTRODUCED
BILL TEXT

INTRODUCED BY Committee on Health (Senators Hernandez (Chair), Anderson, Beall, DeSaulnier, Monning, Nielsen, Pavley, and Wolk)

MARCH 11, 2013

An act to amend Sections 1339.40 and 1339.43 of the Health and Safety Code, and to amend Section 4512 of the Welfare and Institutions Code, relating to health and human services.

LEGISLATIVE COUNSEL'S DIGEST

SB 816, as introduced, Committee on Health. Hospice facilities: developmental disabilities: intellectual disability.

(1) Existing law provides for the licensure and regulation of health facilities, including hospice facilities, by the State Department of Public Health. A violation of those provisions is a crime. Existing law requires a freestanding hospice facility to meet specified requirements relating to the physical environment of the facility until the Office of Statewide Health Planning and Development, in consultation with the Office of the State Fire Marshal, develops and adopts building standards for hospice facilities.

This bill would instead require the Office of the State Fire Marshal to develop and adopt the building standards for hospice facilities in consultation with the Office of Statewide Health Planning and Development and would make other technical changes.

(2) Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities, defined to include mental retardation and disabling conditions related to, or requiring treatment similar to, mental retardation.

This bill would revise this definition of developmental disabilities to instead include intellectual disability and disabling conditions closely related to, or requiring treatment similar to, intellectual disability.

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 1339.40 of the Health and Safety Code is amended to read:

1339.40. For the purposes of this article, the following definitions apply:

(a) "Bereavement services" has the same meaning as defined in subdivision (a) of Section 1746.

(b) "Hospice care" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the primary caregiver and the family of the hospice patient, and that

meets all of the following criteria:

(1) Considers the patient and the patient's family, in addition to the patient, as the unit of care.

(2) Utilizes an interdisciplinary team to assess the physical, medical, psychological, social, and spiritual needs of the patient and the patient's family.

(3) Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care that emphasizes supportive services, including, but not limited to, home care, pain control, and limited inpatient services. Limited inpatient services are intended to ensure both continuity of care and appropriateness of services for those patients who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

(4) Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease, but does not provide for efforts to cure the disease.

(5) Provides for bereavement services following death to assist the family in coping with social and emotional needs associated with the death of the patient.

(6) Actively utilizes volunteers in the delivery of hospice services.

(7) To the extent appropriate, based on the medical needs of the patient, provides services in the patient's home or primary place of residence.

(c) "Hospice facility" means a health facility as defined in subdivision (n) of Section 1250.

(d) "Inpatient hospice care" means hospice care that is provided to patients in a hospice facility, including routine, continuous and inpatient care directly as specified in Section ~~418.10~~ *418.110* of Title 42 of the Code of Federal Regulations, and may include short-term inpatient respite care as specified in Section 418.108 of Title 42 of the Code of Federal Regulations.

(e) "Interdisciplinary team" has the same meaning as defined in subdivision (g) of Section 1746.

(f) "Medical direction" has the same meaning as defined in subdivision (h) of Section 1746.

(g) "Palliative care" has the same meaning as defined in subdivision (j) of Section 1746.

(h) "Plan of care" has the same meaning as defined in subdivision (l) of Section 1746.

(i) "Skilled nursing services" has the same meaning as defined in subdivision (n) of Section 1746.

(j) "Social services/counseling services" has the same meaning as defined in subdivision (o) of Section 1746.

(k) "Terminal disease" or "terminal illness" has the same meaning as defined in subdivision (p) of Section 1746.

(l) "Volunteer services" has the same meaning as defined in subdivision (q) of Section 1746.

SEC. 2. Section 1339.43 of the Health and Safety Code is amended to read:

1339.43. (a) A hospice facility shall provide a home-like environment that is comfortable and accommodating to both the patient and patient's visitors.

(b) Building standards for hospice facilities adopted pursuant to this chapter relating to fire and panic safety, and other regulations for hospice facilities adopted pursuant to this chapter, shall apply uniformly throughout the state. No city, county, city and county, including a charter city or charter county, or fire protection

district shall adopt or enforce any ordinance or local rule or regulation relating to fire and panic safety in buildings or structures subject to this section that is inconsistent with the rules and regulations for hospice facilities adopted pursuant to this chapter.

(c) The hospice facility shall meet the fire protection standards set forth in the federal Medicare conditions of participation (42 C.F.R. Part 418 et seq.).

(d) A hospice facility may operate as a freestanding health facility.

(1) Until the Office of ~~Statewide Health Planning and Development~~ *the State Fire Marshal* , in consultation with the Office of ~~the State Fire Marshal~~ *Statewide Health Planning and Development* , develops and adopts building standards for hospice facilities, a freestanding hospice facility shall meet applicable building standards and requirements relating to the physical environment of the facility as specified in Section ~~418.100~~ *418. 110* of Title 42 of the Code of Federal Regulations. The building standards developed shall, at a minimum, maintain the requirements specified in that section.

(2) A freestanding hospice facility shall be under the jurisdiction of the local building department. As part of the license application, the prospective licensee shall submit evidence of compliance with applicable building standards for hospice facilities.

