AGENDA ITEM: 8.1  
DATE: September 7, 2017

ACTIONS REQUESTED: Discuss Bills of Interest to the Board and Adopt or Modify Positions on the Bills Introduced during the 2017-2018 Legislative Session

REQUESTED BY: Donna Gerber, Chair

BACKGROUND: Bills of interest for the 2017-2018 legislative session are listed on the attached tables.

**Bold** denotes a new bill for Committee or Board consideration or is one that has been amended since the last Committee or Board meeting. An analysis and the bill text for these bills are included for further review.

NEXT STEPS: As directed by the Board

FINANCIAL IMPLICATIONS, IF ANY: As reflected by proposed legislation

PERSON TO CONTACT: Kay Weinkam, M.S., RN, CNS  
Nursing Education Consultant/Legislative Liaison  
(916) 574-7600
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# BILLS IMPACTING THE BOARD

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SUMMARY:
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 a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance.

Existing law authorizes the Department of Justice to conduct audits of the CURES database and its users.

ANALYSIS:
Legislator’s summary: AB 40 would allow health information technology systems to integrate with CURES for the purpose of automatically querying CURES on behalf of a CURES registered user.

This bill would require the Department of Justice to make the electronic history of controlled substances dispensed to an individual under a health care practitioner’s care, based on data contained in the CURES database, available to the practitioner through either an online Internet Web portal or an authorized health information technology system, as defined.

The bill would authorize a health information technology system to establish an integration with and submit queries to the CURES database if the system can certify, among other requirements, that the data received from the CURES database will not be used for any purpose other than delivering the data to an authorized health care practitioner or performing data processing activities necessary to enable delivery, and that the system meets applicable patient privacy and information security requirements of state and federal law.

The bill would also authorize the Department of Justice to require an entity operating a health information technology system to enter into a memorandum of understanding or other agreement setting forth terms and conditions with which the entity must comply.
Amended analysis as of 4/19:
The bill eliminates the provision that would authorize the Department of Justice to conduct audits of any authorized health information technology system integrated with the CURES database.

Amended analysis as of 5/26:
The bill clarifies that the legislation applies to the entity that houses the health information technology system rather than to the system itself.

Amended analysis as of 7/5:
The bill would delete the requirement that the Department of Justice require the entity enter into a memorandum of understanding that sets forth the terms and conditions with which the entity must comply. It now would require an entity operating a health information technology system that is requesting to establish an integration with the CURES database to pay a reasonable system maintenance fee and be subject to enforcement mechanisms, as specified.

Amended analysis as of 7/10:
This bill deletes some language related to what an entity would need to certify related to use of data received from the database.

The bill would prohibit the department from accessing patient-identifiable information in an entity’s health information technology system. The bill would authorize the department to prohibit integration or terminate a health information technology system’s ability to retrieve information in the CURES database if the health information technology system or the entity operating the health information technology system does not comply with specified provision of the bill.

Amended analysis as of 8/22:
The bill would require that the Department of Justice to make the electronic history of controlled substances dispensed to an individual under a pharmacist’s care as well as under the care of a health care practitioner based on data contained in the CURES database available to the pharmacist as well.

The bill would no longer authorize an entity that operates a health information technology system to establish an integration with and submit queries to the CURES database. The bill would authorize a health care practitioner or pharmacist to submit a query to the CURES database through the departments’ online portal or through a health information technology system if the entity operating the system can certify that the system meets applicable patient privacy and information security requirements of state and federal law.

BOARD POSITION: Watch (2/8/17)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/9/17)

SUPPORT:
California Academy of Family Physicians
California Access Coalition
California Health+ Advocates
California Hospital Association
California Pharmacists Association
California State Board of Pharmacy
Consumer Attorneys of California
County Health Executives Association of California
Health Officers Association of California
McKesson Corporation
Tenet Healthcare

OPPOSE:
California Dental Association
Osteopathic Physicians & Surgeons of California
ASSEMBLY BILL No. 40

Introduced by Assembly Member Santiago

December 5, 2016

An act to amend Section 11165.1 of the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL’S DIGEST

AB 40, as amended, Santiago. CURES database: health information technology system.

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 a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance.

This bill would require the Department of Justice to make the electronic history of controlled substances dispensed to an individual
AB 40

under a health care practitioner’s or pharmacist’s care, based on data contained in the CURES database, available to the practitioner, or a practitioner or pharmacist, as specified, through either an online Internet Web portal or an authorized health information technology system, as defined: specified. The bill would authorize an entity that operates a health information technology system to establish an integration with and submit queries to the CURES database if the entity a health care practitioner or pharmacist to submit a query to the CURES database through the department’s online portal or through a health information technology system if the entity operating the system can certify, among other requirements, that the system meets applicable patient privacy and information security requirements of state and federal law. The bill would also require an entity operating a health information technology system that is requesting to establish an integration with the CURES database to pay a reasonable system maintenance fee. The bill would prohibit the department from accessing patient-identifiable information in an entity’s health information technology system. The bill would authorize the department to prohibit integration or terminate a health information technology system’s ability to retrieve information in the CURES database if the health information technology system or the entity operating the health information technology system does not comply with specified provisions of the bill.

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


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

SECTION 1. Section 11165.1 of the Health and Safety Code, as amended by Section 2 of Chapter 708 of the Statutes of 2016, is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of a patient through an
online Internet Web portal that is maintained by the department, or through an authorized health information technology system, that is maintained by the department. Upon approval, the department shall release to that practitioner, through an online Internet Web portal or an authorized health information technology system, practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the department to obtain approval to electronically access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the department, or through an authorized health information technology system, maintained by the department. Upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application to access information contained in the CURES database.

(ii) Failing to maintain effective controls for access to the patient activity report.

(iii) Having his or her federal DEA registration suspended or revoked.

(iv) Violating a 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) Accessing information for a reason other than to diagnose or treat his or her patients, or to document compliance with the law.

(C) An authorized subscriber shall notify the department within 30 days of any changes to the subscriber account.

(D) An entity that operates a health information technology system may establish an integration with and submit queries to the CURES database on either a user-initiated basis or an automated basis if the entity can certify all of the following:
(i) The health information technology system is authorized to query the CURES database on behalf of an authorized health care practitioner or pharmacist on either a user-initiated basis, an automated basis, or both, for purposes of delivering patient data from the CURES database to assist an authorized health care practitioner or pharmacist to evaluate the need for medical or pharmaceutical treatment or provide medical or pharmaceutical treatment to a patient for whom a health care practitioner or pharmacist is providing or has provided care.

(D) An approved health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions Code may use the department’s online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the criteria required in subparagraph (E) to access the CURES database may submit automated queries to the CURES database that are triggered by predetermined criteria.

(E) An approved health care practitioner or pharmacist may submit queries to the CURES database through a health information technology system if the entity that operates the health information technology system can certify all of the following:
   (i) The entity will not use or disclose data received from the CURES database for any purpose other than delivering the data to an approved health care practitioner or pharmacist or performing data processing activities that may be necessary to enable the delivery unless authorized by, and pursuant to, state and federal privacy and security laws and regulations.
   (ii) The health information technology system will authenticate the identity of an authorized health care practitioner or pharmacist initiating queries to the CURES database on either a user-initiated basis or an automated basis and, at the time of the query to the CURES database, the health information technology system submits the following data regarding the query to CURES:
      (I) The date of the query.
      (II) The time of the query.
      (III) The first and last name of the patient queried.
      (IV) The date of birth of the patient queried.
(V) The identification of the CURES user for whom the system is making the query.

(iii) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(F) The department shall develop a programming interface or other method of system integration to allow health information technology systems that meet the requirements in subparagraph (D), (E) to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

(G) The department shall not access patient-identifiable information in an entity’s health information technology system.

(H) An entity that operates a health information technology system that is requesting to establish an integration with the CURES database shall pay a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database.

(I) The department may prohibit integration or terminate a health information technology system’s ability to retrieve information in the CURES database if the health information technology system fails to meet the requirements of subparagraph (D), (E), or the entity operating the health information technology system does not fulfill its obligation under subparagraph (G), (H).

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) A request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the department.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the department may initiate the referral of the history
of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the department pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient’s controlled substance history provided to a practitioner or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

(g) For purposes of this section, the following terms have the following meanings:

1. “Automated basis” means using predefined criteria established or approved by a health care practitioner or pharmacist to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

2. “Department” means the Department of Justice.

3. “Entity” means an organization that operates, or provides or makes available, a health information technology system to a health care practitioner or pharmacist.

4. “Health information technology system” means an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for communication, decisionmaking, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic
medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

(4) “User-initiated basis” means an authorized health care practitioner or pharmacist has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner or pharmacist.

SEC. 2. 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 California Constitution and shall go into immediate effect. The facts constituting the necessity are: In order to ensure that information in the CURES database is available to prescribing physicians so they may prevent the dangerous abuse of prescription drugs and to safeguard the health and safety of the people of this state, it is necessary that this act take effect immediately.
SUMMARY:
Existing law establishes a workers’ 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 requires every employer to establish a utilization review process, and defines “utilization review” as utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with providing medical treatment services. Existing law also provides for an independent medical review process to resolve disputes over utilization review decisions, as defined.

Existing workers’ compensation law generally requires employers to secure the payment of workers’ compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law prohibits aggregate disability payments for a single injury occurring on or after April 19, 2004, causing temporary disability from extending for more than 104 compensable weeks within a period of 2 years from the date of commencement of temporary disability payment. Existing law permits aggregate disability payments for certain injuries or conditions including, but not limited to, amputations, severe burns, and high-velocity eye injuries, to be made for not more than 240 compensable weeks within a period of 5 years from the date of the injury.

ANALYSIS:
This bill would exempt medical treatment for employees or first responders who sustain physical or psychological injury as a result of an act of terrorism or violence in the workplace from the utilization review process and the independent medical review process, and would provide for an expedited proceeding before the Workers’ Compensation Appeals Board to resolve disputes regarding treatment.

The bill would also apply retroactively to the employees and first responders injured in the San Bernardino terrorist attack of December 2, 2015, and any other employees or first responders injured by an act of terrorism or violence in the workplace that occurs prior to January 1, 2018.
This bill would add physical or psychological injury arising from an act of terrorism or violence in the workplace to the list of injuries on conditions for which aggregate disability payments may be made for not more than 240 compensable weeks within a period of 5 years from the date of injury.

Amended analysis as of 4/6:
This bill would define “Acts of terrorism” as “The unlawful use of force and violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives.” and “Violence in the workplace” as “An assault against a person with a firearm or other dangerous weapon that results in serious bodily harm or psychological injury.” for purposes of this section of the Labor Code.

Amended analysis as of 4/20:
The bill as amended deletes the above existing law/proposed revisions language.

Under existing law, an employer must provide reasonably required treatments, including, but not limited to, medical and surgical treatment, to cure or relieve an employee’s injuries sustained in the course of his or her employment.

This bill would require employers to provide immediately accessible advocacy services to employees injured in the course of employment by an act of domestic terrorism, as defined, when the Governor has declared a state of emergency due to that act of domestic terrorism.

Amended analysis as of 6/29:
1. Existing law requires an employer to establish a utilization review process to review, approve, modify, or deny a treatment claim.

This bill would require employers to provide immediately accessible advocacy services to employees, including first responders, injured in the course of employment by an act of domestic terrorism. It removes the requirement that the Governor declare a state of emergency.

The bill would require employer-appointed advocates to assist employees and others to obtain approval for medical treatments, as specified. The bill would establish a disputable presumption that physician-requested treatment is appropriate, set parameters for approving or denying treatment, and create processes for when treatment is denied.

The bill would apply retroactively to employees and first responders injured in an act of domestic terrorism before January 1, 2018.

2. Existing worker’s compensation law prohibits aggregate disability payments for a single injury occurring on or after April 19, 2004, causing temporary disability from extending for more than 104 compensable weeks, as specified. Existing law lists exempted injuries and conditions for which aggregate disability payments may be made for not more than 240 compensable weeks within a 5-year period.

This bill would add injuries arising from an act of domestic terrorism to the list of injuries and conditions for which aggregate disability payments may be made for not more than 240 compensable weeks within a 5-year period.
Amended analysis as of 7/17:
This bill would delete the provision establishing the disputable presumption relating to treatment. It would also delete the provision that the bill applies retroactively to employees and first responders injured in an act of terrorism before January 1, 2018.

The bill would require an employer to provide a prescribed notice to claimants, as specified. The bill would make its provisions applicable only if the Governor declares a state of emergency, as defined, in connection with the act of domestic terrorism.

The bill would delete provisions related to disability payments.

BOARD POSITION: Watch (2/17)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/9/17)

SUPPORT:
American Federation of State, County and Municipal Employees, AFL-CIO
California Applicants’ Attorneys Association
California Professional Firefighters
California Society of Industrial Medicine and Surgery
California Teamsters Public Affairs Council
Los Angeles County Professional Peace Officers Association
Pease Officers Research Association of California
San Diego County Court Employees Association
San Luis Obispo County Employees Association
The Organization of SMUD Employees

OPPOSE:
None received
An act to amend Section 4656 of, and to add Section 4600.05 to, the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST


Existing law establishes a workers’ 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. Under existing law, an employer must provide reasonably required treatments, including, but not limited to, medical and surgical treatment, to cure or relieve an employee’s injuries sustained in the course of his or her employment. Existing law requires an employer to establish a utilization review process to review, approve, modify, or deny a treatment claim.
This bill would require employers to provide immediately accessible advocacy services to employees, including first responders, employees injured in the course of employment by an act of domestic terrorism, as defined, and would require employer-appointed advocates to assist employees and others to obtain approval for medical treatments, as specified. The bill would establish a disputable presumption that physician-requested treatment is appropriate, set parameters for approving or denying treatment, and create processes for when treatment is denied. The bill would apply retroactively to employees and first responders injured in an act of domestic terrorism before January 1, 2018, as specified, and would require an employer to provide a prescribed notice to claimants, as specified. The bill would make its provisions applicable only if the Governor declares a state of emergency, as defined, in connection with the act of domestic terrorism.

Existing worker’s compensation law prohibits aggregate disability payments for a single injury occurring on or after April 19, 2004, causing temporary disability from extending for more than 104 compensable weeks, as specified. Existing law lists exempted injuries and conditions for which aggregate disability payments may be made for not more than 240 compensable weeks within a 5-year period.

This bill would add injuries arising from an act of domestic terrorism to the list of injuries and conditions for which aggregate disability payments may be made for not more than 240 compensable weeks within a 5-year period.

This bill would make related legislative findings and declarations.


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

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

(a) Domestic terrorist attacks, such as the December 2, 2015, attack on the Inland Regional Center in San Bernardino, with the number and severity of the injuries inflicted upon people at work, can present unique issues for the workers’ compensation system.

(b) Victims of domestic terrorist attacks who are at work at the time of injury are entitled to the full benefits of the workers’ compensation laws of this state, including treatment for all
diagnosed physical and mental injuries to the full extent authorized by the law.

(c) Treatment provided to all injured workers, including mental health treatment and counseling services for psychological injuries and post-traumatic stress disorder, is provided by health care providers who are trained and qualified to treat those injuries, and providers who are not competent on the basis of training and experience to treat specific patients referred to the provider have a duty under existing law to refer the patient to a qualified provider.

(d) Because of the unique circumstances surrounding the number and severity of injuries that can be caused by a single domestic terrorist act, and the extent to which the needs to provide this treatment quickly and comprehensively in potentially small service markets, it is appropriate to provide workers with injuries that result from a domestic terrorist attack with additional advocacy services, as provided by this bill.

SECTION 1.
SEC. 2. Section 4600.05 is added to the Labor Code, to read:

4600.05. (a) All employers, as defined in Section 3300, shall provide immediately accessible advocacy services for employees, including first responders, employees injured in the course of employment by an act of domestic terrorism, as defined in Section 2331 of Title 18 of the United States Code, to assist injured employees in obtaining medical treatment and to assist providers of medical services in seeking authorization and payment of medical treatment. These advocacy services may be provided by the employer, the employer’s insurer, or the employer’s claims administrator.

(b) Medical treatment, including psychological counseling, requested by a physician treating an employee pursuant to subdivision (a) shall be presumed to be consistent with the guidelines adopted by the administrative director pursuant to Section 5307.27. This presumption is disputable and may be controverted by other evidence, but unless so controverted, the independent medical reviewer and the appeals board are bound to find in accordance with it. The absence of documentation is not sufficient to rebut this presumption if the documentation is in the possession of, or available to, the employer, the employer’s insurer, or the employer’s claims administrator.
(c) The determination to authorize or deny requested medical treatment 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 request for authorization. If the treatment is denied, an independent medical review determination shall be issued no more than 45 days from the receipt of the request for authorization.

(d) The advocate provided by the employer pursuant to subdivision (a) shall assist the employee, the employee’s physician, and the employee’s representative, if any, to obtain authorization for the requested medical treatment, shall ensure the independent medical review process described in subdivision (c) is initiated in a timely manner, and shall provide the independent medical reviewer a narrative explaining why the treatment should be authorized, including citing relevant medical records.

(e) If the treatment is denied, or if the employer, insurer, or advocate provided by the employer pursuant to subdivision (a) fails to meet the timeframes or any other requirements of this section, the appeals board shall determine whether the requested treatment and all subsequently requested treatment and all subsequently requested treatment is medically necessary. An expedited hearing shall be held and the determination shall be made and filed within 30 days after the declaration of readiness is filed.

(f) This section is not intended to alter the conditions for compensability of an injury, as defined in Section 3600.

(g) The time limits in this section are mandatory. To the extent that the provisions of this section conflict with the provisions of Sections 4610 and 4610.5, the provisions in this section shall control.

(h) The administrative director shall adopt regulations to implement this section no later than July 1, 2018.

(i) This section, and subparagraph (J) of paragraph (3) of subdivision (e) of Section 4656 shall apply retroactively to the employees and first responders injured in the terrorist attack in San Bernardino on December 2, 2015, and any other employees or first responders injured by an act of domestic terrorism that occurred before January 1, 2018.

(b) (1) This section shall apply only if the Governor has declared a state of emergency pursuant to subdivision (b) of Section

(2) Upon the issuance of a declaration pursuant to paragraph (1), an employer that has a pending claim for compensation based on the acts that resulted in the declaration shall provide a notice within three days to the claimant advising the claimant that services provided pursuant to subdivision (a) are available, and that counseling and mental health services for psychological injuries are among the benefits available to claimants. In the case of a claim subject to this section that is filed after the declaration, the employer shall provide the notice to the claimant within three days. The notice shall be in the form adopted by the administrative director pursuant to subdivision (d).

(c) Nothing in this section alters the conditions for compensability of an injury, as described in Section 3600.

(d) The administrative director shall adopt regulations to implement this section.

SEC. 2. Section 4656 of the Labor Code is amended to read:

4656. (a) Aggregate disability payments for a single injury occurring prior to January 1, 1979, causing temporary disability shall not extend for more than 240 compensable weeks within a period of five years from the date of the injury.

(b) Aggregate disability payments for a single injury occurring on or after January 1, 1979, and prior to April 19, 2004, causing temporary partial disability shall not extend for more than 240 compensable weeks within a period of five years from the date of the injury.

(c) (1) Aggregate disability payments for a single injury occurring on or after April 19, 2004, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payment.

(2) Aggregate disability payments for a single injury occurring on or after January 1, 2008, causing temporary disability shall not extend for more than 104 compensable weeks within a period of five years from the date of injury.

(3) Notwithstanding paragraphs (1) and (2), for an employee who suffers from the following injuries or conditions, aggregate disability payments for a single injury occurring on or after April 19, 2004, causing temporary disability shall not extend for more
than 240 compensable weeks within a period of five years from the date of the injury:

(A) Acute and chronic hepatitis B.
(B) Acute and chronic hepatitis C.
(C) Amputations.
(D) Severe burns.
(E) Human immunodeficiency virus (HIV).
(F) High-velocity eye injuries.
(G) Chemical burns to the eyes.
(H) Pulmonary fibrosis.
(I) Chronic lung disease.
(J) Injuries arising from an act of domestic terrorism, as described in Section 4600.05.
SUMMARY:
As introduced 2/7:
The relevant laws for the Board are:
1. Existing law requires a health practitioner employed in a health facility, clinic, physician’s office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person suffering from a physical injury caused by a firearm or that is the result of domestic violence, to immediately make a report. A violation of this requirement is a misdemeanor.

2. Existing law establishes minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault, including child molestation, and the collection and preservation of evidence from those crimes.

3. Existing law prohibits costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault.

Existing law limits the amount that may be charged by a qualified health care professional, hospital, or other emergency medical facility to perform the medical evidentiary examination portion of a medical examination of a victim of a sexual assault to $300.

ANALYSIS:
As introduced 2/7:
1. This bill would make that requirement applicable if the patient discloses that he or she was a victim of a sexual assault, as specified, including rape, assault with the intent to commit those specified crimes, or an attempt to commit any of those crimes.
2. This bill, among other changes, would authorize a licensed hospital or licensed health care practitioner to perform an examination if an alleged victim of sexual assault is unconscious or incapacitated due to drugs, alcohol, head trauma, or a medical disease or condition, or due to a mental disorder or condition, and a reasonable person would conclude that exigent circumstances justify conducting a forensic examination and collecting appropriate evidence. The bill would make other changes relating to the conduct of sexual assault examinations and the storage of related records.

3. This bill would make that provision applicable to costs incurred by a clinic or sexual assault forensic medical examination team.

The bill would repeal the provision limiting the amount that may be charged to $300 and would instead provide that the cost of a sexual assault forensic medical evidentiary examination requested by a sexual assault victim who is choosing not to participate in a criminal investigation shall be treated as a local cost and charged to the local law enforcement agency in whose jurisdiction the alleged offense occurred. The bill would further require that the costs of the examination be reimbursed to the local law enforcement agency by the Office of Emergency Services in an amount not to exceed $1,000.

**Amended analysis as of 4/18:**
The bill now no longer addresses 1., above.

This bill omits the more specific provisions of 2., above.

3. This bill would include nurse practitioners and physician’s assistants within the definition of “qualified health care professionals” who can serve on a sexual assault forensic medical examination team.

The bill would also add a timeframe of sixty days to the provision that the Office of Emergency Services reimburse the local law enforcement agency in whose jurisdiction the alleged offense occurred. The cost of the exam is to be at the locally negotiated rate and not to exceed $1,000.00.

**Amended analysis as of 4/27:**
3. This bill would make that prohibition on charging a victim of sexual assault applicable to costs incurred by a clinic or sexual assault forensic medical examination team, and would include nurse practitioners and physician’s assistants as qualified health care professionals.

The bill would repeal the provision limiting the amount that may be charged to perform the medical evidentiary examination portion of a medical examination to $300.

The bill would further require that the costs of the examination for a sexual assault victim who chooses not to participate in a criminal investigation to be reimbursed to the local law enforcement agency by the Office of Emergency Services at the locally negotiated rate in an amount not to exceed $1,000.

**Amended analysis as of 6/12:**
The bill would clarify that its provisions apply where the assault occurred on or after the plaintiff’s 18th birthday.
BOARD POSITION: Watch (6/8/17)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/9/17)

SUPPORT
California Clinic Forensic Medical Training Center (sponsor)
Board of Supervisors, County of Santa Barbara
California District Attorneys Association
Consumer Attorneys of California
District Attorney, County of Santa Barbara
Enloe Medical Center
Peace Officers Research Association of California
Plumas District Hospital
San Gabriel Valley Medical Center
Santa Clara Valley Medical Center
Santa Cruz County Sheriff’s Office
Sutter Lakeside Hospital
Sutter Health
Four individuals

OPPOSE:
California Coalition Against Sexual Assault
An act to add Section 340.16 to the Code of Civil Procedure, and to amend Sections 13823.5, 13823.11, and 13823.95 of the Penal Code, relating to sexual assault.

LEGISLATIVE COUNSEL’S DIGEST

AB 334, as amended, Cooper. Sexual assault.

Existing law provides that in a civil action for recovery of damages suffered as a result of domestic violence, the time for commencement of the action shall be the later of within 3 years from the date of the last act of domestic violence by the defendant against the plaintiff or within 3 years from the date the plaintiff discovers or reasonably should have discovered that an injury or illness resulted from an act of domestic violence by the defendant against the plaintiff.

This bill would set the time for commencement of any civil action for recovery of damages suffered as a result of sexual assault, as defined, where the assault occurred on or after the plaintiff’s 18th birthday, to the later of within 10 years from the date of the last act, attempted act, or assault with intent to commit an act, of sexual assault by the defendant against the plaintiff or within 3 years from the date the plaintiff discovers
or reasonably should have discovered that an injury or illness resulted from an act, attempted act, or assault with intent to commit an act, of sexual assault by the defendant against the plaintiff.

Existing law establishes minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault, including child molestation and the collection and preservation of evidence from those crimes.

This bill, among other changes, would make changes relating to the conduct of sexual assault examinations and the storage of related records. The existing law prohibits costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. Existing law limits the amount that may be charged by a qualified health care professional, hospital, or other emergency medical facility to perform the medical evidentiary examination portion of a medical examination of a victim of a sexual assault to $300.

This bill would make that prohibition on charging a victim of sexual assault applicable to costs incurred by a clinic or sexual assault forensic medical examination team, and would include nurse practitioners and physician’s assistants as qualified health care professionals. The bill would repeal the provision limiting the amount that may be charged to $300. The bill would further require that the costs of the examination for a sexual assault victim who chooses not to participate in a criminal investigation be reimbursed to the local law enforcement agency by the Office of Emergency Services at the locally negotiated rate in an amount not to exceed $1,000.


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

SECTION 1. Section 340.16 is added to the Code of Civil Procedure, to read:

340.16. (a) In any civil action for recovery of damages suffered as a result of sexual assault, where the assault occurred on or after
the plaintiff's 18th birthday, the time for commencement of the
action shall be the later of the following:
(1) Within 10 years from the date of the last act, attempted act,
or assault with the intent to commit an act of sexual assault by the
defendant against the plaintiff.
(2) Within three years from the date the plaintiff discovers or
reasonably should have discovered that an injury or illness resulted
from an act, attempted act, or assault with the intent to commit an
act, of sexual assault by the defendant against the plaintiff.
(b) As used in this section, “sexual assault” means any of the
crimes described in Section 243.4, 261, 262, 264.1, 286, 288a, or
289 of the Penal Code, assault with the intent to commit any of
those crimes, or an attempt to commit any of those crimes.
(c) This section applies to any action described in subdivision
(a) that is commenced on or after January 1, 2018, to any action
described in subdivision (a) that is filed prior to January 1, 2018,
and still pending on that date, and to any action or causes of action
described in subdivision (a) that would have been barred by the
laws, including the period of limitations, in effect prior to January
1, 2018, thereby reviving those causes of action which had lapsed
or technically expired under the law existing prior to January 1,
2018. Nothing in this section is intended to revive actions or causes
of action as to which there has been a final adjudication on the
merits prior to January 1, 2018. Termination of a prior action on
the basis of the statute of limitations does not constitute a final
adjudication on the merits.
SEC. 2. Section 13823.5 of the Penal Code is amended to read:
13823.5. (a) The Office of Emergency Services, with the
assistance of the advisory committee established pursuant to
Section 13836, shall establish a protocol for the examination and
treatment of victims of sexual assault and attempted sexual assault,
including child molestation, and the collection and preservation
of evidence therefrom. The protocol shall contain recommended
methods for meeting the standards specified in Section 13823.11.
(b) (1) In addition to the protocol, the Office of Emergency
Services shall develop informational guidelines, containing general
reference information on evidence collection and examination of
victims of, and psychological and medical treatment for victims
of, sexual assault and attempted sexual assault, including child
molestation.
(2) In developing the protocol and the informational guidelines, the Office of Emergency Services and the advisory committee shall seek the assistance and guidance of organizations assisting victims of sexual assault; qualified health care professionals, criminalists, and administrators who are familiar with emergency room procedures; victims of sexual assault; and law enforcement officials.

(c) (1) The Office of Emergency Services, in cooperation with the State Department of Public Health and the Department of Justice, shall adopt a standard and a complete form or forms for the recording of medical and physical evidence data disclosed by a victim of sexual assault or attempted sexual assault, including child molestation.

(2) Each qualified health care professional who conducts an examination for evidence of a sexual assault or an attempted sexual assault, including child molestation, shall use the standard form or forms adopted pursuant to this section, and shall make those observations and perform those tests as may be required for recording of the data required by the form. The forms shall be subject to the same principles of confidentiality applicable to other medical records.

(3) The Office of Emergency Services shall make copies of the standard form or forms available to every public or private general acute care hospital, as requested.

The standard form shall be used to satisfy the reporting requirements specified in Sections 11160 and 11161 in cases of sexual assault, and may be used in lieu of the form specified in Section 11168 for reports of child abuse.

(d) The Office of Emergency Services shall distribute copies of the protocol and the informational guidelines to every general acute care hospital, law enforcement agency, and prosecutor’s office in the state.

(e) As used in this chapter, “qualified health care professional” means a physician and surgeon currently licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or a nurse currently licensed pursuant to Chapter 6 (commencing with Section 2700) of Division
2 of the Business and Professions Code and working in consultation
with a physician and surgeon who conducts examinations or
provides treatment as described in Section 13823.9 in a general
acute care hospital or in a physician and surgeon’s office, a nurse
practitioner currently licensed pursuant to Article 8 (commencing
with Section 2834) of Chapter 6 of Division 2 of the Business and
Professions Code, or a physician assistant licensed pursuant to
Chapter 7.7 (commencing with Section 3500) of Division 2 of the
Business and Professions Code.
SEC. 3. Section 13823.11 of the Penal Code is amended to
read:
13823.11. The minimum standards for the examination and
treatment of victims of sexual assault or attempted sexual assault,
including child molestation and the collection and preservation of
evidence therefrom include all of the following:
(a) Law enforcement authorities shall be notified.
(b) In conducting the physical examination, the outline indicated
in the form adopted pursuant to subdivision (c) of Section 13823.5
shall be followed.
(c) Consent for a physical examination, treatment, and collection
of evidence shall be obtained.
(1) Consent to an examination for evidence of sexual assault
shall be obtained prior to the examination of a victim of sexual
assault and shall include separate written documentation of consent
to each of the following:
(A) Examination for the presence of injuries sustained as a result
of the assault.
(B) Examination for evidence of sexual assault and collection
of physical evidence.
(C) Photographs of injuries.
(2) Consent to treatment shall be obtained in accordance with
the usual policy of the hospital, clinic, or other outpatient setting.
(3) A victim of sexual assault shall be informed that he or she
may refuse to consent to an examination for evidence of sexual
assault, including the collection of physical evidence, but that a
refusal is not a ground for denial of treatment of injuries and for
possible pregnancy and sexually transmitted diseases, if the person
wishes to obtain treatment and consents thereto.
(4) Pursuant to Chapter 3 (commencing with Section 6920) of
Part 4 of Division 11 of the Family Code, a minor may consent
to, or withhold consent from, hospital, medical, and surgical care
related to a sexual assault, including a sexual assault forensic
medical examination, without the consent of a parent or guardian.
(5) In cases of known or suspected child abuse, the consent of
the parents or legal guardian is not required. In the case of
suspected child abuse and nonconsenting parents, the consent of
the local agency providing child protective services or the local
law enforcement agency shall be obtained. Local procedures
regarding obtaining consent for the examination and treatment of,
and the collection of evidence from, children from child protective
authorities shall be followed.
(d) A history of sexual assault shall be taken.
The history obtained in conjunction with the examination for
evidence of sexual assault shall follow the outline of the form
established pursuant to subdivision (c) of Section 13823.5 and
shall include all of the following:
(1) A history of the circumstances of the assault.
(2) For a child, any previous history of child sexual abuse and
an explanation of injuries, if different from that given by parent
or person accompanying the child.
(3) Physical injuries reported.
(4) Sexual acts reported, whether or not ejaculation is suspected,
and whether or not a condom or lubricant was used.
(5) Record of relevant medical history.
(e) (1) If indicated by the history of contact, a female victim
of sexual assault shall be provided with the option of postcoital
contraception by a physician or other health care provider.
(2) Postcoital contraception shall be dispensed by a physician
or other health care provider upon the request of the victim.
(f) (1) Each adult and minor victim of sexual assault who
consents to a forensic medical examination for collection of
evidentiary material shall have a physical examination which
includes, but is not limited to, all of the following:
(A) Inspection of the clothing, body, and external genitalia for
injuries and foreign materials.
(B) Examination of the mouth, vagina, cervix, penis, anus, and
rectum, as indicated.
(C) Documentation of injuries and evidence collected.
(2) Prepubertal children shall not have internal vaginal or anal examinations unless absolutely necessary. This prohibition does not preclude careful collection of evidence using a swab.

(g) The collection of physical evidence shall conform to the following procedures:

(1) Each victim of sexual assault who consents to an examination for collection of evidence shall have the following items of evidence collected, except where he or she specifically objects:

(A) Clothing worn during the assault.

(B) Foreign materials revealed by an examination of the clothing, body, external genitalia, and pubic hair combings.

(C) Swabs and slides from the mouth, vagina, rectum, and penis, as indicated, to determine the presence or absence of semen.

(D) If indicated by the history of contact, the victim’s urine and blood sample, for toxicology purposes, to determine if drugs or alcohol were used in connection with the assault. Toxicology results obtained pursuant to this paragraph shall not be admissible in any criminal or civil action or proceeding against any victim who consents to the collection of physical evidence pursuant to this paragraph. Except for purposes of prosecuting or defending the crime or crimes necessitating the examination specified by this section, any toxicology results obtained pursuant to this paragraph shall be kept confidential, may not be further disclosed, and shall not be required to be disclosed by the victim for any purpose not specified in this paragraph. The victim shall specifically be informed of the immunity and confidentiality safeguards provided by this code.

(2) Each victim of sexual assault who consents to an examination for the collection of evidence may have reference specimens taken, except if he or she specifically objects thereto. A reference specimen is a standard from which to obtain baseline information and retain for DNA comparison and analysis. Reference specimens may also be collected at a later time if they are needed. These specimens shall be taken in accordance with the standards of the local criminalistics laboratory.

(3) A baseline gonorrhea culture, and syphilis serology, shall be taken, if indicated by the history of contact. Specimens for a pregnancy test shall be taken, if indicated by the history of contact and the age of the victim. Baseline testing for sexually transmitted infections is relevant for children and may be forensically indicated
for nonsexually active adults, and persons with disabilities or residing in long-term care facilities. In sexually active adults, testing for sexually transmitted infection for forensic purposes is not indicated. Medical indications for sexually transmitted infection testing are not part of the forensic medical examination.

(4) (A) If indicated by the history of contact, a female victim of sexual assault shall be provided with the option of postcoital contraception by a physician or other health care provider.

(B) Postcoital contraception shall be dispensed by a physician or other health care provider upon the request of the victim.

(5) For victims of sexual assault with an assault history of strangulation, best practices shall be followed for a complete physical examination and diagnostic testing to prevent adverse health outcomes or morbidity.

(6) A sexual assault forensic medical examiner shall be referred to as a SAFE, and shall be trained on standardized sexual assault forensic medical curriculum consistent with Sections 13823.5 to 13823.11, inclusive.

(h) Preservation and disposition of physical evidence shall conform to the following procedures:

(1) All swabs and slides shall be air-dried prior to packaging.

(2) All items of evidence including laboratory specimens shall be clearly labeled as to the identity of the source and the identity of the person collecting them.

(3) The evidence shall have a form attached which documents its chain of custody and shall be properly sealed.

(4) The evidence shall be turned over to the proper law enforcement agency.

(5) (A) Sexual assault forensic medical records shall only be released as required by law.

(B) Procedures for the storage of sexual assault forensic reports shall ensure the highest level of confidentiality and prevent copying of these records in response to requests for medical records that are not made in connection with a criminal or juvenile law investigation.

(C) Hospitals, nonprofit organizations, and private businesses that operate sexual assault forensic medical examination teams shall develop and adhere to written protocols and procedures for protecting and maintaining the confidentiality of sexual assault
forensic records, and for the proper disposition of these records if
the examination program ceases to exist.

(5) Hospitals, nonprofit organizations, and private businesses
that conduct sexual assault forensic examinations shall develop
and implement written policies and procedures for maintaining
the confidentiality of sexual assault forensic reports, including
proper disposition of these reports if the examination program
ceases operations. Sexual assault forensic reports shall be released
only as required or authorized by law.

SEC. 4. Section 13823.95 of the Penal Code is amended to
read:

13823.95. (a) Costs incurred by a qualified health care
professional, hospital, clinic, sexual assault forensic medical
examination team, or other emergency medical facility for the
medical evidentiary examination portion of the examination of the
victim of a sexual assault, as described in the protocol developed
pursuant to Section 13823.5, when the examination is performed
pursuant to Sections 13823.5 and 13823.7, shall not be charged
directly or indirectly to the victim of the assault.

(b) Any victim of a sexual assault who seeks a medical
evidentiary examination, as that term is used in Section 13823.93,
shall be provided with a medical evidentiary examination. No A
victim of a sexual assault shall not be required to participate or to
agree to participate in the criminal justice system, either prior to
the examination or at any other time.

(c) The cost of a sexual assault medical evidentiary examination
performed by a qualified health care professional, hospital, or other
emergency medical facility for a victim of a sexual assault shall
be treated as a local cost and charged to, and reimbursed within
60 days by, the local law enforcement agency in whose jurisdiction
the alleged offense was committed, provided, however, that the
committed. The local law enforcement agency may seek
reimbursement, as provided in subdivision (d), for the cost of
conducting the medical evidentiary examination portion of a
medical examination of a sexual assault victim who does not
participate in the criminal justice system.

(d) The cost of a sexual assault forensic medical evidentiary
examination requested by a sexual assault victim who is choosing
not to participate in a criminal investigation shall be treated as a
local cost and charged to and reimbursed within 60 days by the
local law enforcement agency in whose jurisdiction the alleged offense occurred. The costs of the examination shall be reimbursed to the local law enforcement agency by the Office of Emergency Services at the locally negotiated rate, in an amount not to exceed one thousand dollars ($1,000). The Office of Emergency Services shall use the discretionary funds from federal grants awarded to the agency pursuant to the federal Violence Against Women and Department of Justice Reauthorization Act of 2005 and the federal Violence Against Women Reauthorization Act of 2013 through the federal Office on Violence Against Women, specifically, the STOP (Services, Training, Officers, and Prosecutors) Violence Against Women Formula Grant Program, to cover the cost of the medical evidentiary examination portion of a medical examination of a sexual assault victim.
SUMMARY:
The bill was introduced February 19 by Assemblymembers Chiu and Gomez. It was amended February 19, March 22, May 20, and, most recently, July 12.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services (DHCS) and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law authorizes, at the option of the state, preventive services, as defined, to be provided by practitioners other than physicians or other licensed practitioners.

ANALYSIS:
This bill, which would be known as the Asthma Preventive Services Program Act of 2017, would require DHCS to seek an amendment to its Medicaid state plan so that “qualified asthma preventive services providers” would be authorized as providers of asthma preventive services for individuals with poorly controlled asthma in accordance with specified provisions of federal law and regulation.

The bill establishes requirements for the qualified asthma preventive service providers, the curricula for their training, and their supervising by health care providers. Requires DHCS to approve at least two accreditting bodies with expertise in asthma to review and approve training curricula for asthma preventive service providers.

The bill would authorize the department to seek any federal waivers or other state plan amendments as necessary to implement these provisions and would require these provisions to be implemented only if and to the extent that all necessary federal approvals are obtained and federal financial participation is available.

BOARD POSITION: Not previously considered
LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Oppose (8/9/17)

SUPPORT:
California Pan-Ethnic Network (co-sponsor)
Children Now (co-sponsor)
Regional Asthma Management & Prevention (co-sponsor)
Advancement Project
Alameda County Board of Supervisors
Alliance for Boys and Men of Color
American Lung Association of California
Asian Law Alliance
Asthma and Allergy Foundation of America
Asthma Coalition of Kern County
Asthma Coalition of Los Angeles County
Breathe California of the Bay Area
CA4Health
California Children’s Hospital Association
California Immigrant Policy Center
California School Based Health Alliance
Central California Asthma Collaborative
Comite Civico del Valle, Inc.
County Health Executives Association of California
Esperanza Community Housing
Green & Healthy Homes Initiative
Health Access California
Healthy African American Families II
Healthy Homes Collaborative
Imperial County Local Health Authority
Imperial Valley Child Asthma Program
Inquilinos Unidos
La Clinica de La Raza, Inc.
LifeLong Medical Care
Long Beach Alliance for Children with Asthma
Los Angeles Trust for Children’s Health
Merced/Mariposa County Asthma Coalition
National Health Law Program
Public Health Advocates
Queens Care Health Centers
Roots Community Health Center
The Children’s Clinic
Tri-City Health Center
Vision y Compromiso
Several individuals

OPPOSE: None received
ASSEMBLY BILL No. 391

Introduced by Assembly Members Chiu and Gomez

February 9, 2017

An act to add Article 1.6 (commencing with Section 14047) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL’S DIGEST

AB 391, as amended, Chiu. Medi-Cal: asthma preventive services. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law authorizes, at the option of the state, preventive services, as defined, to be provided by practitioners other than physicians or other licensed practitioners.

This bill, which would be known as the Asthma Preventive Services Program Act of 2017, would require the department to seek an amendment to its Medicaid state plan to include qualified asthma preventive services providers, as defined, as providers of asthma preventive services, as defined, for individuals with poorly controlled asthma, under the Medi-Cal program. The bill would require the
department to approve at least 2 governmental or nongovernmental accreditating bodies with expertise in asthma to review and approve training curricula for qualified asthma preventive services providers, as specified, and would require the curricula to be, at a minimum, 16 hours of instruction on specified topics. The bill would require an individual to satisfy specified educational and experience requirements in order to become a qualified asthma preventive services provider and would require any entity or supervising licensed provider who employs or contracts with a qualified asthma preventive services provider to comply with specified requirements. The bill would authorize the department to seek any federal waivers or other state plan amendments as necessary to implement these provisions and would require these provisions to be implemented only if and to the extent that all necessary federal approvals are obtained and federal financial participation is available.


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

SECTION 1. Article 1.6 (commencing with Section 14047) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

14047. This article shall be known, and may be cited as, the Asthma Preventive Services Program Act of 2017.

14047.1. The Legislature finds and declares all of the following:

(a) Asthma is a significant public health problem with notable disparities by race, ethnicity, and income.

(b) Asthma is of particular concern for low-income Californians enrolled in Medi-Cal. Low-income populations have higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations. When uncontrolled, patients with asthma may seek care in more expensive settings.

(c) There are also significant asthma disparities by race, ethnicity, and age.
(d) Patient asthma education and environmental asthma trigger assessments reduce more costly emergency department visits and hospitalizations, improve asthma control, decrease the frequency of symptoms, decrease work and school absenteeism, and improve quality of life. These outcomes are consistent across a large body of research findings, from the federal Community Preventive Services Task Force to local programs throughout California.

(e) Increasing access to asthma education and environmental asthma trigger assessments will help fulfill California’s quadruple aim goal of providing strengthening health care quality, improving health outcomes, reducing health care costs, and advancing health equity.

14047.2. For purposes of this article, the following definitions shall apply:

(a) “Asthma preventive services” means the provision of asthma education, environmental asthma trigger assessments, and other preventive services.

(b) “Asthma education” means providing to a patient information about the basic facts of asthma, the use of medications, self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms, consistent with the National Institutes of Health’s 2007 Guidelines for the Diagnosis and Management of Asthma (EPR-3), and any future updates of those guidelines.

(c) “Environmental asthma trigger assessment” means the identification of environmental asthma triggers commonly found in and around the home and other locations, including allergens and irritants. This assessment shall guide the self-management education about actions to mitigate or control environmental exposures.

(d) “Qualified asthma preventive services provider” means any individual who provides evidence-based asthma preventive services, including asthma education and environmental asthma trigger assessments for individuals with asthma, and who meets all of the requirements described in Section 14047.4.

(e) “Supervision” or “supervising” means the supervision of a qualified asthma preventive services provider providing asthma preventive services, by any of the following Medi-Cal-rendering providers who is acting within the scope of his or her respective practices:
(1) A licensed physician.
(2) A licensed nurse practitioner.
(3) A licensed physician assistant.