(3) The physical environment of the hospice facility shall be adequate to provide the level of care and service required by the residents of the facility as determined by the department.

(e) A hospice facility may be located within the physical plant of another health facility.

(1) Notwithstanding subdivision (d) and paragraphs (8) and (9) of subdivision (b) of Section 129725, a hospice facility located within the physical plant of another licensed health facility that is under the jurisdiction of the Office of Statewide Health Planning and Development, shall meet the building standards for that category of health facility within which the hospice facility is located, and plans shall be submitted to the office for review of any new construction or renovation of these hospice facilities. As part of the license application, the prospective licensee shall submit evidence of compliance with the building codes enforced by the Office of Statewide Health Planning and Development.

(2) The physical environment of the facility shall be adequate to provide the level of care and service required by the residents of the facility as determined by the department.

(3) In the event the space used by the hospice facility reverts back to the facility with which the hospice facility shared the space, the building standards applicable to the former shared space, as identified by date of enactment of the standards, shall not change due solely to the reversion.

(4) A hospice facility that provides inpatient hospice care and is located within, adjacent to or physically connected to another health facility shall provide all of the following:

(A) A designated nursing station.

(B) Adequate space for the preparation of drugs with lockable, secure storage that is accessible only by authorized personnel.

(C) Signage that shall clearly demarcate the hospice facility area from the facility with which the hospice facility shares space.

(D) Doors for every exit and entrance to the hospice facility.

(E) Contiguous beds within the designated area set aside for the

hospice facility.

(f) If a freestanding hospice facility is located on the site of or is physically connected to a health facility that is under the jurisdiction of the Office of Statewide Health Planning and Development or both, the hospice facility shall submit plans for any new construction or renovation of the hospice facility to the office for plan review and approval. The Office of Statewide Health Planning and Development shall review the hospice facility plans to identify any impacts to the health facility under the office's jurisdiction that may compromise the health facility's continued compliance with applicable laws and regulations.

SEC. 3. Section 4512 of the Welfare and Institutions Code is amended to read:

4512. As used in this division:

(a) "Developmental disability" means a disability that originates before an individual attains ~~age~~ 18 ~~years,~~ *years of age;* continues, or can be expected to continue, ~~indefinitely,~~ *indefinitely;* and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include ~~mental retardation~~ *intellectual disability* , cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to *intellectual disability* or to require treatment similar to that required for individuals with ~~mental retardation~~ *an intellectual disability* , but shall not include other handicapping conditions that are solely physical in nature.

(b) "Services and supports for persons with developmental disabilities" means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-term out-of-home care, social skills

training, specialized medical and dental care, supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. Nothing in this subdivision is intended to expand or authorize a new or different service or support for any consumer unless that service or support is contained in his or her individual program plan.

(c) Notwithstanding subdivisions (a) and (b), for any organization or agency receiving federal financial participation under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, as amended, "developmental disability" and "services for persons with developmental disabilities" mean the terms as defined in the federal act to the extent required by federal law.

(d) "Consumer" means a person who has a disability that meets the definition of developmental disability set forth in subdivision (a).

(e) "Natural supports" means personal associations and relationships typically developed in the community that enhance the quality and security of life for people, including, but not limited to, family relationships, friendships reflecting the diversity of the neighborhood and the community, associations with fellow students or employees in regular classrooms and workplaces, and associations developed through participation in clubs, organizations, and other civic activities.

(f) "Circle of support" means a committed group of community members, who may include family members, meeting regularly with an individual with developmental disabilities in order to share experiences, promote autonomy and community involvement, and assist the individual in establishing and maintaining natural supports. A circle of support generally includes a plurality of members who neither provide nor receive services or supports for persons with developmental disabilities and who do not receive payment for participation in the circle of support.

(g) "Facilitation" means the use of modified or adapted materials, special instructions, equipment, or personal assistance by an individual, such as assistance with communications, that will enable a consumer to understand and participate to the maximum extent possible in the decisions and choices that effect his or her life.

(h) "Family support services" means services and supports that are provided to a child with developmental disabilities or his or her family and that contribute to the ability of the family to reside together.

(i) "Voucher" means any authorized alternative form of service delivery in which the consumer or family member is provided with a payment, coupon, chit, or other form of authorization that enables the consumer or family member to choose his or her own service provider.

(j) "Planning team" means the individual with developmental disabilities, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of Section 4705, one or more regional center representatives, including the designated regional center service coordinator pursuant to subdivision (b) of Section 4640.7, any individual, including a service provider, invited by the consumer, the parents or legally appointed guardian of a minor consumer or the legally appointed conservator of an adult consumer, or the authorized representative, including those appointed pursuant to subdivision (d) of Section 4548 and subdivision (e) of

Section 4705, and including a minor's, dependent's, or ward's court-appointed developmental services decisionmaker appointed pursuant to Section 319, 361, or 726.

(k) "Stakeholder organizations" means statewide organizations representing the interests of consumers, family members, service providers, and statewide advocacy organizations.

(l) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.

(2) Receptive and expressive language.

(3) Learning.

(4) Mobility.

(5) Self-direction.

(6) Capacity for independent living.

(7) Economic self-sufficiency.

Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.