14047.3. The department shall approve at least two governmental or nongovernmental accreditng bodies with expertise in asthma to review and approve training curricula for qualified asthma preventive services providers. In approving the accrediting bodies, the department shall consult with external stakeholders. The accrediting bodies shall approve training curricula that align with the National Institutes of Health’s 2007 Guidelines for the Diagnosis and Management of Asthma (EPR-3), and any future updates of the guidelines. The curricula shall be, at a minimum, 16 hours, and shall include, but not be limited to, all of the following:

(a) Basic facts about asthma, including, but not limited to, contrasts between airways of a person who has and a person who does not have asthma, airflow obstruction, and the role of inflammation.
(b) Roles of medications, including the difference among long-term control medication, quick relief medications, any other medications demonstrated to be effective in asthma management or control, medication skills, and device usage.
(c) Environmental control measures, including how to identify, avoid, and mitigate environmental exposures, such as allergens and irritants, that worsen the patient’s asthma.
(d) Asthma self-monitoring to assess level of asthma control, monitor symptoms, and recognize the early signs and symptoms of worsening asthma.
(e) Understanding the concepts of asthma severity and asthma control.
(f) Educating patients on how to read an asthma action plan and reinforce the messages of the plan to the patient.
(g) Effective communication strategies, including, at a minimum, cultural and linguistic competency and motivational interviewing.
(h) The roles of various members of the care team and when and how to make referrals to other care providers and services, as appropriate.

14047.4. In order to be a qualified asthma preventive services provider, an individual shall, at a minimum, satisfy all of the following requirements:
(a) (1) Successful completion of a training program approved by an accrediting body appointed by the department pursuant to Section 14047.3.

(2) An individual who has completed an approved training curricula program after 2007, the year of the most recent update of the National Institutes of Health’s Guidelines for the Diagnosis and Management of Asthma (EPR-3), shall be considered as satisfying this training requirement.

(b) (1) Successful completion of, at a minimum, 16 hours of face-to-face client interaction training focused on asthma management and prevention within a six-month period. This training shall be observed and assessed by a licensed physician, nurse practitioner, or a physician assistant.

(2) An individual who has completed the minimum face-to-face client contact after 2007, the year of the most recent update of the National Institutes of Health’s Guidelines for the Diagnosis and Management of Asthma (EPR-3), shall be considered as satisfying this face-to-face client contact requirement.

(c) Successful completion of four hours of continuing education annually.

(d) Provide asthma preventive services under the supervision of a licensed provider.

(e) Be employed by or under contract with an entity or a supervising licensed provider that meets the requirements described in Section 14047.5.

(f) Be 18 years of age or older and have a high school education or the equivalent.

14047.5. Any entity or supervising licensed provider who employs or contracts with a qualified asthma preventive services provider shall:

(a) Maintain documentation that the qualified asthma preventive services provider has met all of the requirements described in Section 14047.4.

(b) Ensure that the qualified asthma preventive services provider is providing services consistent with Sections 14047.3 and 14047.6.

(c) Maintain written documentation of services provided by the qualified asthma preventive services provider.

(d) Ensure documentation of the provision of services is provided to the referring licensed medical provider, provider and, if different, the patient’s licensed primary care provider.
The department shall seek an amendment to its Medicaid state plan to include qualified asthma preventive services providers as providers of asthma preventive services for individuals with poorly controlled asthma in accordance with Section 1905(a)(13) of the Social Security Act (42 U.S.C. Sec. 1396d(a)(13)) and Section 440.130(c) of Title 42 of the Code of Federal Regulations.

(a) The department may seek any federal waivers or other state plan amendments as necessary to implement this article. 
(b) This article shall be implemented only if and to the extent that all necessary federal approvals are obtained and federal financial participation is available.
SUMMARY:
This bill was introduced on February 16 as Health facilities: pain management. The bill was amended March 21 with the subject change, above. The section most applicable to the Board is:

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health.

Existing las requires a health facility to, as a condition of licensure, include pain as an item to be assessed at the same time vital signs are taken and to ensure that pain assessment is performed in a consistent manner that is appropriate to the patient. Violation of these provisions is a crime.

ANALYSIS:
1. This bill would remove the requirement that pain be assessed at the same time as vital signs.

2. The bill would also prohibit a general acute care hospital or acute psychiatric hospital from in any way conditioning or basing executive compensation, as defined, on patient satisfaction measurements for pain management. By creating a new crime, this bill would impose a state-mandated local program.

Amended analysis as of 4/19:
The bill now deletes item 2. of the Analysis, above.

Amended analysis as of 4/27:
The bill corrected a typo. Otherwise, continues with the provision that removes the requirement that pain be assessed at the same time as vital signs.

Amended analyses of 6/15:
The bill would delete the provision that the pharmacist can collect the copayment for entire prescription at the time of first partial fill and the prohibition of the pharmacy from charging additional fees for prescriptions dispensed as partial fills.

The bill would now authorize a pharmacist to charge a dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription.
Background: Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plan contracts issued by health care service plans and health insurance policies issued by health insurers, including those that cover prescription drug benefits.

This bill now prohibits a health care service plan contract or a health insurance policy from considering the issue of copayments or payments for the ingredient costs of the drug paid for a pharmacy for a partial fill of a prescription to be an excess payment recoverable by a health care service plan or by the insurer or as a basis for denial of the pharmacy’s claim for reimbursement for the medication.

Amended analysis as of 6/21:
This bill would provide that the full prescription shall be dispensed no more than 30 days from the date on which the prescription was written rather than 30 days from the date of the first partial fill. The bill would provide that the prescription shall expire thirty-one days after the date on which the prescription was written and no more of the drug shall be dispensed without a subsequent prescription.

Amended analysis as of 7/3:
This bill would provide an operative date of July 1, 2018, and that neither a health care service plan nor an insurer shall prorate a copayment for a partial fill of a prescription dispensed pursuant to Section 4052.10 of the Business and Professions Code.

BOARD POSITION: Watch (6/8/17)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/9/17)

SUPPORT:
California Medical Association (sponsor)
American Medical Association
California Academy of Family Physicians
California Academy of PAs
California Hospital Association
California Pharmacists Association
California Retailers Association
California Society of Interventional Pain Physicians
Consumer Attorneys of California
McKesson Corporation
Medical Board of California
National Association of Chain Drug Stores
Osteopathic Physicians and Surgeons Association
Western Occupational and Environmental Medicine Association

OPPOSE: None received
An act to add Section 4052.10 to the Business and Professions Code, to amend Section 1254.7 of, and to add Section 1367.43 to, the Health and Safety Code, and to add Section 10123.203 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL’S DIGEST


(1) The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber’s order, and to administer immunizations pursuant to a protocol with a prescriber. A violation of the Pharmacy Law is a crime.
This bill would, beginning July 1, 2018, authorize a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber. The bill would require the pharmacy to retain the original prescription, with a notation of how much of the prescription has been filled, the date and amount of each partial fill, and the initials of the pharmacist dispensing each partial fill, until the prescription has been fully dispensed. The bill would authorize a pharmacist to charge a professional dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription. By creating a new crime, this bill would impose a state-mandated local program.

(2) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires a health facility, as a condition of licensure, to include pain as an item to be assessed at the same time vital signs are taken and to ensure that pain assessment is performed in a consistent manner that is appropriate to the patient.

This bill would remove the requirement that pain be assessed at the same time as vital signs.

(3) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plan contracts issued by health care service plans and health insurance policies issued by health insurers, including those that cover prescription drug benefits, as specified.

This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2018, from allowing the health care service plan, the insurer, or the entity with which either contracts to administer prescription drug benefits from considering a copayment or any portion thereof, or the payment for the ingredient costs of the drug, paid to a pharmacy for a partial fill of a prescription, to be an excess payment recoverable by the plan, the insurer, or the contracting entity or a basis for denial of the pharmacy’s claim for reimbursement for the medication. The bill would also require a health care service plan and an insurer to prorate a copayment for a partial fill of a prescription. By creating a new crime
under the Knox-Keene Act, this bill would impose a state-mandated local program.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.


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

SECTION 1. Section 4052.10 is added to the Business and Professions Code, to read:

4052.10. (a) A pharmacist may dispense a Schedule II controlled substance, as listed in Section 11055 of the Health and Safety Code, as a partial fill if requested by the patient or the prescriber.

(b) If a pharmacist dispenses a partial fill on a prescription pursuant to this section, the pharmacy shall retain the original prescription, with a notation of how much of the prescription has been filled, until the prescription has been fully dispensed. The total quantity dispensed shall not exceed the total quantity prescribed.

(c) Subsequent fills, until the original prescription is completely dispensed, shall occur at the pharmacy where the original prescription was partially filled. The full prescription shall be dispensed not more than 30 days after the date on which the prescription was written. Thirty-one days after the date on which the prescription was written, the prescription shall expire and no more of the drug shall be dispensed without a subsequent prescription.

(d) The pharmacist shall record in the state prescription drug monitoring program only the actual amounts of the drug dispensed.

(e) The pharmacist shall record the date and amount of each partial fill in a readily retrievable form and on the original prescription, and shall include the initials of the pharmacist who dispensed each partial fill.

(f) A pharmacist may charge a dispensing fee, as defined in Section 14105.45 of the Welfare and
Institutions Code, to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription.

(g) This section is not intended to conflict with or supersede any other requirement established for the prescription of a Schedule II controlled substance.

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

1. “Original prescription” means the prescription presented by the patient to the pharmacy or submitted electronically to the pharmacy.

2. “Partial fill” means a part of a prescription filled that is of a quantity less than the entire prescription.

(i) This section shall become operative on July 1, 2018.

SEC. 2. Section 1254.7 of the Health and Safety Code is amended to read:

1254.7. (a) It is the intent of the Legislature that pain be assessed and treated promptly, effectively, and for as long as pain persists.

(b) A health facility licensed pursuant to this chapter shall, as a condition of licensure, include pain as an item to be assessed. The health facility shall ensure that pain assessment is performed in a consistent manner that is appropriate to the patient. The pain assessment shall be noted in the patient’s chart.

SEC. 3. Section 1367.43 is added to the Health and Safety Code, to read:

1367.43. (a) A health care service plan contract that is issued, amended, or renewed on or after January 1, 2018, shall not allow the health care service plan or the entity with which it contracts to administer prescription drug benefits for enrollees, enrollees to consider a copayment or any portion thereof, or the payment for the ingredient costs of the drug, paid to a pharmacy for a partial fill of a prescription pursuant to Section 4052.10 of the Business and Professions Code, Code to be an excess payment recoverable by the plan or its contracting entity or a basis for denial of the pharmacy’s claim for reimbursement for the medication.

(b) A health care service plan shall prorate a copayment for a partial fill of a prescription dispensed pursuant to Section 4052.10 of the Business and Professions Code.

SEC. 4. Section 10123.203 is added to the Insurance Code, to read:
10123.203. (a) A health insurance policy that is issued, amended, or renewed on or after January 1, 2018, shall not allow the insurer or the entity with which it contracts to administer prescription drug benefits for the insured to consider a copayment or any portion thereof, or the payment for the ingredient costs of the drug, paid to a pharmacy for a partial fill of a prescription pursuant to Section 4052.10 of the Business and Professions Code to be an excess payment recoverable by the insurer or its contracting entity or a basis for denial of the pharmacy’s claim for reimbursement for the medication.

(b) An insurer shall prorate a copayment for a partial fill of a prescription dispensed pursuant to Section 4052.10 of the Business and Professions Code.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIXB 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 XIXB of the California Constitution.
SUMMARY:
This bill was introduced as Healing arts: records on February 17, 2017. It was amended March 21st to: Nurse practitioners: supervision.

The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. The act authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision. The act prohibits a physician and surgeon from supervising more than 4 nurse practitioners at one time for purposes of furnishing drugs or devices.

ANALYSIS:
This bill would delete that cap on the number of nurse practitioners a physician and surgeon may supervise at one time for purposes of furnishing drugs or devices.

Amended analysis as of 5/8:
As it relates to the Nursing Practice Act, existing law authorizes the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to any person licensed under the Nursing Practice Act that meets certain qualifications.

Existing law authorizes a certified-nurse midwife to, among other things, furnish or order drugs and devices under specified circumstances subject to physician and surgeon supervision. Existing law prohibits a physician and surgeon from supervising more than 4 certified-nurse midwives at one time for purposes of furnishing or ordering drugs or devices.

This bill now applies to nurse-midwives and physician assistants. It would prohibit a physician and surgeon from supervising more than 18 nurse practitioners, certified nurse-midwives, and physician assistants at any one time.

Amended analysis as of 7/3:
This bill would prohibit a surgeon from supervising more than 12 nurse practitioners, certified nurse-midwives, and physician assistants at any one time, as specified.
BOARD POSITION: Watch (6/8/17)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/9/17)

SUPPORT:
California Association for Nurse Practitioners (CANP)
Association of California Healthcare Districts
Bay Area Council
California Academy of Physician Assistants
California Council of Community Behavioral Health Agencies
California Health Advocates

OPPOSE:
California Chapter of the American College of Cardiology
Union of American Physicians and Dentists/AFSCME-Local 206
An act to amend Sections 2746.51, 2836.1, 3516, and 3516.5 of, and to add Sections 2746.54 and 2836.4 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST


The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. The act authorizes a nurse practitioner to, among other things, furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision. The act prohibits a physician and surgeon from supervising more than 4 nurse practitioners at one time for purposes of furnishing drugs or devices.

Existing law authorizes the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to any person licensed under the Nursing Practice Act that meets certain qualifications. Existing law authorizes a certified nurse-midwife to, among other things, furnish or order drugs and devices under specified circumstances subject to physician and surgeon supervision. Existing
law prohibits a physician and surgeon from supervising more than 4 certified nurse-midwives at one time for purposes of furnishing or ordering drugs or devices.

The Physician Assistance Practice Act provides for the licensure and regulation of physician assistants by the Physician Assistant Board, which is within the jurisdiction of the Medical Board of California. The act authorizes a physician assistant licensed by the Physician Assistant Board to be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision. The act prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time, except as specified.

This bill would instead prohibit a physician and surgeon from supervising more than 12 nurse practitioners, certified nurse-midwives, and physician assistants at any one time, as specified.


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

SECTION 1. Section 2746.51 of the Business and Professions Code is amended to read:

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

(1) The drugs or devices are furnished or ordered incidentally to the provision of any of the following:

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

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

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

(2) The drugs or devices are furnished or ordered by a certified
nurse-midwife in accordance with standardized procedures or
protocols. For purposes of this section, standardized procedure
means a document, including protocols, developed and approved
by the supervising physician and surgeon, the certified
nurse-midwife, and the facility administrator or his or her designee.
The standardized procedure covering the furnishing or ordering
of drugs or devices shall specify all of the following:
(A) Which certified nurse-midwife may furnish or order drugs
or devices.
(B) Which drugs or devices may be furnished or ordered and
under what circumstances.
(C) The extent of physician and surgeon supervision.
(D) The method of periodic review of the certified
nurse-midwife’s competence, including peer review, and review
of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in
Sections 11055 and 11056 of the Health and Safety Code, are
furnished or ordered by a certified nurse-midwife, the controlled
substances shall be furnished or ordered in accordance with a
patient-specific protocol approved by the treating or supervising
physician and surgeon. For Schedule II controlled substance
protocols, the provision for furnishing the Schedule II controlled
substance shall address the diagnosis of the illness, injury, or
condition for which the Schedule II controlled substance is to be
furnished.

(4) The furnishing or ordering of drugs or devices by a certified
nurse-midwife occurs under physician and surgeon supervision.:  
For purposes of this section, no physician and surgeon shall
supervise more certified nurse-midwives than allowed by Section
2746.54 at one time. Physician and surgeon supervision shall not
be construed to require the physical presence of the physician, but
does include all of the following:
(A) Collaboration on the development of the standardized procedure or protocol.

(B) Approval of the standardized procedure or protocol.

(C) Availability by telephonic contact at the time of patient examination by the certified nurse-midwife.

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

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

(3) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(4) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(5) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.
(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

1. The drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (2) to (4), inclusive, of subdivision (a) and in paragraphs (1) to (3), inclusive, of subdivision (b).

2. When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure or protocol. Use of the term “furnishing” in this section shall include the following:

1. The ordering of a drug or device in accordance with the standardized procedure or protocol.

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

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

SEC. 2. Section 2746.54 is added to the Business and Professions Code, to read:
2746.54. A physician and surgeon shall not supervise more
than 18 certified nurse-midwives, 12 certified nurse-midwives
functioning under Section 2746.51, nurse—practitioners,
practitioners functioning under Section 2836.1, and physician
assistants licensed under Chapter 7.7 (commencing with Section
3500) at any one time.
SEC. 3. Section 2836.1 of the Business and Professions Code
is amended to read:
2836.1. Neither this chapter nor any other law shall be
construed to prohibit a nurse practitioner from furnishing or
ordering drugs or devices when all of the following apply:
(a) The drugs or devices are furnished or ordered by a nurse
practitioner in accordance with standardized procedures or
protocols developed by the nurse practitioner and the supervising
physician and surgeon when the drugs or devices furnished or
ordered are consistent with the practitioner’s educational
preparation or for which clinical competency has been established
and maintained.
(b) The nurse practitioner is functioning pursuant to standardized
procedure, as defined by Section 2725, or protocol. The
standardized procedure or protocol shall be developed and
approved by the supervising physician and surgeon, the nurse
practitioner, and the facility administrator or the designee.
(c) (1) The standardized procedure or protocol covering the
furnishing of drugs or devices shall specify which nurse
practitioners may furnish or order drugs or devices, which drugs
or devices may be furnished or ordered, under what circumstances,
the extent of physician and surgeon supervision, the method of
periodic review of the nurse practitioner’s competence, including
peer review, and review of the provisions of the standardized
procedure.
(2) In addition to the requirements in paragraph (1), for Schedule
II controlled substance protocols, the provision for furnishing
Schedule II controlled substances shall address the diagnosis of
the illness, injury, or condition for which the Schedule II controlled
substance is to be furnished.
(d) The furnishing or ordering of drugs or devices by a nurse
practitioner occurs under physician and surgeon supervision.
Physician and surgeon supervision shall not be construed to require
the physical presence of the physician, but does include (1)
collaboration on the development of the standardized procedure, 
(2) approval of the standardized procedure, and (3) availability by 
telephonic contact at the time of patient examination by the nurse 
practitioner.
(e) (1) Drugs or devices furnished or ordered by a nurse 
practitioner may include Schedule II through Schedule V controlled 
substances under the California Uniform Controlled Substances 
Act (Division 10 (commencing with Section 11000) of the Health 
and Safety Code) and shall be further limited to those drugs agreed 
upon by the nurse practitioner and physician and surgeon and 
specified in the standardized procedure.
(2) When Schedule II or III controlled substances, as defined 
in Sections 11055 and 11056, respectively, of the Health and Safety 
Code, are furnished or ordered by a nurse practitioner, the 
controlled substances shall be furnished or ordered in accordance 
with a patient-specific protocol approved by the treating or 
supervising physician. A copy of the section of the nurse 
practitioner’s standardized procedure relating to controlled 
substances shall be provided, upon request, to any licensed 
pharmacist who dispenses drugs or devices, when there is 
uncertainty about the nurse practitioner furnishing the order.
(f) (1) The board has certified in accordance with Section 
2836.3 that the nurse practitioner has satisfactorily completed a 
course in pharmacology covering the drugs or devices to be 
furnished or ordered under this section.
(2) A physician and surgeon may determine the extent of 
supervision necessary pursuant to this section in the furnishing or 
ordering of drugs and devices.
(3) Nurse practitioners who are certified by the board and hold 
an active furnishing number, who are authorized through 
standardized procedures or protocols to furnish Schedule II 
controlled substances, and who are registered with the United 
States Drug Enforcement Administration, shall complete, as part 
of their continuing education requirements, a course including 
Schedule II controlled substances based on the standards developed 
by the board. The board shall establish the requirements for 
satisfactory completion of this subdivision.
(g) Use of the term “furnishing” in this section, in health 
facilities defined in Section 1250 of the Health and Safety Code, 
shall include (1) the ordering of a drug or device in accordance
with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

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

SEC. 4. Section 2836.4 is added to the Business and Professions Code, to read:

2836.4. A physician and surgeon shall not supervise more than 12 nurse practitioners, certified nurse-midwives, practitioners functioning under Section 2836.1, certified nurse-midwives functioning under Section 2746.51, and physician assistants licensed under Chapter 7.7 (commencing with Section 3500) at any one time.

SEC. 5. Section 3516 of the Business and Professions Code is amended to read:

3516. (a) Notwithstanding any other law, a physician assistant licensed by the board shall be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision.

(b) A physician and surgeon shall not supervise more than 12 physician assistants, nurse practitioners licensed under Chapter 6 (commencing with Section 2700), and functioning under Section 2836.1, and certified nurse-midwives certified under Article 2.5 (commencing with Section 2746) of Chapter 6 and functioning under Section 2746.51 at any one time, except as provided in Section 3502.5.

(c) The Medical Board of California may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon
from supervising physician assistants outside of the field of
specialty of the physician and surgeon.

SEC. 6. Section 3516.5 of the Business and Professions Code
is amended to read:

3516.5. (a) Notwithstanding any other law and in accordance
with regulations established by the Medical Board of California,
the director of emergency care services in a hospital with an
approved program for the training of emergency care physician
assistants, may apply to the Medical Board of California for
authorization under which the director may grant approval for
emergency care physicians on the staff of the hospital to supervise
emergency care physician assistants.

(b) The application shall encompass all supervising physicians
employed in that service.

(c) A violation of this section by the director of emergency care
services in a hospital with an approved program for the training
of emergency care physician assistants constitutes unprofessional
conduct within the meaning of Chapter 5 (commencing with
Section 2000).

(d) A violation of this section shall be grounds for suspension
of the approval of the director or disciplinary action against the
director or suspension of the approved program under Section
3527.
SUMMARY:
1. Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, the licensure and regulation of chronic dialysis clinics. Existing law requires the department to adopt regulations to implement these provisions, and requires those regulations to prescribe, among other things, minimum standards for staffing with duly qualified personnel. Violation of these provisions is a crime.

2. Existing law requires every clinic for which a license or special permit has been issued to be periodically inspected, with the frequency to be determined based on the type and complexity of the clinic or special service to be inspected. Existing law makes this provision inapplicable to an end stage renal disease facility.

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

ANALYSIS:
1. This bill would establish minimum staffing requirements for chronic dialysis clinics and establish a minimum transition time between patients receiving dialysis services at a treatment station. The ratios described would constitute the minimum number of nurses, technicians, and social workers assigned to patients at all times. Additional nurses, technicians, and social workers shall be assigned to the extent necessary to ensure that an adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient-to-staff ratio is appropriate to the level of dialysis care given and meets the needs of patients.

The bill would require chronic dialysis clinics to maintain certain information relating to the minimum staffing and minimum transition time requirements and provide that information, certified by the medical director and the chief executive officer or administrator under penalty of perjury, to the department on a schedule and in a format specified by the department, but no less frequently than 4 times per year.
The bill would establish a schedule of penalties and actions to be taken for failing to comply with the minimum staffing and minimum transition time requirements, including, among other things, the imposition of civil fines and the requirement that chronic dialysis clinic submit a correction action plan.

The bill would also establish a private right of action to enforce the minimum staffing and minimum transition time requirements. Because failure to comply with the minimum staffing and minimum transition time requirements would be a crime, and by expanding the crime of perjury, this bill would impose a state-mandated local program.

2. This bill would delete that exception and require the department to conduct an inspection of a chronic dialysis clinic at least once per year and as often as necessary to, among other things, ensure compliance with the minimum staffing and minimum transition time requirements and ensure the adequacy of care being provided.

The bill would require the department to issue regulations necessary to implement the bill no later than 180 days following its effective date.

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

Amended analysis as of 4/3:
The bill now:
Removes the medical director as a party who it to certify certain information to be maintained by chronic dialysis clinics and provided to the department.

Changes the meaning of “transition time”. It now means the period of time beginning when one patient has completed treatment and has been disconnected from the dialysis machine.

Changes the date from July 1, 2018, to January 1, 2019, for ensuring that minimum staffing ratios of at least one registered nurse providing care for every eight patients and at least one technician providing care for every three patients are met, a social worker is not assigned to more than 75 patients, and that transition times are at least 45 minutes.

Deletes one provision in the section of the code related to the meaning of the term “Gross staffing-related violation” and adds two provisions:
(D) Five or more staffing-related violations in a 12-month period.
(E) Being out of compliance with one of the staffing ratios for a period of time that extends beyond a single working shift of a nurse, for purposes of the nurse staffing requirement, or a single working shift of a technician, for purposes of the technician staffing requirement.

Makes permissive the imposition of penalties and revises the amounts and ranges of the civil penalties that can be imposed for staffing-related violation.

Amended analysis as of 4/17:
Co-authors Senators Bradford, Hertzberg, and Newman are added.
This bill deletes the “under penalty of perjury requirement” for the clinic administrator who certifies information related to minimum staffing and transition times provided to the department.

The bill deletes provisions under 3., above, in both the Summary and Analysis.

Amended analysis as of 5/3:
This bill would provide that a nonmanagerial employee shall not be within the meaning of “responsible individual” as used in this section. A “responsible individual” means a person described in subparagraph (A) or (B) who, with respect to a staffing-related violation or gross staffing-related violation, knew or should have known that the violation would occur and possessed, but failed to exercise, direct responsibility and authority to prevent the violation from occurring, or knew or should have known that the violation had occurred and possessed, but failed to exercise, direct responsibility and authority to substantially remedy the violation.

This bill adds that nothing in this act is intended to impact nurse-to-patient ratios applicable to health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

Amended analysis as of 6/29:
This bill would provide definitions for what constitutes “full-time equivalent” and a “rural county”.

The bill now provides for an operative date of January 1, 2020, for implementation of the ratios and ensuring that the transition time is at least 45 minutes between patients at a dialysis station.

The bill now clarifies the ratios for full-time equivalent social workers and registered dietitians.

The bill now authorizes the department to grant a waiver to a chronic dialysis clinic in a rural county of the provisions related to staffing ratios, the dialysis clinic’s ability to comply with the requirements, and the information that the clinic must submit to the department if the waiver does not jeopardize the health, safety, and well-being of affected patients and is needed for increased operational efficiency.

Amended analysis as of 8/22:
This bill clarifies that, beginning January 1, 2020, a chronic dialysis clinic shall ensure that a full-time equivalent individual social worker or registered dietitian is not assigned more that 75 patients receiving care from the clinic regardless of the location where each patient undergoes dialysis.

The bill deletes the provision for mandating a transition time between patient use of stations to be at least 45 minutes. The bill now provides that the department shall issue regulations no later than January 1, 2020, that specify an appropriate minimum transition time taking specific factors into account. If the department has not issued those regulations on or before January 1, 2020, a chronic dialysis clinic shall ensure that the minimum transition time is at least 45 minutes.

BOARD POSITION: Watch (4/5/17)

LEGISLATIVE COMMITTEE RECOMMENDED POSITION: Watch (8/9/17)
SUPPORT:
California State Council of the Service Employees International Union (cosponsor)
United Nurses Associations of California/Union of Health Care Professionals
(UNAC/UHCP) (co-sponsor)
SEIU State Council (co-sponsor)
Black AIDS Institute
Black Women for Wellness
California Academy of Nutrition & Dietetics
California Alliance for Retired Americans
California Labor Federation
California Retired Teachers Association
Central Labor Council Contra Costa County, AFL-CIO
Centro Binacional para el Desarrollo Indigena Oaxaqueno
Centro La Familia Advocacy Services
Congress of California Seniors
El Concilio de Fresno, Inc.
Fresno Center for New Americans
Fresno Immigration Coalition
Latino Coalition for a Healthy California
Latino Diabetes Association
Latino Equity Alliance
Men of Imperial Courts
Mi Familia Vota
NAACP- Fresno, #1038
National Association of Social Workers- California Chapter
New Congregational Church
Radio Bilingue, Inc.
Sistahs in Sync
Street Level Health Project
Unitarian Universalist Church of Fresno
Watts Century Latino Organization
Watts Labor Community Action Committee
Individual

OPPOSE:
Alliance Management, LLC
American G.I Forum of California
American Legion- Department of California
American Nurses Association- California
AMVETS- Department of California
Association of California Healthcare Districts
Association of California Nurse Leaders
AV Kidney Institute
Cal Chamber
California Association of County Veterans Service Officers
California Association of Rural Health Clinics
California Children’s Hospital Association
California Dialysis Council
Numerous physicians, patients, caregivers, and individuals
An act to amend Sections 1226 and 1228 of, to add Sections 1226.4, 1240.1, 1240.2, and 1266.2 to, and to repeal and add the heading of Article 5 (commencing with Section 1240) of Chapter 1 of Division 2 of, the Health and Safety Code, relating to clinics.

LEGISLATIVE COUNSEL’S DIGEST

SB 349, as amended, Lara. Chronic dialysis clinics: staffing requirements.

(1) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, the licensure and regulation of chronic dialysis clinics. Existing law requires the department to adopt regulations to implement these provisions, and requires those regulations to prescribe, among other things, minimum
standards for staffing with duly qualified personnel. Violation of these provisions is a crime.

This bill would establish minimum staffing requirements for chronic dialysis clinics and establish a minimum transition time between patients receiving dialysis services at a treatment station. The bill would require chronic dialysis clinics to maintain certain information relating to the minimum staffing and minimum transition time requirements and provide that information, certified by the chief executive officer or administrator, to the department on a schedule and in a format specified by the department, but no less frequently than 4 times per year. The bill would authorize the department to assess an administrative penalty for a violation of these provisions and other licensing provisions and would require the department to promulgate regulations to establish criteria for assessing these penalties. The bill would authorize a chronic dialysis clinic that disputes an alleged deficiency or failure to correct a deficiency, or the reasonableness of a proposed deadline for correction of a violation or an amount of an administrative penalty, to request a hearing. Because failure to comply with the minimum staffing and minimum transition time requirements would be a crime, this bill would impose a state-mandated local program.

(2) Existing law requires every clinic for which a license or special permit has been issued to be periodically inspected, with the frequency to be determined based on the type and complexity of the clinic or special service to be inspected. Existing law makes this provision inapplicable to an end-stage renal disease facility.

This bill would delete that exception and require the department to conduct an inspection of a chronic dialysis clinic at least once per year and as often as necessary to, among other things, ensure compliance with the minimum staffing and minimum transition time requirements and ensure the adequacy of care being provided.

The bill would generally require the department to issue regulations necessary to implement the bill no later than 2 years following its effective date.

(3) 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.

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

(a) Dialysis is a critical, lifesaving treatment for Californians suffering from end-stage renal disease.

(b) There are currently more than 66,000 dialysis patients, and more than 570 licensed outpatient dialysis clinics, in California.

(c) There is broad consensus among medical professionals, academics, and other experts that higher ratios of direct caregiving staff to patients at outpatient dialysis clinics improve patient outcomes, including by reducing the rate at which patients suffer infections or must be hospitalized.

(d) There is also broad consensus among medical professionals, academics, and other experts that adequate time to prepare a treatment station for a patient to be dialyzed is necessary to ensure safety and hygiene protocols are followed, and directly improve patient outcomes, including by reducing the rate at which patients suffer infections or must be unnecessarily hospitalized.

(e) Worker safety is also enhanced by higher ratios of caregiving staff to patients and transition time between patients, including by reducing the risk of injury on the job.

(f) Current staffing levels in outpatient dialysis clinics in California are inadequate to protect patient health and worker safety, and therefore are presently causing harm to dialysis patients, including unnecessary and avoidable deaths, hospitalizations, infections, and medication errors.

(g) Other states mandate minimum direct care staffing requirements in order to enhance patient safety and health at outpatient dialysis clinics.

SEC. 2. Section 1226 of the Health and Safety Code is amended to read:

1226. (a) The regulations shall prescribe the kinds of services which may be provided by clinics in each category of licensure and shall prescribe minimum standards of adequacy, safety, and sanitation of the physical plant and equipment, and, subject to Section 1226.4, minimum standards for staffing with duly qualified personnel and minimum standards for providing the services offered. These minimum standards shall be based on the type of
facility, the needs of the patients served, and the types and levels
of services provided.

(b) The Office of Statewide Health Planning and Development,
in consultation with the Community Clinics Advisory Committee,
shall prescribe minimum construction standards of adequacy and
safety for the physical plant of clinics as found in the California
Building Standards Code.

(c) (1) A city or county, as applicable, shall have plan review
and building inspection responsibilities for the construction or
alteration of buildings described in paragraphs (1) and (2) of
subdivision (b) of Section 1204 and shall apply the provisions of
the latest edition of the California Building Standards Code in
conducting these plan review responsibilities. For these buildings,
construction and alteration shall include conversion of a building
to a purpose specified in paragraphs (1) and (2) of subdivision (b)
of Section 1204.

(2) Upon the initial submittal to a city or county by the
governing authority or owner of these clinics for plan review and
building inspection services, the city or county shall reply in
writing to the clinic whether or not the plan review by the city or
county will include a certification as to whether or not the clinic
project submitted for plan review meets the standards as
propounded by the office in the California Building Standards
Code.

(3) If the city or county indicates that its review will include
this certification, it shall do both of the following:
(A) Apply the applicable clinic provisions of the latest edition
of the California Building Standards Code.
(B) Certify in writing, to the applicant within 30 days of
completion of construction whether or not these standards have
been met.

(d) If upon initial submittal, the city or county indicates that its
plan review will not include this certification, the governing
authority or owner of the clinic shall submit the plans to the Office
of Statewide Health Planning and Development, which shall review
the plans for certification whether or not the clinic project meets
the standards, as propounded by the office in the California
Building Standards Code.
(e) When the office performs review for certification, the office shall charge a fee in an amount that does not exceed its actual costs.

(f) The Office of the State Fire Marshal shall prescribe minimum safety standards for fire and life safety in surgical clinics.

(g) Notwithstanding subdivision (c), the governing authority or owner of a clinic may request the office to perform plan review services for buildings described in subdivision (c). If the office agrees to perform these services, after consultation with the local building official, the office shall charge an amount not to exceed its actual costs. The construction or alteration of these buildings shall conform to the applicable provisions of the latest edition of the California Building Standards Code for purposes of the plan review by the office pursuant to this subdivision.

(h) Regulations adopted pursuant to this chapter establishing standards for laboratory services shall not be applicable to any clinic that operates a clinical laboratory licensed pursuant to Section 1265 of the Business and Professions Code.

SEC. 3. Section 1226.4 is added to the Health and Safety Code, to read:

1226.4. (a) For purposes of this section, the following terms have the following meanings:

(1) “At all times” includes times during which employees, including, but not limited to, nurses and technicians, are provided meal periods and rest or other breaks.

(2) “Charge nurse” means a charge nurse as described in Section 494.140(b)(3) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(3) “Direct care” means initiating and discontinuing dialysis, monitoring patients during treatment, and administering medications, and physical presence in the dialysis treatment area.

(4) “Full-time equivalent” means employment by a chronic dialysis clinic for 2,080 hours of work in 12 consecutive months.

(5) “Nurse” means a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(6) “Nurse manager” means a nurse manager as described in Section 494.140(b)(1) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.
(7) “Registered dietitian” means a dietitian as described in Section 494.140(c) of Title 42 of the Code of Federal Regulations, as it read on December 31, 2016.

(8) “Rural county” means a county that has a population of less than 250,000 and does not have a single urbanized area with a population of greater than 50,000.

(9) “Social worker” means a social worker as described in Section 494.140(d) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(10) “Technician” means a person who holds both of the following qualifications:

(A) The person is a patient care dialysis technician, as described in Section 494.140(e) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(B) The person is a Certified Hemodialysis Technician certified pursuant to Article 3.5 (commencing with Section 1247) of Chapter 3 of Division 2 of the Business and Professions Code.

(11) “Trainee” means a person who is undergoing training to become a technician, but who has not yet been certified as a Certified Hemodialysis Technician pursuant to Article 3.5 (commencing with Section 1247) of Chapter 3 of Division 2 of the Business and Professions Code.

(12) “Transition time” means the period of time beginning when one patient has completed treatment and has been disconnected from the dialysis machine and ending when the next patient is placed in the treatment station, but does not mean the period of time after the last patient of the day leaves the treatment station.

(13) “Treatment station” means a physical location within a chronic dialysis clinic where an individual patient is dialyzed.

(b) (1) Commencing January 1, 2020, a chronic dialysis clinic shall ensure that the following minimum staffing ratios are met at all times that patients are receiving, or preparing to receive, direct care:

(A) At least one nurse is providing direct care for every eight patients. A nurse shall only count toward this ratio during time periods the nurse has no responsibilities other than direct care. A nurse manager or charge nurse shall not count toward this ratio.

(B) At least one technician is providing direct care for every three patients. A technician shall only count toward this ratio during time periods the technician has no responsibilities other than direct care.
care. Trainees shall not count toward this ratio. Nurses counted toward the nurse-to-patient ratio shall not count toward this ratio.

(2) Commencing January 1, 2020, a chronic dialysis clinic shall ensure that a full-time equivalent individual social worker is not assigned more than 75 patients, patients receiving care from the chronic dialysis clinic, regardless of the location where each patient undergoes dialysis.

(3) Commencing January 1, 2020, a chronic dialysis clinic shall ensure that a full-time equivalent individual registered dietitian is not assigned more than 75 patients, patients receiving care from the chronic dialysis clinic, regardless of the location where each patient undergoes dialysis.

(4) The ratios described in paragraphs (1), (2), and (3) shall constitute the minimum number of nurses, technicians, social workers, and registered dietitians assigned to patients at all times. Additional nurses, technicians, social workers, and registered dietitians shall be assigned to the extent necessary to ensure that an adequate number of qualified personnel are present whenever patients are undergoing dialysis so that the patient-to-staff ratio is appropriate to the level of dialysis care given and meets the needs of patients.

(5) Commencing January 1, 2020, a chronic dialysis clinic shall ensure that the transition time is at least 45 minutes.

(5) No later than January 1, 2020, the department shall issue regulations that specify an appropriate minimum transition time. This appropriate minimum transition time shall give patients sufficient time to recuperate after treatment and provide sufficient time to comply with safety and hygiene protocols, including, but not limited to, compliance with recommendations from the Centers for Disease Control and Prevention regarding hygiene practices. If the department has not issued those regulations on or before January 1, 2020, a chronic dialysis clinic shall ensure that the minimum transition time is at least 45 minutes.

(c) The department shall not issue a license to any chronic dialysis clinic unless that chronic dialysis clinic demonstrates the ability and intention to comply with this section.

(d) (1) Every chronic dialysis clinic for which a license has been issued shall maintain, and provide to the department on a form prescribed by the department, at a minimum, the following information:
(A) Actual staffing ratio and transition time data for the period covered by the submission, which shall include, at a minimum, daily all of the following: (1) daily totals of the total number and actual hours worked by nurses, technicians, social workers, and registered dietitians; (2) the total number of patients and actual hours receiving direct care; and care; (3) the daily average transition time for each treatment station; and (4) for each week, the total number of full-time equivalent social workers and registered dietitians and the total number of patients assigned to social workers and registered dietitians.

(B) Every instance, no matter how brief, during the period covered by the submission when staffing ratios or transition times did not meet the requirements of subdivision (b) and the reasons and circumstances therefor.

(2) The chief executive officer or administrator of the chronic dialysis clinic shall personally certify that he or she is satisfied, after review, that all information submitted pursuant to paragraph (1) is accurate and complete.

(3) The chronic dialysis clinic shall periodically submit the information described in paragraph (1) to the department on a schedule and in a format prescribed by the department, provided that the clinic shall submit that information no less frequently than four times per year.

(e) The department may grant a waiver of subdivisions (b), (c), and (d) to a chronic dialysis clinic in a rural county if the waiver does not jeopardize the health, safety, and well-being of affected patients and is needed for increased operational efficiency.

(f) The department shall inspect each chronic dialysis clinic for which a license has been issued at least once per year, and shall conduct such inspections as often as necessary to ensure compliance with the requirements of subdivision (b), the accuracy and completeness of information provided pursuant to subdivision (d), and the adequacy of the quality of care being provided.

(g) Within 60 days of receiving a complaint from an employee, an association of employees, a vendor, a contractor, a patient, an association of patients, or a family member of a patient of a chronic dialysis clinic that the chronic dialysis clinic has committed a violation of the requirements of this chapter, the department shall investigate the chronic dialysis clinic and, if the evidence shows
a violation has occurred, the department shall impose discipline pursuant to Section 1240.1.

(h) (1) Any writing, record, or document received, owned, used, or retained by the department in connection with subdivisions (c), (d), and (f) of this section, subdivisions (b) to (g), inclusive, of Section 1240.1, and Section 1240.2, is a public record within the meaning of subdivision (e) of Section 6252 of the Government Code, and, as such, is open to public inspection pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) The department shall redact from any writing, record, or document described in this subdivision personal identifying information associated with named individuals to the extent required to prevent an unwarranted invasion of personal privacy, as that term is used in subdivision (c) of Section 6254 of the Government Code, but the department shall not withhold any such writing, record, or document in its entirety under subdivision (c) of Section 6254 of the Government Code.

(3) Information required to be submitted under subdivision (d), and complaints submitted under subdivision (g), shall not be withheld on the basis of subdivision (f) of Section 6254 of the Government Code.

(i) (1) With the exception of paragraphs (2) and (3) of subdivision (b), the provisions of this section shall not apply to home dialysis, as defined in Section 494.10 of Title 42 of the Code of Federal Regulations, as it read on December 31, 2016, and home dialysis-related services and training, as described in Section 494.100 of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(2) Home dialysis-related services and training, as described in Section 494.100 of Title 42 of the Code of Federal Regulations, as it read on December 31, 2016, are not included within the definition of direct care for the purposes of this section.

SEC. 4. Section 1228 of the Health and Safety Code is amended to read:

1228. (a) Except as provided in subdivision (c), every clinic for which a license or special permit has been issued shall be periodically inspected. Except as provided in Section 1226.4, the frequency of inspections shall depend upon the type and complexity of the clinic or special service to be inspected. Inspections shall
be conducted no less often than once every three years and as often as necessary to ensure the quality of care being provided.

(b) (1) During inspections, representatives of the department shall offer any advice and assistance to the clinic as they deem appropriate. The department may contract with local health departments for the assumption of any of the department’s responsibilities under this chapter. In exercising this authority, the local health department shall conform to the requirements of this chapter and to the rules, regulations, and standards of the department.

(2) The department shall reimburse local health departments for services performed pursuant to this section, and these payments shall not exceed actual cost. Reports of each inspection shall be prepared by the representative conducting it upon forms prepared and furnished by the department and filed with the department.

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

(1) A rural health clinic.

(2) A primary care clinic accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), or any other accrediting organization recognized by the department.

(3) An ambulatory surgical center.

(4) A comprehensive outpatient rehabilitation facility that is certified to participate either in the Medicare Program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or the Medicaid program under Title XIX (42 U.S.C. Sec. 1396 et seq.) of the federal Social Security Act, or both.

(d) Notwithstanding paragraph (2) of subdivision (c), the department shall retain the authority to inspect a primary care clinic pursuant to Section 1227, or as necessary to ensure the quality of care being provided.

SEC. 5. The heading of Article 5 (commencing with Section 1240) of Chapter 1 of Division 2 of the Health and Safety Code is repealed.

SEC. 6. The heading of Article 5 (commencing with Section 1240) is added to Chapter 1 of Division 2 of the Health and Safety Code, to read:

Article 5. Suspension, Revocation, and Penalties
SEC. 7. Section 1240.1 is added to the Health and Safety Code, to read:

1240.1. (a) The director may assess an administrative penalty against a chronic dialysis clinic for a violation of this chapter. Each penalty issued pursuant to this chapter shall be classified as a major violation, an intermediate violation, or a minor violation according to the nature of the violation and the threat of harm to patients. A major violation shall be subject to an administrative penalty of up to ten thousand dollars ($10,000), and an intermediate violation shall be subject to an administrative penalty of up to five thousand dollars ($5,000). The director shall not assess an administrative penalty for a minor violation.

(b) The department shall promulgate regulations establishing the criteria to assess an administrative penalty against a chronic dialysis clinic, clinic that shall include, but not be limited to, a consideration of all of the following:

1. The probability and severity of the risk that the violation presents to the patient.
2. The actual harm to patients, if any.
3. The nature, scope, and severity of the violation.
4. The chronic dialysis clinic’s history of compliance with related state and federal statutes and regulations, including, but not limited to, the similarity in circumstances of the violation to any previous violation by the chronic dialysis clinic within a 24-month period.
5. Factors beyond the control of the chronic dialysis clinic that restricts its ability to comply with this chapter or the rules and regulations promulgated thereunder.
6. The demonstrated willfulness of the violation.
7. The extent to which the chronic dialysis clinic detected the violation and took immediate action to correct the violation and prevent that type of violation from recurring.

(c) If a chronic dialysis clinic disputes a determination by the director regarding an alleged deficiency or failure to correct a deficiency, or the reasonableness of a proposed deadline for correction of a violation or an amount of an administrative penalty, the chronic dialysis clinic may, within 10 working days, request a hearing pursuant to Section 131071. A chronic dialysis clinic shall pay all administrative penalties when all appeals have been exhausted and the department’s position has been upheld.
SEC. 8. Section 1240.2 is added to the Health and Safety Code, to read:

1240.2. (a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1240.1, if a chronic dialysis clinic receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient or employee and is required to submit a plan of correction, the department may assess the licensee an administrative penalty of up to ten thousand dollars ($10,000).

(b) If a licensee disputes a determination by the department regarding an alleged deficiency or the alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 days, request an administrative hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and if the department’s position has been upheld.

(c) For purposes of this section “immediate jeopardy” means a situation in which the licensee’s noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to one or more patients or employees.

(d) This section shall only apply to incidents occurring on or after January 1, 2018, except that this section shall only apply to violations of subdivision (b) of Section 1226.4 occurring on or after January 1, 2020.

(e) Notwithstanding Section 11 of the act that added this section, new regulations are not required or authorized for implementation of this section.

(f) This section shall become inoperative on the effective date of regulations promulgated by the department pursuant to Section 1240.1.

SEC. 9. Section 1266.2 is added to the Health and Safety Code, to read:

1266.2. It is the intent of the Legislature that California taxpayers not be financially responsible for implementation and enforcement of minimum staffing requirements at chronic dialysis clinics. In order to effectuate that intent, when calculating, assessing, and collecting fees imposed on chronic dialysis clinics pursuant to Section 1266, the department shall take into account all costs associated with implementing and enforcing Sections 1226.4 and 1240.1.
SEC. 10. Nothing in this act is intended to impact nurse-to-patient ratios applicable to health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

SEC. 11. The State Department of Public Health shall issue regulations necessary to implement this act no later than two years following its effective date.

SEC. 12. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 13. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB 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.
SUMMARY:
As introduced February 16th, the subject of this bill was “Nurse practitioners: independent practice.” It was amended April 17th to the subject, above. Although it also applies to physician assistants, this analysis will reflect the laws and proposals that apply to nurse practitioners.

As introduced: Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing.

Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including ordering durable medical equipment in accordance with standardized procedures, certifying disability for purposes of unemployment insurance after physical examination and collaboration with a physician and surgeon, and, for an individual receiving home health services or personal care services, approving, signing, modifying, or adding to a plan of treatment or plan of care after consultation with a physician and surgeon. A violation of these provisions is a crime.

Amended summary as of 4/17:
Existing federal law requires practitioners, as defined, who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment to obtain annually a separate registration with the United States Attorney General for that purpose.

Existing federal law authorizes waiver of the registration requirement for a qualifying practitioner who submits specified information to the United States Secretary of Health and Human Services.

Existing federal law, the Comprehensive Addiction Recovery Act of 2016, defines a qualifying practitioner for these purposes to include, among other practitioners, a nurse practitioner or physician assistant who, among other requirements, has completed not fewer than 24 hours of initial training, as specified, and is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by state law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

Existing state law, the Nursing Practice Act, establishes the Board of Registered Nursing in the Department of Consumer Affairs for the licensure and regulation of nurse practitioners. The act
authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision.

**ANALYSIS:**
As introduced: This bill would authorize a nurse practitioner who holds a certification from a national certifying body, recognized by the board, to be certified by the board as an independent nurse practitioner and to perform certain nursing functions without the supervision of a physician and surgeon, if the independent nurse practitioner meets specified requirements and practices in underserved geographic areas, as determined by the board.

The bill would prohibit a person from advertising, or holding himself or herself out as an “independent nurse practitioner,” unless the person is certified by the board as an independent nurse practitioner pursuant to this bill.

**Amended analysis as of 4/17:**
This bill would delete provisions related to certification of the “independent nurse practitioner”.

The bill now would prohibit construing the Nursing Practice Act or any provision of state law from prohibiting a nurse practitioner from furnishing or ordering buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act.

**Amended analysis as of 6/14:**
The bill would remove the names of specific organizations that would provide the 24 hours of initial training for nurse practitioners and physician assistants and refers these professionals to organizations listed in sections of Title 21 of the United States Code or any other organization that the United States Secretary of Health and Human Services determines is appropriate.

The bill would clarify that the requirement that the nurse practitioner have other training or experience that the United States Secretary of Health and Human Services determines will demonstrate the ability of the nurse practitioner to treat and manage opiate-dependent patients is an alternative requirement, and not in addition to, the 24 hours of initial training.

**BOARD POSITION:** Support (6/8/17)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Support (8/9/17)

**SUPPORT:**
Board of Registered Nursing
California Academy of PAs
California Association for Nurse Practitioners
California Hospital Association
Medical Board of California

**OPPOSE:**
None identified
An act to add Sections 2836.4 and 3502.1.5 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST


Existing federal law requires practitioners, as defined, who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment to obtain annually a separate registration with the United States Attorney General for that purpose. Existing federal law authorizes waiver of the registration requirement for a qualifying practitioner who submits specified information to the United States Secretary of Health and Human Services. Existing federal law, the Comprehensive Addiction Recovery Act of 2016, defines a qualifying practitioner for these purposes to include, among other practitioners, a nurse practitioner or physician assistant who, among other requirements, has completed not fewer than 24 hours of prescribed initial training, or has other training or experience as specified, and is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by state law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.
Existing state law, the Nursing Practice Act, establishes the Board of Registered Nursing in the Department of Consumer Affairs for the licensure and regulation of nurse practitioners. The act authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision.

This bill would prohibit construing the Nursing Practice Act or any provision of state law from prohibiting a nurse practitioner from furnishing or ordering buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act, as specified.

Existing state law, the Physician Assistant Practice Act, establishes the Physician Assistant Board within the jurisdiction of the Medical Board of California for the licensure and regulation of physician assistants. The act authorizes a physician assistant, while under the supervision of a licensed physician authorized to supervise a physician assistant, to administer or provide medication to a patient, or transmit orally, or in writing on a patient’s record or in a drug order, an order to a person who may lawfully furnish the medication, as specified.

This bill would prohibit construing the Physician Assistant Practice Act or any provision of state law from prohibiting a physician assistant from administering or providing buprenorphine to a patient, or transmit orally, or in writing on a patient’s record or in a drug order, an order for buprenorphine to a person who may lawfully furnish buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act, as specified.


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

SECTION 1. Section 2836.4 is added to the Business and Professions Code, to read:

Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act—(Public Law 114-198), as enacted on July 22, 2016, including the following:

(a) The requirement that the nurse practitioner complete not fewer than 24 hours of initial training provided by the American
Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, an organization listed in sub-subclause (aa) of subclause (II) of clause (iv) of subparagraph (G) of paragraph (2) of subdivision (g) of Section 823 of Title 21 of the United States Code, or any other organization that the United States Secretary of Health and Human Services determines is appropriate for the purposes of that sub-subclause, that addresses the following:

1. Opioid maintenance and detoxification.
2. Appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder.
3. Initial and periodic patient assessments, including substance use monitoring.
4. Individualized treatment planning, overdose reversal, and relapse prevention.
5. Counseling and recovery support services.
7. Diversion control.
8. Other best practices, as identified by the United States Secretary of Health and Human Services.

(b) The alternative requirement that the nurse practitioner have other training or experience that the United States Secretary of Health and Human Services determines will demonstrate the ability of the nurse practitioner to treat and manage opiate-dependent patients.

(c) The requirement that the nurse practitioner be supervised by, or work in collaboration with, a licensed physician and surgeon.

SEC. 2. Section 3502.1.5 is added to the Business and Professions Code, to read:

3502.1.5. Neither this chapter nor any other provision of law shall be construed to prohibit a physician assistant from administering or providing buprenorphine to a patient, or transmitting orally, or in writing on a patient’s record or in a drug order, an order to a person who may lawfully furnish buprenorphine when done in compliance with the provisions of the Comprehensive...
Addiction Recovery Act (Public Law 114-198), as enacted on July 22, 2016, including the following:

(a) The requirement that the physician assistant complete not fewer than 24 hours of initial training provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, an organization listed in sub-subclause (aa) of subclause (II) of clause (iv) of subparagraph (G) of paragraph (2) of subdivision (g) of Section 823 of Title 21 of the United States Code, or any other organization that the United States Secretary of Health and Human Services determines is appropriate for the purposes of that sub-subclause, that addresses the following:

1. Opioid maintenance and detoxification.
2. Appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder.
3. Initial and periodic patient assessments, including substance use monitoring.
4. Individualized treatment planning, overdose reversal, and relapse prevention.
5. Counseling and recovery support services.
7. Diversion control.
8. Other best practices, as identified by the United States Secretary of Health and Human Services.

(b) The alternative requirement that the physician assistant have other training or experience that the United States Secretary of Health and Human Services determines will demonstrate the ability of the nurse practitioner to treat and manage opiate-dependent patients.

(c) The requirement that the physician assistant be supervised by, or work in collaboration with, a licensed physician and surgeon.
SUMMARY:
Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. PPACA required each state, by January 1, 2014, to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package.

Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. 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.

ANALYSIS:
This bill was introduced February 17, 2017, as legislation that would establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state. The bill was amended March 29 to reflect the language that follows. The bill was further amended April 17, but the changes were nonsubstantive. A Senate analysis indicates that further amendments were adopted by the Committee on May 25, but that language isn’t available at this time. The primary one may be a provision that makes operation of the bill contingent on the availability of revenues to fund its implementation.

This bill, the Healthy California Act, would create the Healthy California program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that the
program cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including, but not limited to, the state’s Children’s Health Insurance Program (CHIP), Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program.

The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to the Healthy California program, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would also provide for the participation of health care providers in the program, require care coordination for members, provide for payment for health care services and care coordination, and specify program standards.

The bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the Healthy California program. The bill would create the Healthy California Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would create the Healthy California Board to govern the program, made up of nine members with demonstrated and acknowledged expertise in health care, and appointed as provided. The bill would provide the board with all the powers and duties necessary to establish the Healthy California program, including, but not limited to, determining when individuals may start enrolling into the program, employing necessary staff, and negotiating and entering into any necessary contracts. The bill would also require the Secretary of California Health and Human Services to establish a public advisory committee to advise the board on all matters of policy for the Healthy California program.

This bill would prohibit health care service plans and health insurers from offering health benefits or covering any service for which coverage is offered to individuals under the program, except as provided. The bill would authorize health care providers, as defined, to collectively negotiate rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies using a third-party representative, as provided.

**Amended analysis as of 5/26:**
This bill would add the provision that the Healthy California Act shall not become operative until the date the Secretary of California Health and Human Services notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that he or she has determined that the Healthy California Trust Fund has the revenues to fund the costs of implementing this act.

This bill would require that the California Health and Human Services Agency publish a copy of the notice on its Internet Web site.

**BOARD POSITION:** Support in Concept (6/8/17)

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Support (8/9/17)
SUPPORT:
California Nurses Association/National Nurses United (sponsor)
California Insurance Commissioner Dave Jones
13 Pages Progressive Alliance for Government Ethics and Sanity
28ers
9to5 Working Women
A New Path
Alameda Progressives
Albany City Council
Albany Democratic Club
Alliance of Californians for Community Empowerment Institute
Alliance San Diego
AM Green Construction
American Association of Community Psychiatrists
American Civil Liberties Union
American Federation of Musicians Local 47
AFSCME Council 57
AFSCME Retirees Chapter 36
Americans for Democratic Action, Southern California
Arbeter Ring/Workmen's Circle
Arlington Community Church
Art Between Us
Asian Pacific American Labor Alliance
Asian Pacific Environmental Network
Bagg Lady Handbags
Bay Area Chapter of Resource Generation
Bay Area Veterans of the Civil Rights Movement
Bay Rising
Bell Everman, Inc.
Bend the Arc
Berniecrats Labor Alliance Chartered Democratic Club of Yolo County
Biomech Incorporated
Breast Cancer Action
Business Alliance for a Healthy California
Butte County Health Care Coalition
Cabrillo College Federation of Teachers, AFT 4400
California Alliance for Retired Americans
California Association of Marriage and Family Therapists East Bay Chapter
California Capital Chapter of Physicians for a National Health Program
California Center for Rural Policy
California Council of Churches IMPACT
California Democratic Party State Central Committee San Gabriel Valley
California Domestic Workers Coalition
California Faculty Association - San Francisco State University Chapter
California Federation of Teachers, AFT, AFL-CIO
California Foundation for Independent Living Centers
California Health Professionals Student Alliance
California Healthy Nail Salon Collaborative
California Labor Federation, AFL-CIO
California National Organization for Women
California One Care
California Partnership
California Physicians Alliance
California Public Health Association-North
California School Employees Association
California Teachers Association
California Youth Empowerment Network
Californians United for a Responsible Budget
Campaign for a Healthy California
Caring Across Generations
Catalina’s List
Central Valley Indivisible
Central Valley-Sierra Progressives
CEO to CEO
Chinese Progressive Association
City and County of San Francisco
City Designworks
City of Berkeley
City of El Cerrito
City of Emeryville
City of Los Angeles
City of Oakland
City of Richmond
City of Richmond- Laurel Park Neighborhood Council
City of West Hollywood
Clergy & Laity United for Economic Justice
Clinica Romero
Code Pink
Communications Workers of American District 9
Community Health Councils
Concilio Latino of West Contra Costa County
Congresswoman Karen Bass
Consider the Homeless
Consumer Federation of California
Contra Costa AFL-CIO Labor Council
County of Marin Board of Supervisors
County of Nevada Board of Supervisors
County of San Clara Board of Supervisors
County of San Francisco Board of Supervisors
Courage Campaign
Courageous Resistance of Humboldt
CREDO Action
Cutting Edge Capital
Decus Biomedical
Dell Arte International
Democracy for America-Marin
Democratic Action Club of Chico
Democratic Club of Carlsbad-Oceanside
Democratic Club of Santa Maria Valley
Democratic Club of Southern Sonoma County
Democratic Party of Contra Costa
Democratic Party of Orange County
Democratic Socialists of America – Los Angeles
Democratic Socialists of America, Orange County Chapter
Democratic Socialists of America, San Francisco
Democratic Socialists of America, Ventura County Chapter
Democratic Women’s Club of San Diego County
Democratic Women's Coalition of Tuolumne County
Disability Action Center
Divine Feminine Yoga
Douglas L. Applegate Law Office
East Bay Democratic Socialists of America
East Bay Single Payer Coalition
East Contra Costa Democratic Club
Easter Hill United Methodist Church
Eastlake Bonita Center for Human Rights
Ecological Farming Association
El Cerrito Progressives
Elder Care Providers' Coalition
Elsdon Organizational Renewal
Empowered Investments
Encore
Far Leaves Tea
First They Came for the Homeless
For Grace
Forward Together
Fresno Economic Opportunities Commission
Friends Committee on Legislation
Giraud Photography, Inc.
Give Something Back Office Supplies
Glenview Area Groups for Action
Gray Panthers of San Francisco
Green Party of Alameda County
Green Party of Contra Costa County
Green Party of San Bernardino County
Green Party of Santa Clara County
Green Party of Yolo County
Haight Ashbury Neighborhood Council
Haiks German Autohaus
Hand in Hand
Harvey Milk LGBT Democratic Club
Health Care for All - Alameda County
Health Care for All - California 15 Chapters
Health Care for All - Contra Costa County
Health Care for All - Los Angeles Chapter
Health Care for All - Marin
Health Care for All - Nevada County Chapter
Health Care for All - Sacramento Valley Chapter
Health Care for All - San Fernando Valley Chapter
Health Care for All - San Gabriel Valley County
Health Care for All - Santa Barbara County Chapter
Health Care for All - Santa Clara County Chapter
Healthy California
Human Agenda
Humanist Society of Santa Barbara
Hunger Action Los Angeles
Independent Living Resource Center San Francisco
Indivisible Claremont
Indivisible East Contra Costa County
Indivisible Ladera
Indivisible Mader
Indivisible Orange County
Inland Coalition for Immigrant Justice
Inland Empire Immigrant Youth Collective
Inland Greens
International Longshore & Warehouse Union Southern California
J. Glynn & Company
Jane Thomas Press
Jobs with Justice San Francisco
Justice for All Ventura County
Justice for Palestinians
Kate Harris Consulting
KNA Copy Centre
Korean Community Center of the East Bay
Kramer Translations
La Jolla Democratic Club
Labor United for Universal Healthcare
Laguna Woods Democratic Club
Lake County Democratic Central Committee
Lamorinda Peace and Justice Group
Latina/Latino Roundtable
Latino Coalition for a Healthy California
Law & Mediation Office of Leslie A. Levy
Law Offices of Douglas L. Applegate
Lawyers for Good Government
League of Women Voters of California
Legal Services for Children
Lonely Liberals Indivisible of San Luis Obispo County
Long Beach Gray Panthers
Loving Way Midwifery
Low-Income Self Help Center
Lucille Design
Maddala Music
March and Rally Los Angeles
Martin Luther King Coalition of Greater Los Angeles
McGee-Spaulding Neighbors in Action
Media Alliance
Merced Collective Action Network
Mi Familia Vota
Mini-Vacation Massage
Mobilize the Immigrant Vote
Monkey Out, Voters In
Monkey Wrench Brigade
Mountain Bears Democratic Club
Mt. Diablo Peace and Justice Center
Multi-Faith ACTION Coalition
Musicians Union Local 6
National Association of Retired and Veteran Railway Employees
National Association of Social Workers
National Association of Social Workers-Fresno County
National Economic and Social Rights Initiative
National Union of Health Care Workers
Nevada County Democratic Women's Club
Nevada County Green Party
No Coal in Oakland
North Bay Jobs with Justice
Oakland Livable Wage Assembly
Oakley, California Mayor Sue Higgins
Occupy Torrance
One Page Plan
Organizacion en California de Lideres Campesinas, Inc.
Otis Chiropractic Neurology, Inc.
Our Developing World
Our Revolution
Our Revolution, Long Beach
Our Revolution, West San Fernando Valley
Pacific Palisades Democratic Club
Pacifica Social Justice
Painters & Allied Trades District Council 36
Peace and Freedom Party of California
People Power of Marina Del Ray
Peralta Retirees Organization
Physicians for a National Health Program CA
Pilipino Workers Center of Southern California
Pomona Valley Democratic Club
Poverty Matters
Progressive Action for Glendale
Progressive Asian Network for Action
Progressive Asset Management
Progressive Democrats of America - California
Progressive Democrats of America - Greater Palm Springs Area
Progressive Democrats of America - Lake County Chapter
Progressive Democrats of America - Orange County Chapter
Progressive Democrats of America - San Francisco Chapter
Progressive Democrats of America - Santa Monica Chapter
Progressive Democrats of America - Ventura County Chapter
Project Inform
Rancho Penasquitos Democratic Club
Resource Generation
Richmond Progressive Alliance
Riverside All of Us or None
Riverside County Young Democrats
Riverside Temple Beth El
San Francisco Berniecrats
San Francisco Green Party
San Francisco Labor Council
San Francisco Latino Democratic Club
San Joaquin Valley Democratic Club
San Jose Peace and Justice Center
San Mateo Central Labor Council
Santa Barbara Women's Political Committee
Santa Clara County Board of Supervisors
Santa Clara County Green Party San Francisco Berniecrats
Santa Cruz for Bernie
Santa Cruz Indivisible
Santa Rosa Democratic Club
School of the America Watch Los Angeles
Senior and Disability Action
Sierra Foothills Democratic Club
Sign Display and Allied Crafts Local Union No. 510
Silicon Valley Independent Living Center
SoCal 350 Climate Action
Social and Economic Justice Coalition
Social Justice Alliance of the Interfaith Council of Contra Costa
Sol2Economics
South Bay Labor Council
Steve Giraud Photography
Strike Debt
Sue's Hair Salon
Sunflower Alliance
TDA Investment Group
Tenants Together
The Democracy Project
The Latina/Latino Roundtable
The Refill Shop
Therapists for Single Payer
Together to End Solidarity Santa Cruz
Trout in Hand Productions
Tuolumne County Democratic Central Community
Tuolumne County Democratic Club
UFCW, Local 5
Unitarian Universalist Justice Ministry of California
United Democrats of El Dorado County
United Electrical, Radio, and Machine Workers of America Western Region
United Steelworkers, Local 2801
United Steelworkers, Local 675
UNITE-HERE, AFL-CIO
University Council American Federation of Teachers Local 1474
University Professional and Technical Employees, Local 9119
Uprise Campaigns
Veterans Democratic Club of LA County
Veterans for Peace, South Bay Chapter
Vision y Compromiso
Voices for Mothers and Others
Wellstone Democratic Renewal Club
Word Spark Writing & Editing
Yes We Can Democratic Club
Yolo MoveOn
Numerous individuals

**OPPOSE:**
America’s Health Insurance Plans
Anthem Blue Cross
Association of California Insurance Companies
Association of California Life & Health Insurance Companies
Bay Area Council
BizFed, Los Angeles County Business Federation
Blue Shield of California
California Association of Health Plans
California Association of Health Underwriters
California Business Roundtable
California Chamber of Commerce
California Farm Bureau Federation
California Framing Contractors Association
California League of Food Processors
California Manufacturers & Technology Association
California Medical Association
California Professional Association of Specialty Contractors
California Retailers Association
California Taxpayers Association
California Trucking Association
Camarillo Chamber of Commerce
El Centro Chamber of Commerce and Tourist Bureau
Fresno Chamber of Commerce
Greater Riverside Chambers of Commerce
Greater San Fernando Valley Chamber of Commerce
Health Net
Howard Jarvis Taxpayers Association
Independent Insurance Agents and Brokers of California
Kaiser Permanente
Long Beach Chamber of Commerce
Molina Healthcare
Murrieta Chamber of Commerce
National Association of Insurance and Financial Advisors of California
National Federation of Independent Business
North Orange County Chamber of Commerce
Oceanside Chamber of Commerce
Orange County Business Council
Oxnard Chamber of Commerce
Redondo Beach Chamber of Commerce and Tourist Bureau
Santa Maria Valley Chamber of Commerce
South Bay Association of Chambers of Commerce
Southwest California Legislative Council
Torrance Chamber of Commerce
Valley Industry and Commerce Association
Western Growers Association
Yuba-Sutter Chamber of Commerce
An act to add Title 22.2 (commencing with Section 100600) to the Government Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 562, as amended, Lara. The Healthy California Act.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. PPACA required each state, by January 1, 2014, to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. 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.

This bill, the Healthy California Act, would create the Healthy California program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that the program cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including, but not limited to, the state’s Children’s Health Insurance Program (CHIP), Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to the Healthy California program, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would also provide for the participation of health care providers in the program, require care coordination for members, provide for payment for health care services and care coordination, and specify program standards. The bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the Healthy California program. The bill would create the Healthy California Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would create the Healthy California Board to govern the program, made up of 9 members with demonstrated and acknowledged expertise in health care, and appointed as provided. The bill would provide the board with all the powers and duties necessary to establish the Healthy California program, including, but not limited to,
determining when individuals may start enrolling into the program, employing necessary staff, and negotiating and entering into any necessary contracts. The bill would also require the Secretary of California Health and Human Services to establish a public advisory committee to advise the board on all matters of policy for the Healthy California program.

This bill would prohibit health care service plans and health insurers from offering health benefits or covering any service for which coverage is offered to individuals under the program, except as provided. The bill would authorize health care providers, as defined, to collectively negotiate rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies using a 3rd-party representative, as provided.

This bill would prohibit this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the Healthy California Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its Internet Web site.

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

This bill would make legislative findings to that effect.


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

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

1. All residents of this state have the right to health care. While the federal Patient Protection and Affordable Care Act (PPACA) brought many improvements in health care and health care coverage, it still leaves many Californians without coverage or with inadequate coverage.

2. Californians, as individuals, employers, and taxpayers, have experienced a rise in the cost of health care and health care
coverage in recent years, including rising premiums, deductibles, and copays, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan’s economic needs rather than consumers’ health care needs.

(5) To address the fiscal crisis facing the health care system and the state, and to ensure Californians can exercise their right to health care, comprehensive health care coverage needs to be provided.

(6) It is the intent of the Legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.

(b) (1) It is further the intent of the Legislature to establish the Healthy California (HC) program to provide universal health coverage for every Californian based on his or her ability to pay and funded by broad-based revenue.

(2) It is the intent of the Legislature for the state to work to obtain waivers and other approvals relating to Medi-Cal, the state’s Children’s Health Insurance Program, Medicare, the PPACA, and any other federal programs so that any federal funds and other subsidies that would otherwise be paid to the State of California, Californians, and health care providers would be paid by the federal government to the State of California and deposited in the Healthy California Trust Fund.

(3) Under those waivers and approvals, those funds would be used for health coverage that provides health benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(4) Those programs would be replaced and merged into the HC program, which will operate as a true single-payer program.

(5) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan amendments and seek waivers and approvals to maximize, and
make as seamless as possible, the use of federally matched public
health programs and federal health programs in the HC program.

(6) Thus, even if other programs such as Medi-Cal or Medicare
can contribute to paying for care, it is the goal of this act that the
coverage be delivered by the HC program, and, as much as
possible, that the multiple sources of funding be pooled with other
HC program funds and not be apparent to HC program members
or participating providers.

(c) This act does not create any employment benefit, nor does
it require, prohibit, or limit the providing of any employment
benefit.

(d) (1) It is the intent of the Legislature not to change or impact
in any way the role or authority of any licensing board or state
agency that regulates the standards for or provision of health care
and the standards for health care providers as established under
current law, including, but not limited to, the Business and
Professions Code, the Health and Safety Code, the Insurance Code,
and the Welfare and Institutions Code, as applicable.

(2) This act would in no way authorize the Healthy California
Board, the Healthy California program, or the Secretary of
California Health and Human Services to establish or revise
licensure standards for health care providers.

(e) It is the intent of the Legislature that neither health
information technology nor clinical practice guidelines limit the
effective exercise of the professional judgment of physicians and
registered nurses. Physicians and registered nurses shall be free to
override health information technology and clinical practice
guidelines if, in their professional judgment, it is in the best interest
of the patient and consistent with the patient’s wishes.

(f) (1) It is the intent of the Legislature to prohibit the HC
program, a state agency, a local agency, or a public employee
acting under color of law from providing or disclosing to anyone,
including, but not limited to, the federal government, any
personally identifiable information obtained, including, but not
limited to, a person’s religious beliefs, practices, or affiliation,
national origin, ethnicity, or immigration status, for law
enforcement or immigration purposes.

(2) This act would also prohibit law enforcement agencies from
using the HC program’s funds, facilities, property, equipment, or
personnel to investigate, enforce, or assist in the investigation or
enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

(g) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

SEC. 2. Title 22.2 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 22.2. THE HEALTHY CALIFORNIA ACT

Chapter 1. General Provisions

100600. This title shall be known, and may be cited, as the Healthy California Act.
100601. There is hereby established in state government the Healthy California program to be governed by the Healthy California Board pursuant to Chapter 2 (commencing with Section 100610).
100602. For the purposes of this title, the following definitions apply:

(a) “Affordable Care Act” or “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(b) “Allied health practitioner” means a group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat, and rehabilitate people of all ages and in all specialties. Together with a range of technical and support staff, they may deliver direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include, but are not limited to, audiologists, occupational therapists, social workers, and radiographers.

(c) “Board” means the Healthy California Board described in Section 100610.
(d) “Care coordination” means services provided by a care coordinator under Section 100637.
(e) “Care coordinator” means an individual or entity approved by the board to provide care coordination under Section 100637.
(f) “Carrier” means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.
(g) “Committee” means the public advisory committee established pursuant to Section 100611.
(h) “Essential community providers” means persons or entities acting as safety net clinics, safety net health care providers, or rural hospitals.
(i) “Federally matched public health program” means the state’s Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the state’s Children’s Health Insurance Program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).
(j) “Fund” means the Healthy California Trust Fund established under Section 100655.
(k) “Health care organization” means an entity that is approved by the board under Section 100640 to provide health care services to members under the program.
(l) “Health care service” means any health care service, including care coordination, that is included as a benefit under the program.
(m) “Healthy California” or “HC” means the Healthy California program established in Section 100601.
(n) “Implementation period” means the period under subdivision (f) of Section 100612 during which the program is subject to special eligibility and financing provisions until it is fully implemented under that section.
(o) “Integrated health care delivery system” means a provider organization that meets both of the following criteria:
(1) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventive care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.
(2) Is compensated by Healthy California using capitation or facility budgets for the provision of health care services.

(p) “Long-term care” means long-term care, treatment, maintenance, or services not covered under the state’s Children’s Health Insurance Program, as appropriate, with the exception of short-term rehabilitation, and as defined by the board.

(q) “Medicaid” or “medical assistance” means a program that is one of the following:

(1) The state’s Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The state’s Children’s Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(r) “Medicare” means Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(s) “Member” means an individual who is enrolled in the program.

(t) “Out-of-state health care service” means a health care service provided in person to a member while the member is physically located out of the state under either of the following circumstances:

(1) It is medically necessary that the health care service be provided while the member physically is out of the state.

(2) It is clinically appropriate and necessary, and cannot be provided in the state, because the health care service can only be provided by a particular health care provider physically located out of the state. However, any health care service provided to an HC member by a health care provider qualified under Section 100635 that is located outside the state shall not be considered an out-of-state service and shall be covered as otherwise provided in this title.

(u) “Participating provider” means any individual or entity that is a health care provider qualified under Section 100635 that provides health care services to members under the program, or a health care organization.

(v) “Prescription drugs” means prescription drugs as defined in subdivision (n) of Section 130501 of the Health and Safety Code.

(w) “Program” means the Healthy California program established in Section 100601.
(x) “Resident” means an individual whose primary place of abode is in the state, without regard to the individual’s immigration status.

100603. This title does not preempt any city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this title.

100604. To the extent any provision of California law is inconsistent with this title or the legislative intent of the Healthy California Act, this title shall apply and prevail, except when explicitly provided otherwise by this title.

Chapter 2. Governance

100610. (a) The Healthy California Board shall be an independent public entity not affiliated with an agency or department. The board shall be governed by an executive board consisting of nine members who are residents of California. Of the members of the board, four shall be appointed by the Governor, two shall be appointed by the Senate Committee on Rules, and two shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee shall serve as a voting, ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years. Appointments by the Governor shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of his or her successor. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care.

(2) Appointing authorities shall also consider the expertise of the other members of the board and attempt to make appointments so that the board’s composition reflects a diversity of expertise in the various aspects of health care.

(3) Appointments to the board by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall be composed of:
(A) At least one representative of a labor organization representing registered nurses.

(B) At least one representative of the general public.

(C) At least one representative of a labor organization.

(D) At least one representative of the medical provider community.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this title, the Affordable Care Act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program, and to ensure the operational well-being and fiscal solvency of the program.

(e) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board’s composition reflects the communities of California.

(f) (1) A member of the board or of the staff of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health care provider, a health care facility, or a health clinic while serving on the board or on the staff of the board. A member of the board or of the staff of the board shall not be a member, a board member, or an employee of a trade association of health facilities, health clinics, or health care providers while serving on the board or on the staff of the board. A member of the board or of the staff of the board shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a health care practice.

(2) A board member shall not receive compensation for his or her service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(3) For purposes of this subdivision, “health care provider” means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act.
(g) A member of the board shall not make, participate in making, or in any way attempt to use his or her official position to influence the making of a decision that he or she knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

1. Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

2. Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(h) There shall not be liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this title.

(i) The board shall hire an executive director to organize, administer, and manage the operations of the board. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(j) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(k) The board may adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

100611. (a) The Secretary of California Health and Human Services shall establish a public advisory committee to advise the board on all matters of policy for the program.
(b) The members of the committee shall include all of the following:

(1) Four physicians, all of whom shall be board certified in their fields, and at least one of whom shall be a psychiatrist. The Senate Committee on Rules and the Governor shall each appoint one member. The Speaker of the Assembly shall appoint two of these members, both of whom shall be primary care providers.

(2) Two registered nurses, to be appointed by the Senate Committee on Rules.

(3) One licensed allied health practitioner, to be appointed by the Speaker of the Assembly.

(4) One mental health care provider, to be appointed by the Senate Committee on Rules.

(5) One dentist, to be appointed by the Governor.

(6) One representative of private hospitals, to be appointed by the Governor.

(7) One representative of public hospitals, to be appointed by the Governor.

(8) One representative of an integrated health care delivery system, to be appointed by the Governor.

(9) Four consumers of health care. The Governor shall appoint two of these members, one of whom shall be a member of the disabled community. The Senate Committee on Rules shall appoint a member who is 65 years of age or older. The Speaker of the Assembly shall appoint the fourth member.

(10) One representative of organized labor, to be appointed by the Speaker of the Assembly.

(11) One representative of essential community providers, to be appointed by the Senate Committee on Rules.

(12) One member of organized labor, to be appointed by the Senate Committee on Rules.

(13) One representative of small business, which is a business that employs less than 25 people, to be appointed by the Governor.

(14) One representative of large business, which is a business that employs more than 250 people, to be appointed by the Speaker of the Assembly.

(15) One pharmacist, to be appointed by the Speaker of the Assembly.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly.
Assembly shall make good faith efforts to ensure that their
appointments, as a whole, reflect, to the greatest extent feasible,
the social and geographic diversity of the state.
(d) Any member appointed by the Governor, the Senate
Committee on Rules, or the Speaker of the Assembly shall serve
a four-year term. These members may be reappointed for
succeeding four-year terms.
(e) Vacancies that occur shall be filled within 30 days after the
occurrence of the vacancy, and shall be filled in the same manner
in which the vacating member was initially selected or appointed.
The Secretary of California Health and Human Services shall notify
the appropriate appointing authority of any expected vacancies on
the public advisory committee.
(f) Members of the committee shall serve without compensation,
but shall be reimbursed for actual and necessary expenses incurred
in the performance of their duties to the extent that reimbursement
for those expenses is not otherwise provided or payable by another
public agency or agencies, and shall receive one hundred dollars
($100) for each full day of attending meetings of the committee.
For purposes of this section, “full day of attending a meeting”
means presence at, and participation in, not less than 75 percent
of the total meeting time of the committee during any particular
24-hour period.
(g) The public advisory committee shall meet at least six times
per year in a place convenient to the public. All meetings of the
committee shall be open to the public, pursuant to the
Bagley-Keene Open Meeting Act (Article 9 (commencing with
Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).
(h) The public advisory committee shall elect a chairperson who
shall serve for two years and who may be reelected for an
additional two years.
(i) Appointed committee members shall have worked in the
field they represent on the committee for a period of at least two
years prior to being appointed to the committee.
(j) It is unlawful for the committee members or any of their
assistants, clerks, or deputies to use for personal benefit any
information that is filed with, or obtained by, the committee and
that is not generally available to the public.
100612. (a) The board shall have all powers and duties
necessary to establish and implement Healthy California under
this title. The program shall provide comprehensive universal
single-payer health care coverage and a health care cost control
system for the benefit of all residents of the state.
(b) The board shall, to the maximum extent possible, organize,
administer, and market the program and services as a single-payer
program under the name “HC,” “Healthy California,” or any other
name as the board determines, regardless of which law or source
the definition of a benefit is found, including, on a voluntary basis,
retiree health benefits. In implementing this title, the board shall
avoid jeopardizing federal financial participation in the programs
that are incorporated into Healthy California and shall take care
to promote public understanding and awareness of available
benefits and programs.
(c) The board shall consider any matter to effectuate the
provisions and purposes of this title. The board shall have no
executive, administrative, or appointive duties except as otherwise
provided by law.
(d) The board shall employ necessary staff and authorize
reasonable expenditures, as necessary, from the Healthy California
Trust Fund to pay program expenses and to administer the program.
(e) The board may do all of the following:
(1) Negotiate and enter into any necessary contracts, including,
but not limited to, contracts with health care providers, integrated
health care delivery systems, and care coordinators.
(2) Sue and be sued.
(3) Receive and accept gifts, grants, or donations of moneys
from any agency of the federal government, any agency of the
state, and any municipality, county, or other political subdivision
of the state.
(4) Receive and accept gifts, grants, or donations from
individuals, associations, private foundations, and corporations,
in compliance with the conflict-of-interest provisions to be adopted
by the board by regulation.
(5) Share information with relevant state departments, consistent
with the confidentiality provisions in this title, necessary for the
administration of the program.
(f) The board shall determine when individuals may begin
enrolling in the program. There shall be an implementation period
that begins on the date that individuals may begin enrolling in the
program and ends on a date determined by the board.
(g) A carrier may not offer benefits or cover any services for which coverage is offered to individuals under the program, but may, if otherwise authorized, offer benefits to cover health care services that are not offered to individuals under the program. However, this title does not prohibit a carrier from offering either of the following:

1. Any benefits to or for individuals, including their families, who are employed or self-employed in the state but who are not residents of the state.
2. Any benefits during the implementation period to individuals who enrolled or may enroll as members of the program.

(h) After the end of the implementation period, a person shall not be a board member unless he or she is a member of the program, except the ex officio member.

(i) No later than two years after the effective date of this section, the board shall develop the following proposals:

1. The board shall develop a proposal, consistent with the principles of this title, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the principles of this title, for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties.
2. The board shall develop proposals for both of the following:
   (A) Accommodating employer retiree health benefits for people who have been members of HC but live as retirees out of the state.
   (B) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state prior to the implementation of HC and live as retirees out of the state.
3. The board shall develop a proposal for HC coverage of health care services currently covered under the workers’ compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

100613. The board may contract with not-for-profit organizations to provide both of the following:
(a) Assistance to consumers with respect to selection of a care coordinator or health care organization, enrolling, obtaining health care services, disenrolling, and other matters relating to the program.

(b) Assistance to health care providers providing, seeking, or considering whether to provide health care services under the program, with respect to participating in a health care organization and interacting with a health care organization.

100614. The board shall provide grants from funds in the Healthy California Trust Fund or from funds otherwise appropriated for this purpose to health planning agencies established pursuant to Section 127155 of the Health and Safety Code to support the operation of those health planning agencies.

100615. The board shall provide funds from the Healthy California Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers for health care, whose jobs may be or have been ended as a result of the implementation of the program, consistent with otherwise applicable law.

100616. (a) The board shall provide for the collection and availability of all of the following data to promote transparency, assess adherence to patient care standards, compare patient outcomes, and review utilization of health care services paid for by the program:

(1) Inpatient discharge data, including acuity and risk of mortality.

(2) Emergency department and ambulatory surgery data, including charge data, length of stay, and patients’ unit of observation.

(3) Hospital annual financial data, including all of the following:
   (A) Community benefits by hospital in dollar value.
   (B) Number of employees and classification by hospital unit.
   (C) Number of hours worked by hospital unit.
   (D) Employee wage information by job title and hospital unit.
   (E) Number of registered nurses per staffed bed by hospital unit.
   (F) Type and value of healthy information technology.
(G) Annual spending on health information technology, including purchases, upgrades, and maintenance.

(b) The board shall make all disclosed data collected under subdivision (a) publicly available and searchable through an Internet Web site and through the Office of Statewide Health Planning and Development public data sets.

(c) The board shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the Healthy California program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs of the Office of Statewide Health Planning and Development and the California Health and Human Services Agency, consistent with this title and otherwise applicable law.

(d) Prior to full implementation of the program, the board shall provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for all of the following categories of Office of Statewide Health Planning and Development data items:

1. Patients receiving charity care.
2. Contractual adjustments of county and indigent programs, including traditional and managed care.
3. Bad debts.

100617. (a) Notwithstanding any other law, Healthy California, any state or local agency, or a public employee acting under color of law shall not provide or disclose to anyone, including, but not limited to, the federal government any personally identifiable information obtained, including, but not limited to, a person’s religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status for law enforcement or immigration purposes.

(b) Notwithstanding any other law, law enforcement agencies shall not use Healthy California moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.
Chapter 3. Eligibility and Enrollment

100620. (a) Every resident of the state shall be eligible and entitled to enroll as a member under the program. (b) (1) A member shall not be required to pay any fee, payment, or other charge for enrolling in or being a member under the program. (2) A member shall not be required to pay any premium, copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits. (c) A college, university, or other institution of higher education in the state may purchase coverage under the program for a student, or a student’s dependent, who is not a resident of the state.

Chapter 4. Benefits

100630. (a) Covered health care benefits under the program include all medical care determined to be medically appropriate by the member’s health care provider. (b) Covered health care benefits for members shall include, but are not limited to, all of the following: (1) Licensed inpatient and licensed outpatient medical and health facility services. (2) Inpatient and outpatient professional health care provider medical services. (3) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services. (4) Medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for individual use. (5) Inpatient and outpatient rehabilitative care. (6) Emergency care services. (7) Emergency transportation. (8) Necessary transportation for health care services for persons with disabilities or who may qualify as low income. (9) Child and adult immunizations and preventive care. (10) Health and wellness education. (11) Hospice care. (12) Care in a skilled nursing facility.
(13) Home health care, including health care provided in an assisted living facility.
(14) Mental health services.
(15) Substance abuse treatment.
(16) Dental care.
(17) Vision care.
(18) Prescription drugs.
(19) Pediatric care.
(20) Prenatal and postnatal care.
(21) Podiatric care.
(22) Chiropractic care.
(23) Acupuncture.
(24) Therapies that are shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective.
(25) Blood and blood products.
(26) Dialysis.
(27) Adult day care.
(28) Rehabilitative and habilitative services.
(29) Ancillary health care or social services previously covered by county integrated health and human services programs pursuant to Chapter 12.96 (commencing with Section 18986.60) and Chapter 12.991 (commencing with Section 18986.86) of Part 6 of Division 9 of the Welfare and Institutions Code.
(30) Ancillary health care or social services previously covered by a regional center for persons with developmental disabilities pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.
(31) Case management and care coordination.
(32) Language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers.
(33) Health care and long-term supportive services currently covered under Medi-Cal or the state’s Children’s Health Insurance Program.
(34) Covered benefits for members shall also include all health care services required to be covered under any of the following provisions, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:
(A) The state’s Children’s Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).
(B) Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).
(C) The federal Medicare program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).
(D) Health care service plans 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).
(E) Health insurers, as defined in Section 106 of the Insurance Code, pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code.
(F) Any additional health care services authorized to be added to the program’s benefits by the program.
(G) All essential health benefits mandated by the Affordable Care Act as of January 1, 2017.

Chapter 5. Delivery of Care

Article 1. Health Care Providers

100635. (a) (1) Any health care provider who is licensed to practice in California and is otherwise in good standing is qualified to participate in the program as long as the health care provider’s services are performed within the State of California.
(2) The board shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under the program for members who require out-of-state health care services while the member is temporarily located out of the state.
(b) Any health care provider qualified to participate under this section may provide covered health care services under the program, as long as the health care provider is legally authorized to perform the health care service for the individual and under the circumstances involved.
(c) A member may choose to receive health care services under the program from any participating provider, consistent with provisions of this title, the willingness or availability of the provider, subject to provisions of this title relating to
discrimination, and the appropriate clinically relevant circumstances.
(d) A person who chooses to enroll with an integrated health care delivery system, group medical practice, or essential community provider that offers comprehensive services, shall retain membership for at least one year after an initial three-month evaluation period during which time the person may withdraw for any reason.
   (1) The three-month period shall commence on the date when a member first sees a primary care provider.
   (2) A person who wants to withdraw after the initial three-month period shall request a withdrawal pursuant to the dispute resolution procedures established by the board and may request assistance from the patient advocate, which shall be provided for in the dispute resolution procedures, in resolving the dispute. The dispute shall be resolved in a timely fashion and shall not have an adverse effect on the care a patient receives.

Article 2. Care Coordination

100637. (a) Care coordination shall be provided to the member by his or her care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the board and with the statutory requirements and regulations of the care coordinator’s licensure.
   (b) Care coordination includes administrative tracking and medical recordkeeping services for members, except as otherwise specified for integrated health care delivery systems.
   (c) Care coordination administrative tracking and medical recordkeeping services for members shall not be required to utilize a certified electronic health record, meet any other requirements of the federal Health Information Technology for Economic and Clinical Health, Health Act, enacted under the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), or meet certification requirements of the federal Centers for Medicare and Medicaid Services’ Electronic Health Records Incentive Programs, including meaningful use requirements.
   (d) The care coordinator shall comply with all federal and state privacy laws, including, but not limited to, the federal Health
Insurance Portability and Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code), and Section 1798.81.5 of the Civil Code.

(e) Referrals from a care coordinator are not required for a member to see any eligible provider.

(f) A care coordinator may be an individual or entity that is approved by the program that is any of the following:

1. A health care practitioner that is any of the following:
   (A) The member’s primary care provider.
   (B) The member’s provider of primary gynecological care.
   (C) At the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition.

2. An entity licensed pursuant to any of the following provisions:
   (A) Health facility, Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.
   (B) Health care service plan, 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).
   (C) Long-term health care facility, as defined in Section 1418 of the Health and Safety Code, or a program developed pursuant to paragraph (1) of subdivision (i) of Section 100612, or a long-term health care facility with respect to a member who receives mental health care services.
   (D) County medical facility, Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.
   (E) Residential care facility for persons with chronic life-threatening illness, Chapter 3.01 (commencing with Section 1568.01) of Division 2 of the Health and Safety Code.
   (F) Alzheimer’s day care resource center, Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code.
(G) Residential care facility for the elderly, Chapter 3.2 (commencing with Section 1569) of Division 2 of the Health and Safety Code.

(H) Home health agency, Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(I) Private duty nursing agency, Chapter 8.3 (commencing with Section 1743) of Division 2 of the Health and Safety Code.

(J) Hospice, Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(K) Pediatric day health and respite care facility, Chapter 8.6 (commencing with Section 1760) of Division 2 of the Health and Safety Code.

(L) Home care service, Chapter 13 (commencing with Section 1796.10) of Division 2 of the Health and Safety Code.

(M) Mental health care provider, pursuant to Division 4 (commencing with Section 4000) of the Welfare and Institutions Code.

(3) A health care organization.

(4) A Taft-Hartley health and welfare fund, with respect to its members and their family members. This provision does not preclude a Taft-Hartley health and welfare fund from becoming a care coordinator under paragraph (5) or a health care organization under Section 100640.

(5) Any not-for-profit or governmental entity approved by the program.

(g) (1) A health care provider shall only be reimbursed for services if the member is enrolled with a care coordinator at the time the health care service is provided.

(2) Every member shall be encouraged to enroll with a care coordinator that agrees to provide care coordination prior to receiving health care services to be paid for under the program. If a member receives health care services before choosing a care coordinator, the program shall assist the member, when appropriate, with choosing a care coordinator.

(3) The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coordinators on terms at least as permissive as Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) relating to an individual
changing his or her primary care provider or managed care provider.

(h) A health care organization may establish rules relating to care coordination for members in the health care organization that are different from this section but otherwise consistent with this title and other applicable laws.

(i) This section does not authorize any individual to engage in any act in violation of the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code.

(j) An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual’s professional scope of practice or the entity’s legal authority.

(k) (1) The board shall develop and implement procedures and standards, by regulation, for an individual or entity to be approved as a care coordinator in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice, licensure standards, and regulations established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, as applicable.

(3) In developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the board shall consult with the Mental Health Services Division of the State Department of Health Care Services and the Director of Developmental Services.

(l) To maintain approval under the program, a care coordinator shall do all of the following:

(1) Renew its status every three years pursuant to regulations adopted by the board.

(2) Provide to the program any data required by the Office of Statewide Health Planning and Development pursuant to Division 107 (commencing with Section 127000) of the Health and Safety
Code that would enable the board to evaluate the impact of care coordinators on quality, outcomes, and cost of health care.

Article 3. Payment for Health Care Services and Care Coordination

100639. (a) The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

(b) Health care services provided to members under the program, except for care coordination, shall be paid for on a fee-for-service basis unless and until another payment methodology is established by the board.

(c) Notwithstanding subdivision (b), integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

(d) The program shall engage in good faith negotiations with health care providers’ representatives under Chapter 8 (commencing with Section 100660), including, but not limited to, in relation to rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations shall be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

(e) (1) Payment for health care services established under this title shall be considered payment in full.

(2) A participating provider shall not charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and shall not
solicit or accept payment from any member or third party for any
health care service, except as provided under a federal program.
(3) However, this section does not preclude the program from
acting as a primary or secondary payer in conjunction with another
third-party payer when permitted by a federal program.
(f) The program may adopt, by regulation, payment
methodologies for the payment of capital-related expenses for
specifically identified capital expenditures incurred by
not-for-profit or governmental entities that are health facilities
pursuant to Chapter 2 (commencing with Section 1250) of Division
2 of the Health and Safety Code. Any capital-related expense
generated by a capital expenditure that requires prior approval
shall have received that approval in order to be paid by the
program. That approval shall be based on achievement of the
program standards described in Chapter 6 (commencing with
Section 100645).
(g) Payment methodologies and payment rates shall include a
distinct component of reimbursement for direct and indirect
graduate medical education.
(h) The board shall adopt, by regulation, payment methodologies
and procedures for paying for health care services provided to a
member while the member is located out of the state.

Article 4. Health Care Organizations

100640. (a) A member may choose to enroll with and receive
program care coordination and ancillary health care services from
a health care organization.
(b) A health care organization shall be a not-for-profit or
governmental entity that is approved by the board that is either of
the following:
(1) A county integrated health and human services program
under Chapter 12.96 (commencing with Section 18986.60) and
Chapter 12.991 (commencing with Section 18986.86) of Part 6 of
Division 9 of the Welfare and Institutions Code.
(2) A regional center for persons with developmental disabilities
under Chapter 5 (commencing with Section 4620) of Division 4.5
of the Welfare and Institutions Code.
(c) (1) The board shall develop and implement procedures and
standards, by regulation, for an entity to be approved as a health
care organization in the program, including, but not limited to,
procedures and standards relating to the revocation, suspension,
limitation, or annulment of approval on a determination that the
entity is incompetent to be a health care organization or has
exhibited a course of conduct that is inconsistent with program
standards and regulations, or that exhibits an unwillingness to meet
those standards and regulations, or is a potential threat to the public
health or safety.

(2) The procedures and standards adopted by the board shall be
consistent with professional practice and licensure standards
established pursuant to the Business and Professions Code, the
Health and Safety Code, the Insurance Code, and the Welfare and
Institutions Code, as applicable.

(3) In developing and implementing standards of approval of
health care organizations, the board shall consult with the Mental
Health Services Division of the State Department of Health Care
Services and the Director of Developmental Services.

(d) To maintain approval under the program, a health care
organization shall do both of the following:

(1) Renew its status at a frequency determined by the board.
(2) Provide data to the California Health and Human Services
Agency, as required by the board, to enable the board to evaluate
the health care organization in relation to the quality of health care
services, health care outcomes, and cost.

(e) The board may adopt narrowly focused regulations relating
solely to health care organizations for the sole and specific purpose
of ensuring consistent compliance with this title.

(f) This title may not be construed to alter in any way the
professional practice of health care providers or their licensure
standards established pursuant to Division 2 (commencing with
Section 500) of the Business and Professions Code.

(g) Health care organizations shall not use health information
technology or clinical practice guidelines that limit the effective
exercise of the professional judgment of physicians and registered
nurses. Physicians and registered nurses shall be free to override
health information technology and clinical practice guidelines if,
in their professional judgment, it is in the best interest of the patient
and consistent with the patient’s wishes.
Chapter 6. Program Standards

Healthy California shall establish a single standard of safe, therapeutic care for all residents of the state by the following means:

(a) The board shall establish requirements and standards, by regulation, for the program and for health care organizations, care coordinators, and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:

(1) The scope, quality, and accessibility of health care services.

(2) Relations between health care organizations or health care providers and members.

(3) Relations between health care organizations and health care providers, including credentialing and participation in the health care organization, and terms, methods, and rates of payment.

(b) The board shall establish requirements and standards, by regulation, under the program that include, but are not limited to, provisions to promote all of the following:

(1) Simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable.

(2) In-person primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and promotion of public, environmental, and occupational health.

(3) Elimination of health care disparities.

(4) Consistent with the Unruh Civil Rights Act (Section 51 of the Civil Code), nondiscrimination with respect to members and health care providers on the basis of race, color, ancestry, national origin, religion, citizenship, immigration status, primary language, mental or physical disability, age, sex, gender, sexual orientation, gender identity or expression, medical condition, genetic information, marital status, familial status, military or veteran status, or source of income; however, health care services provided
under the program shall be appropriate to the patient’s clinically relevant circumstances.

(5) Accessibility of care coordination, health care organization services, and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(6) Providing care coordination, health care organization services, and health care services in a culturally competent manner.

(c) The board shall establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with the Healthy California program health care services and ancillary services currently provided by other programs, including, but not limited to, Medicare, the Affordable Care Act, and federally matched public health programs.

(d) Any participating provider or care coordinator that is organized as a for-profit entity shall be required to meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to those entities shall not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

(e) Every participating provider shall furnish information as required by the Office of Statewide Health Planning and Development pursuant to Division 107 (commencing with Section 127000) of the Health and Safety Code and permit examination of that information by the program as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

(f) In developing requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.
Chapter 7. Funding

Article 1. Federal Health Programs and Funding

100650. (a) The board shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate the program consistent with this title. (b) (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs that provide federal funds for payment for health care services that are necessary to enable all Healthy California members to receive all benefits under the program through the program, to enable the state to implement this title, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the Healthy California Trust Fund, created pursuant to Section 100655, and to use those funds for the program and other provisions under this title. (2) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to Healthy California in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs. (3) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this title. Information provided by members to the board for the purposes of this subdivision shall not be used for any other purpose. (4) The board may take any additional actions necessary to effectively implement Healthy California to the maximum extent possible as a single-payer program consistent with this title. (c) The board may take actions consistent with this article to enable the program to administer Medicare in California, and the program shall be a provider of supplemental insurance coverage (Medicare Part B) and shall provide premium assistance drug

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coverage under Medicare Part D for eligible members of the program.

(d) The board may waive or modify the applicability of any provisions of this section relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to the program under this section, provided that the board, in consultation with the Director of Finance, determines that the waiver or modification is in the best interest of the state and members affected by the action.

(e) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare shall not cause any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

(f) (1) Notwithstanding any other law, the board, by regulation, shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual’s coinsurance, cost-sharing, or premium obligations or increase an individual’s eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(2) The board may act under this subdivision, upon a finding approved by the Director of Finance and the board that the action does all of the following:

(A) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual’s coinsurance, cost-sharing, or premium obligations or increase an individual’s eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(B) Will not diminish any individual’s access to any health care service or right the individual would otherwise have.

(C) Is in the interest of the program.

(D) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.
(3) Actions under this subdivision shall not apply to eligibility for payment for long-term care.

(g) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(h) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(i) The program shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under Section 1860D of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(j) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member’s eligibility for that subsidy; however, the board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(k) The program shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member’s coverage under the program may be terminated. Information provided by members to the board for the purposes of this section shall not be used for any other purpose.
The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

Article 2. The Healthy California Trust Fund

100655. (a) The Healthy California Trust Fund is hereby created in the State Treasury for the purposes of this title. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

(c) The board shall establish and maintain a prudent reserve in the fund.

(d) The board or staff of the board shall not utilize any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) The fund shall consist of all of the following:

1. All moneys obtained pursuant to legislation enacted as proposed under Section 100657.

2. Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the Affordable Care Act.

3. The amounts paid by the State Department of Health Care Services that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the Affordable Care Act for health
benefits that are equivalent to health benefits covered under Healthy California.

(4) Federal and state funds for purposes of the provision of services authorized under Title XX of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under Healthy California.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care services for services and benefits covered under Healthy California. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this title.

(g) All federal moneys shall be placed into the Healthy California Federal Funds Account, which is hereby created within the Healthy California Trust Fund.

(h) Moneys in the fund shall only be used for the purposes established in this title.

Article 3. Healthy California Financing

100657. (a) It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the program. In developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

(b) It is the intent of the Legislature to enact legislation that would require all state revenues from the program to be deposited in an account within the Healthy California Trust Fund to be established and known as the Healthy California Trust Fund Account.

Chapter 8. Collective Negotiation by Health Care Providers with Healthy California

Article 1. Definitions

100660. For purposes of this chapter, the following definitions apply:
(a) (1) “Health care provider” means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code and who is any of the following:

(A) An individual who practices that profession as a health care provider or as an independent contractor.

(B) An owner, officer, shareholder, or proprietor of a health care provider.

(C) An entity that employs or utilizes health care providers to provide health care services, including, but not limited to, a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A health care provider under Division 2 (commencing with Section 500) of the Business and Professions Code who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.

(b) “Health care providers’ representative” means a third party that is authorized by health care providers to negotiate on their behalf with Healthy California over terms and conditions affecting those health care providers.

(c) “Healthy California” or “HC” means the Healthy California program established in Section 100601.

Article 2. Collective Negotiation Authorized

100662. (a) Health care providers may meet and communicate for the purpose of collectively negotiating with Healthy California on any matter relating to Healthy California, including, but not limited to, rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

(b) This chapter shall not be construed to allow or authorize an alteration of the terms of the internal and external review procedures set forth in law.

(c) This chapter shall not be construed to allow a strike of Healthy California by health care providers related to the collective negotiations.

(d) This chapter shall not be construed to allow or authorize terms or conditions that would impede the ability of Healthy
California to obtain or retain accreditation by the National Committee for Quality Assurance or a similar body, or to comply with applicable state or federal law.

Article 3. Collective Negotiation Requirements

100664. (a) Collective negotiation rights granted by this chapter shall meet all of the following requirements:
   1. Health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with HC.
   2. Health care providers may communicate with health care providers’ representatives.
   3. A health care providers’ representative is the only party authorized to negotiate with HC on behalf of the health care providers as a group.
   4. A health care provider can be bound by the terms and conditions negotiated by the health care providers’ representatives.
   5. In communicating or negotiating with the health care providers’ representative, HC is entitled to offer and provide different terms and conditions to individual competing health care providers.

(b) This chapter does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

(c) This chapter does not affect or limit collective action or collective bargaining on the part of a health care provider with his or her employer or any other lawful collective action or collective bargaining.

100666. (a) Before engaging in collective negotiations with HC on behalf of health care providers, a health care providers’ representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative’s plan of operation, and the representative’s procedures to ensure compliance with this chapter.

(b) Each person who acts as the representative of negotiating parties under this chapter shall pay a fee to the board to act as a representative. The board, by regulation, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this chapter.
Article 4. Prohibited Collective Action

100668. (a) This chapter does not authorize competing health care providers to act in concert in response to a health care providers’ representative’s discussions or negotiations with HC, except as authorized by other law.

(b) A health care providers’ representative shall not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider’s scope of practice, license, registration, or certificate.

Chapter 9. Operative Date

100670. (a) Notwithstanding any other law, this title shall not become operative until the date the Secretary of California Health and Human Services notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that he or she has determined that the Healthy California Trust Fund has the revenues to fund the costs of implementing this title.

(b) The California Health and Human Services Agency shall publish a copy of the notice on its Internet Web site.

SEC. 3. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Sections 100610 and 100617 to the Government Code, imposes a limitation on the public’s right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:
In order to protect private, confidential, and proprietary information, it is necessary for that information to remain confidential.
**SUMMARY:**
This bill allows Board to assign petitions for reinstatement or modification to an administrative law judge and explicitly gives Board authority to employ legal counsel.

**ANALYSIS:**

*Existing law:*
- The Nursing Practice Act authorizes a registered nurse whose license has been revoked or suspended or who has been placed on probation to petition the board for reinstatement or modification of penalty.
- Requires the Board itself to hear the petition and the ALJ to prepare a written decision.

*This bill would:*
- Provide the Board authority to employ legal counsel as deemed necessary.
- Provides the Board the option to assign the petition to an ALJ assigned to the Medical Quality Hearing Panel.

*Fiscal Impact:*
- Minor and absorbable costs

*Comments:*
- SB 547 contains omnibus provisions for various boards under Department of Consumer Affairs and includes BRN sponsored revisions intended to ease the Board’s petition caseload.

**BOARD POSITION:** Not previously considered

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Support (8/9/2017)

**SUPPORT:**
- Board of Podiatric Medicine
• Board of Psychology
• California Agricultural Commissioners and Sealers Association

OPPOSE:
• None on file
An act to amend Sections 156, 2499.5, 2570.16, 2715, 2760.1, 2987, 4008, 4887, 5063.3, 5096.9, 5810, 7332, 7583.23, 7583.24, 7583.47, 7635, 11302, 11320.5, 11321, 11323, 11324, 11345, 11345.2, 11345.6, 11422, 12241, 12304, 12305, 12310, and 12500 of, to amend, repeal, and add Sections 6980.79, 7506.10, 7511, 7574.11, 7574.13, 7582.11, 7582.17, 7583.12, 7583.17, 7583.20, 7585.16, 7588, 7596.5, 7598.14, 7598.17, and 7599.70 of, to add Sections 11345.5 and 1006, 7574.35, 11345.5, and 11345.8 to, to repeal Section 303 of, and to repeal and add Section 11345.3 of, the Business and Professions Code, and to amend 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 thereof, and repealing all acts and parts of acts inconsistent therewith” approved by electors November 7, 1922, by amending Section 12 thereof, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL’S DIGEST

SB 547, as amended, Hill. Professions and vocations: weights and measures.
(1) Existing law establishes the Department of Consumer Affairs within the Business, Consumer Services, and Housing Agency and provides that the department is under the control of the Director of Consumer Affairs. Existing law establishes within the department a Division of Consumer Services under the supervision and control of a chief who is appointed by the Governor. Existing law authorizes the Department of Consumer Affairs to enter into a contract with a vendor for the licensing and enforcement of the BreEZe system, which is a specified integrated, enterprisewide enforcement case management and licensing system, no sooner than 30 days after written notification to certain committees of the Legislature.

This bill would repeal the provision establishing the Division of Consumer Services. The bill would require the director to report progress on release 3 entities’ transition to the new licensing technology platform to the appropriate committees of the Legislature, as specified.

(2) Existing law, the Chiropractic Act, enacted by initiative, provides for the licensure and regulation of chiropractors by the State Board of Chiropractic Examiners. Under the act, each person practicing chiropractic, after a license has been issued, is annually required to pay the board a renewal fee not exceeding $250. Existing law authorizes the Legislature to fix these fees. Existing law directs the deposit of these funds into the State Board of Chiropractic Examiners’ Fund, a continuously appropriated fund.

This bill, until July 1, 2019, would require a licensee to pay an annual renewal fee of $300. By increasing the amount deposited in the State Board of Chiropractic Examiners’ Fund, the bill would make an appropriation. The bill would also require the State Board of Chiropractic Examiners to submit a report to the appropriate policy and fiscal committees of the Legislature by July 1, 2018, that contains, at a minimum, the status of the board’s fee audit and an update on the board’s plans for restructuring its license fees.

(2)

(3) Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs.

(A) Existing law provides for the certification and regulation of podiatrists by the California Board of Podiatric Medicine within the jurisdiction of the Medical Board of California and requires certain fees
to be paid to the board, including a fee for the application and issuance of a certificate to practice podiatric medicine.

This bill would revise the fees, as specified.

(B) Existing law, the Occupational Therapy Practice Act, provides for the licensure and regulation of occupational therapists and occupational therapy assistants by the California Board of Occupational Therapy and requires certain fees to be paid to the board, including a fee to collect fingerprints for a criminal history record check.

This bill would prohibit the fee for the criminal history record check from exceeding the amount charged by the agency providing the criminal history record check. The bill would also require the board to charge a fee to query the National Practitioner Data Bank for applicants for licensure and renewal of licensure and would prohibit that fee from exceeding the amount charged per query.

(B)

(C) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs and sets forth its powers and duties regarding the licensure and regulation of registered nurses. That act authorizes a registered nurse whose license has been revoked or suspended or who has been placed on probation to petition the board for reinstatement or modification of penalty.

This bill would authorize the board to hear the petition or to assign the petition to an administrative law judge, as specified.

(C)

(D) Existing law, the Psychology Licensing Law, establishes the Board of Psychology to license and regulate the practice of psychology and authorizes the board to collect specified fees, including a delinquency fee of $25.

This bill would instead make the delinquency fee 50 percent of the renewal fee for each license type, not to exceed $150.

(D)

(E) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and authorizes the board to employ inspectors of pharmacy.

This bill would also authorize the board to employ legal counsel.

(E)

(F) Existing law, the Veterinary Medicine Practice Act, provides for the licensure and regulation of veterinarians and the practice of veterinary medicine by the Veterinary Medical Board and authorizes a person whose license or registration has been revoked or placed on
probation to petition the board for reinstatement or modification of penalty after a period of not less than one year.

This bill would instead provide that a person may petition the board for reinstatement or modification of penalty after at least 3 years for reinstatement of a surrendered or revoked license, at least 2 years for early termination or modification of probation of 3 years or more, or at least one year for modification of a condition or termination of probation of less than 3 years. The bill would authorize the board, upon a showing of good cause, to specify in an order imposing probation of more than 3 years that the person may petition for reissuement, modification, or termination of probation after one year.

(G) Existing law provides for the licensure and regulation of accountants by the California Board of Accountancy, which is within the Department of Consumer Affairs. Existing law prohibits confidential information obtained by a licensee concerning a client from being disclosed by the licensee without the written permission of the client, except when the disclosure is made by a licensee or a licensee’s duly authorized representative to another licensee in connection with a proposed sale or merger of the licensee’s professional practice.

This bill would additionally authorize that disclosure in that same connection to another person, provided the parties enter into a written nondisclosure agreement.

Existing law, until January 1, 2019, authorizes an individual otherwise meeting a condition for a practice privilege to perform certain audit and financial statement review services only through a firm of certified public accountants that is required to be registered with the board and authorizes such an individual qualified for the practice privilege to practice public accountancy in this state without the imposition of a notice, fee, or any other requirements. Existing law authorizes the board to adopt regulations to carry out the practice privilege provisions and regulations have been adopted, which become inoperative on January 1, 2019.

To ensure uninterrupted implementation of the practice privilege provisions, this bill would authorize the board to adopt or amend regulations to remove or extend the inoperative date of these regulations. The bill would require the Office of Administrative Law to consider the board’s action to remove or extend the inoperative dates of these regulations as a change without regulatory effect and would exempt the

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board from complying with the Administrative Procedure Act with respect to that removal or extension.

(H) Existing law authorizes a certified interior designer, as defined, to obtain a stamp from an interior design organization, as defined, that uniquely identifies the designer and certifies that he or she meets certain qualifications and requires the use of that stamp on all drawings and documents submitted to any governmental agency by the designer. Existing law provides that these provisions are repealed on January 1, 2018. This bill would instead repeal those provisions on January 1, 2022.

(I) Existing law, the Barbering and Cosmetology Act, provides for the licensing and regulation of persons engaging in the practice of barbering, cosmetology, or electrolysis, as specified. Existing law authorizes an apprentice, as defined, to perform services under the supervision of a licensee approved by the State Board of Barbering and Cosmetology, as specified. Practicing barbering, cosmetology, or electrolysis without being properly licensed is a crime. This bill would define the term “under the supervision of a licensee” for these provisions to mean a person supervised at all times by a licensee while performing services in a licensed establishment. The bill would also prohibit an apprentice from being the only person working in an establishment and would deem an apprentice who is not being supervised by a licensee to be practicing under the act without a license. Because this bill would expand the scope of a crime, it would impose a state-mandated local program.

(J) Existing law, the Private Security Services Act, provides for the licensing and regulation of private patrol operators by the Bureau of Security and Investigative Services. Existing law requires the bureau to issue a firearms permit to a licensee, a qualified manager of a licensee, or a registered security guard if certain conditions are met. Existing law, beginning on January 1, 2018, requires an applicant for a firearms permit if he or she is a registered security guard to complete an assessment, as defined, and be found capable of exercising appropriate judgment, restraint, and self-control, as specified. This bill would instead make those requirements applicable beginning either on January 1, 2018, or upon a date determined by the bureau, but not later then July 1, 2018.
The Cemetery and Funeral Act provides for the licensure and regulation of cemeteries, crematories, funeral establishments, and their personnel by the Cemetery and Funeral Bureau, and requires any person employed by, or an agent of, a licensed funeral establishment who consults with the family or representatives of the family of a deceased person for the purpose of arranging certain services to receive documented training, as specified.

This bill would require that training to be completed at least once every 3 years.

Existing law provides for the licensure and regulation of locksmiths and their employees, repossession and their employees and contractors, proprietary private security officers, proprietary private security employers, private security officers, private security employers, and alarm companies by the Department of Consumer Affairs and the Bureau of Security and Investigative Services. Existing law requires the payment of various fees for the application, issuance, renewal, and reinstatement of licenses and registrations for those vocations.

This bill, commencing July 1, 2018, would increase these fees, as specified. The bill, commencing July 1, 2018, would require a verification document to include specified information, and would impose a fee of a specified amount for an endorsed verification of licensure. The bill, commencing July 1, 2018, would impose a fee of a specified amount for the replacement of a lost or destroyed registration card, license, or certificate and would require the request for the replacement be made in the manner prescribed by the bureau.

Existing state law, the Real Estate Appraisers’ Licensing and Certification Law, provides for the licensure, certification, and regulation of real estate appraisers and appraisal management companies by the Bureau of Real Estate Appraisers within the Department of Consumer Affairs, which is headed by the Chief of the Bureau of Real Estate Appraisers. Existing state law prohibits a person from engaging in federally related real estate appraisal activity without an active license. Existing state law defines “federally related transaction” as any real estate-related financial transaction which a federal financial institutions regulatory agency engages in, contracts for, or regulates, and which requires the services of a state licensed real estate appraiser.

Existing state law prohibits a person or entity from acting in the capacity of an appraisal management company without first obtaining a certificate of registration from the bureau. Existing state law defines
an “appraisal management company” as a person or entity that maintains
an approved list or lists, containing 11 or more independent contractor
licensed or certified appraisers, or employs 11 or more licensed or
certified appraisers, receives requests for appraisals from one or more
clients, and for a fee paid by one or more of its clients, delegates
appraisal assignments for completion by its independent contractor or
employee appraisers.

Existing federal law, the Dodd-Frank Wall Street Reform and
Consumer Protection Act, requires the Board of Governors of the
Federal Reserve System, the Comptroller of the Currency, the Federal
Deposit Insurance Corporation, the National Credit Union
Administration Board, the Federal Housing Finance Agency, and the
Bureau of Consumer Financial Protection to jointly, by rule, establish
minimum requirements to be applied by a state in the registration of
appraisal management companies. These minimum requirements include
a requirement that an appraisal management company (1) register with
and be subject to supervision by a state appraiser certifying and licensing
agency in each state in which that company operates, (2) verify that
only licensed or certified appraisers are used for federally related
transactions, (3) require that appraisals coordinated by an appraisal
management company comply with the Uniform Standards of
Professional Appraisal Practice, and (4) require that appraisals are
conducted independently and free from inappropriate influence and
coercion, as provided. Existing federal law does not prohibit states from
establishing additional requirements.

Existing federal law prohibits an appraisal management company
from being registered by a state or included on the national registry if
the company is owned by any person whose appraiser license or
certificate was refused, denied, canceled, surrendered in lieu of
revocation, or revoked in any state.

This bill would conform to federal law by, among other things,
redefining an “appraisal management company” as a person that (1)
provides appraisal management services to creditors or to secondary
mortgage market participants, including affiliates, (2) provides those
services in connection with valuing a consumer’s principal dwelling as
security for a consumer credit transaction or incorporating such
transactions into securitizations, and (3) within a given 12–month period,
oversees an appraiser panel of more than 15 State-certified or
State-licensed appraisers in a State or 25 or more
State-certified or State-licensed appraisers.
in two or more States. The bill would define “appraiser panel” and prescribe the method for determining whether an appraiser is a part of the appraisal management company’s appraiser panel. The bill would additionally prohibit a person or entity from representing itself to the public as an appraisal management company, either in advertising or through its business name, without a certificate of registration.

Existing state law prohibits a person other than a licensee from signing an appraisal and authorizes a specified trainee to sign an appraisal if it is also signed by the licensee. Existing law authorizes an individual who is not a licensee to assist in the preparation of an appraisal under certain conditions.

This bill would prohibit a person other than a licensee from signing an appraisal in a federally related transaction. The bill would authorize a trainee to sign an appraisal in such a transaction if it is also signed by a licensee. The bill would authorize an individual who is not a licensee to assist in the preparation of an appraisal in a federally related transaction under certain conditions.

Existing state law prohibits the chief from issuing a certificate of registration to an appraisal management company unless the appraisal management company confirms in its application for registration that all of its contracts with clients include specified standard business practices.

This bill would delete that provision and require all appraisal management companies to, among other things, direct the appraiser to perform the assignment in accordance with the Uniform Standards of Professional Appraisal Activity Practice and engage appraisal panel members with an engagement letter that shall include terms of payment.

Existing federal law requires a federally regulated appraisal management company to report to the State or States in which it operates the information required to be submitted by the State pursuant to the policies of the Appraisal Subcommittee of the Federal Financial Institutions Examination Council regarding the determination of the fee imposed by the AMC National Registry, which is the registry of state-registered appraisal management companies and federally regulated appraisal management companies maintained by the Appraisal Subcommittee.

This bill would require a federally regulated appraisal management company operating in California to report to the bureau the information required to be submitted by the bureau to the Appraisal Subcommittee. The bill would authorize the bureau to charge the federally regulated
appraisal management company a fee in an amount not to exceed the reasonable regulatory cost to the board for processing the information.

This bill would also define various other terms for purposes of carrying out these provisions.

This bill would make various other nonsubstantive and technical changes.

(A) Existing law provides for the regulation of commercial weighing and measuring devices by the Department of Food and Agriculture, and provides for the enforcement of those provisions by the State Sealer and by county sealers of weights and measures in each county. Existing law requires the department to keep the standards of the state for weights and measures in a suitable laboratory location or, if transportable, to maintain the standards under appropriate environmental conditions and requires the department to have the standards directly certified by the National Institute of Standards and Technology or by any measurement assurance procedures approved by that institute. Existing law requires the department to use the standards of the state to certify similar standards and any dissimilar standards which are dependent on the values represented by the state standards. Existing law requires the department, or a certified laboratory designated by the department, to certify standards of the county sealers at specified intervals.

Existing law, until January 1, 2019, requires the Secretary of Food and Agriculture to establish by regulation an annual administrative fee to recover reasonable administrative and enforcement costs incurred by the Department of Food and Agriculture for exercising supervision over and performing investigations in connection with specified activities performed by sealers, and requires the administrative fee to be collected for every device registered with each county office of weights and measures and paid annually to the Department of Food and Agriculture Fund.

This bill would additionally require the annual administrative fee to be used to recover reasonable costs incurred by the department for the safekeeping and certification of the state standards, for using the state standards to certify other standards, and for certifying the standards of county sealers.

(B) Existing law defines various terms for purposes of regulating weighing and measuring devices, including the term “commercial purposes.”
This bill would provide that commercial purposes does not include the determination of the weight of any animal or human by a qualified health provider, licensed doctor of veterinary medicine, California-licensed veterinarian, licensed physician and surgeon, or staff members within the business operations of and under the supervision of a licensed doctor of veterinary medicine, California-licensed veterinarian, or licensed physician and surgeon for the purposes of determining the appropriate dosage of any medication or medical treatment or the volume, duration, or application of any medical procedure.

(4)(5) 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.


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

SECTION 1. Section 156 of the Business and Professions Code is amended to read:

156. (a) The director may, for the department and at the request and with the consent of a board within the department on whose behalf the contract is to be made, enter into contracts pursuant to Chapter 3 (commencing with Section 11250) of Part 1 of Division 3 of Title 2 of the Government Code or Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code for and on behalf of any board within the department.

(b) In accordance with subdivision (a), the director may, in his or her discretion, negotiate and execute contracts for examination purposes, which include provisions that hold harmless a contractor where liability resulting from a contract between a board in the department and the contractor is traceable to the state or its officers, agents, or employees.

(c) The director shall report progress on release 3 entities’ transition to a new licensing technology platform to all the appropriate committees of the Legislature by December 31 of each
year. Progress reports shall include updated plans and timelines for completing all of the following:

1. Business process documentation.
2. Cost benefit analyses of IT information technology options.
3. IT—Information technology system development and implementation.
4. Any other relevant steps needed to meet the IT needs of release 3 entities.
5. Any other information as the Legislature may request.

SEC. 2. Section 303 of the Business and Professions Code is repealed.

SEC. 3. Section 1006 is added to the Business and Professions Code, immediately following Section 1005, to read:

1006. (a) By July 1, 2018, the State Board of Chiropractic Examiners shall submit a report to the appropriate policy and fiscal committees of the Legislature that contains, but is not limited to, both of the following:

1. The status of the State Board of Chiropractic Examiners’ fee audit.
2. An update on the State Board of Chiropractic Examiners’ plans for restructuring its license fees.

(b) The report to the Legislature under subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 4. Section 2499.5 of the Business and Professions Code is amended to read:

2499.5. The following fees apply to certificates to practice podiatric medicine. The amount of fees prescribed for doctors of podiatric medicine shall be determined by the board and shall be as described below. Fees collected pursuant to this section shall be fixed by the board in amounts not to exceed the actual costs of providing the service for which the fee is collected.

(a) Each applicant for a certificate to practice podiatric medicine shall pay an application fee of no more than one hundred dollars ($100) at the time the application is filed. If the applicant qualifies for a certificate, he or she shall pay a fee not to exceed one hundred dollars ($100) nor less than five dollars ($5) for the issuance of the certificate.
(b) The oral examination fee shall be seven hundred dollars ($700), or the actual cost, whichever is lower, and shall be paid by each applicant. If the applicant’s credentials are insufficient or if the applicant does not desire to take the examination, and has so notified the board 30 days prior to the examination date, only the examination fee is returnable to the applicant. The board may charge an examination fee for any subsequent reexamination of the applicant.

(c) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required by this section, shall pay an initial license fee. The initial license fee shall be eight hundred dollars ($800). The initial license shall expire the second year after its issuance on the last day of the month of birth of the licensee. The board may reduce the initial license fee by up to 50 percent of the amount of the fee for any applicant who is enrolled in a postgraduate training program approved by the board or who has completed a postgraduate training program approved by the board within six months prior to the payment of the initial license fee.

(d) The biennial renewal fee shall be nine hundred dollars ($900). Any licensee enrolled in an approved residency program shall be required to pay only 50 percent of the biennial renewal fee at the time of his or her first renewal.

(e) The delinquency fee shall be one hundred fifty dollars ($150).

(f) The duplicate wall certificate fee shall be no more than one hundred dollars ($100).

(g) The duplicate renewal receipt fee shall be no more than fifty dollars ($50).

(h) The endorsement fee shall be thirty dollars ($30).

(i) The letter of good standing fee or for loan deferment shall be no more than one hundred dollars ($100).

(j) There shall be a fee of no more than one hundred dollars ($100) for the issuance of a resident’s license under Section 2475.

(k) The filing fee to appeal the failure of an oral examination shall be no more than one hundred dollars ($100).

(l) The fee for approval of a continuing education course or program shall be no more than two hundred fifty dollars ($250).

SEC. 5. Section 2570.16 of the Business and Professions Code is amended to read:
2570.16. Initial license and renewal fees shall be established by the board in an amount that does not exceed a ceiling of one hundred fifty dollars ($150) per year. The board shall establish the following additional fees:

(a) An application fee not to exceed fifty dollars ($50).
(b) A late renewal fee as provided for in Section 2570.10.
(c) A limited permit fee.
(d) A fee to collect fingerprints for criminal history record checks. This fee shall not exceed the amount charged by the agency providing the criminal history record checks.
(e) A fee to query the National Practitioner Data Bank for applicants for licensure and renewal of licensure. The fee shall not exceed the amount charged per query.

SEC. 4.

SEC. 6. Section 2715 of the Business and Professions Code is amended to read:
2715. (a) The board shall prosecute all persons guilty of violating this chapter.
(b) Except as provided by Section 159.5, the board, in accordance with the Civil Service Law, may employ personnel, including legal counsel, as it deems necessary to carry into effect this chapter.
(c) The board shall have and use a seal bearing the name “Board of Registered Nursing.” The board may adopt, amend, or repeal, in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the rules and regulations that may be reasonably necessary to enable it to carry into effect this chapter.

SEC. 5.

SEC. 7. Section 2760.1 of the Business and Professions Code is amended to read:
2760.1. (a) A registered nurse whose license has been revoked or suspended or who has been placed on probation may petition the board for reinstatement or modification of penalty, including reduction or termination of probation, after a period not less than the following minimum periods has elapsed from the effective date of the decision ordering that disciplinary action, or if the order of the board or any portion of it is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety, or for a registered nurse whose initial
license application is subject to a disciplinary decision, from the
date the initial license was issued:

(1) Except as otherwise provided in this section, at least three
years for reinstatement of a license that was revoked, except that
the board may, in its sole discretion, specify in its order a lesser
period of time provided that the period shall be not less than one
year.

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

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

(b) The board shall give notice to the Attorney General of the
filing of the petition. The petitioner and the Attorney General shall
be given timely notice by letter of the time and place of the hearing
on the petition, and an opportunity to present both oral and
documentary evidence and argument to the board. The petitioner
shall at all times have the burden of proof to establish by clear and
convincing evidence that he or she is entitled to the relief sought
in the petition.

(c) The hearing may be continued from time to time as the board
deems appropriate.

(d) (1) The petition may be heard by the board or the board
may assign the petition to an administrative law judge, as specified

(2) If the board assigns the petition to an administrative law
judge, the administrative law judge shall submit a proposed
decision to the board for its consideration, which shall include
reasons supporting the proposed decision.

(e) The board may grant or deny the petition, or may impose
any terms and conditions that it reasonably deems appropriate as
a condition of reinstatement or reduction of penalty.

(f) In considering a petition for reinstatement or modification
of a penalty, the board or the administrative law judge shall
evaluate and consider evidence of rehabilitation submitted by the
petitioner using criteria specified in regulations promulgated by
the board.

(g) The board may impose, or the administrative law judge may
recommend, terms and conditions on the petitioner in reinstating
a license, certificate, or permit or in modifying a penalty.
(h) The petitioner shall provide a current set of fingerprints accompanied by the necessary fingerprinting fee.

(i) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole, or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(j) Except in those cases where the petitioner has been disciplined pursuant to Section 822, the board may in its discretion deny without hearing or argument any petition that is filed pursuant to this section within a period of two years from the effective date of a prior decision following a hearing under this section.

SEC. 6.

SEC. 8. Section 2987 of the Business and Professions Code is amended to read:

2987. The amount of the fees prescribed by this chapter shall be determined by the board, and shall be as follows:

(a) The application fee for a psychologist shall not be more than fifty dollars ($50).

(b) The examination and reexamination fees for the examinations shall be the actual cost to the board of developing, purchasing, and grading of each examination, plus the actual cost to the board of administering each examination.

(c) The initial license fee is an amount equal to the renewal fee in effect on the last regular renewal date before the date on which the license is issued.

(d) The biennial renewal fee for a psychologist shall be four hundred dollars ($400). The board may increase the renewal fee to an amount not to exceed five hundred dollars ($500).

(e) The application fee for registration as a psychological assistant under Section 2913 shall not be more than seventy-five dollars ($75).

(f) The annual renewal fee for registration of a psychological assistant shall not be more than seventy-five dollars ($75).

(g) The duplicate license or registration fee is five dollars ($5).

(h) The delinquency fee is 50 percent of the renewal fee for each license type, not to exceed one hundred fifty dollars ($150).

(i) The endorsement fee is five dollars ($5).
Notwithstanding any other provision of law, the board may reduce any fee prescribed by this section, when, in its discretion, the board deems it administratively appropriate.

SEC. 7.

SEC. 9. Section 4008 of the Business and Professions Code is amended to read:

4008. (a) Except as provided by Section 159.5, the board may employ legal counsel and inspectors of pharmacy. The inspectors, whether the inspectors are employed by the board or the department’s Division of Investigation, may inspect during business hours all pharmacies, wholesalers, dispensers, stores, or places where drugs or devices are compounded, prepared, furnished, dispensed, or stored.

(b) Notwithstanding subdivision (a), a pharmacy inspector may inspect or examine a physician’s office or clinic that does not have a permit under Section 4180 or 4190 only to the extent necessary to determine compliance with and to enforce either Section 4080 or 4081.

(c) (1) (A) A pharmacy inspector employed by the board or in the department’s Division of Investigation shall have the authority, as a public officer, to arrest, without warrant, any person whenever the officer has reasonable cause to believe that the person to be arrested has, in his or her presence, violated a provision of this chapter or of Division 10 (commencing with Section 11000) of the Health and Safety Code.

(B) If the violation is a felony, or if the arresting officer has reasonable cause to believe that the person to be arrested has violated any provision that is declared to be a felony, although no felony has in fact been committed, he or she may make an arrest although the violation or suspected violation did not occur in his or her presence.

(2) In any case in which an arrest authorized by this subdivision is made for an offense declared to be a misdemeanor, and the person arrested does not demand to be taken before a magistrate, the arresting inspector may, instead of taking the person before a magistrate, follow the procedure prescribed by Chapter 5C (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code. That chapter shall thereafter apply with reference to any proceeding based upon the issuance of a citation pursuant to this authority.
(d) There shall be no civil liability on the part of, and no cause of action shall arise against, a person, acting pursuant to subdivision (a) within the scope of his or her authority, for false arrest or false imprisonment arising out of an arrest that is lawful, or that the arresting officer, at the time of the arrest, had reasonable cause to believe was lawful. An inspector shall not be deemed an aggressor or lose his or her right to self-defense by the use of reasonable force to effect the arrest, to prevent escape, or to overcome resistance.

(e) Any inspector may serve all processes and notices throughout the state.

(f) A pharmacy inspector employed by the board may enter a facility licensed pursuant to subdivision (c) or (d) of Section 1250 of the Health and Safety Code to inspect an automated drug delivery system operated pursuant to Section 4119 or 4119.1.

SEC. 8.

SEC. 10. Section 4887 of the Business and Professions Code is amended to read:

4887. (a) (1) A person whose license or registration has been revoked or who has been placed on probation may petition the board for reinstatement or modification of penalty including modification or termination of probation after the period as described below in subparagraphs (A) to (C), inclusive, has elapsed from the effective date of the decision ordering the disciplinary action. The petition shall state facts as required by the board. The period shall be as follows:

(A) At least three years for reinstatement of a surrendered or revoked license.

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

(C) At least one year for modification of a condition or termination of probation of less than three years.

(2) Notwithstanding paragraph (1), the board may, upon a showing of good cause, specify in a revocation order, a surrender order, or an order imposing probation of more than three years that the person may petition the board for reinstatement or modification or termination of probation after one year.

(b) The petition shall be accompanied by at least two verified recommendations from veterinarians licensed by the board who have personal knowledge of the activities of the petitioner since
the disciplinary penalty was imposed. The petition shall be heard by the board. The board may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner’s activities since the license or registration was in good standing, and the petitioner’s rehabilitation efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the board finds necessary.

(c) The board reinstating the license or registration or modifying a penalty may impose terms and conditions as it determines necessary. To reinstate a revoked license or registration or to otherwise reduce a penalty or modify probation shall require a vote of five of the members of the board.

(d) The petition shall not be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 9.
SEC. 11. Section 5063.3 of the Business and Professions Code is amended to read:

5063.3. (a) No confidential information obtained by a licensee, in his or her professional capacity, concerning a client or a prospective client shall be disclosed by the licensee without the written permission of the client or prospective client, except the following:

(1) Disclosures made by a licensee in compliance with a subpoena or a summons enforceable by order of a court.

(2) Disclosures made by a licensee regarding a client or prospective client to the extent the licensee reasonably believes it is necessary to maintain or defend himself or herself in a legal proceeding initiated by the client or prospective client.

(3) Disclosures made by a licensee in response to an official inquiry from a federal or state government regulatory agency.

(4) Disclosures made by a licensee or a licensee’s duly authorized representative to another licensee or person in connection with a proposed sale or merger of the licensee’s professional practice, provided the parties enter into a written
nondisclosure agreement with regard to all client information shared between the parties.

(5) Disclosures made by a licensee to either of the following:
(A) Another licensee to the extent necessary for purposes of professional consultation.
(B) Organizations that provide professional standards review and ethics or quality control peer review.

(6) Disclosures made when specifically required by law.
(7) Disclosures specified by the board in regulation.

(b) In the event that confidential client information may be disclosed to persons or entities outside the United States of America in connection with the services provided, the licensee shall inform the client in writing and obtain the client’s written permission for the disclosure.

SEC. 10.
SEC. 12. Section 5096.9 of the Business and Professions Code is amended to read:

5096.9. (a) The board is authorized to adopt regulations to implement, interpret, or make specific the provisions of this article.
(b) The board shall adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to establish policies, guidelines, and procedures to initially implement this article as it goes into effect on July 1, 2013. The adoption of the regulations shall be considered by the Office of Administrative Law to be necessary for the immediate preservation of the public peace, health and safety, or general welfare. The emergency regulations shall be submitted to the Office of Administrative Law for filing with the Secretary of State in accordance with the Administrative Procedure Act.
(c) (1) Notwithstanding any other law, to ensure uninterrupted implementation of this article, the board may adopt or amend regulations consistent with Section 100 of Title 1 of the California Code of Regulations to remove or extend the inoperative date of its regulations in Article 3 (commencing with Section 18) of Division 1 of Title 16 of the California Code of Regulations, or to remove the inoperative dates for the regulations in Article 4 (commencing with Section 26) of Division 1 of Title 16 of the California Code of Regulations.
(2) Notwithstanding any other law, the Office of Administrative Law shall consider the board’s action to remove or extend the inoperative dates of these regulations as a change without regulatory effect as described in Section 100 of Title 1 of the California Code of Regulations that exempts the board from complying with the rulemaking procedure specified in the Administrative Procedure Act (Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 11.
SEC. 13. Section 5810 of the Business and Professions Code is amended to read:
5810. (a) This chapter shall be subject to review by the appropriate policy committees of the Legislature.
(b) This chapter shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 14. Section 6980.79 of the Business and Professions Code is amended to read:
6980.79. The fees prescribed by this chapter are those fixed in the following schedule:
(a) A locksmith license application fee may not exceed thirty dollars ($30).
(b) An original license and renewal fee for a locksmith license may not exceed forty-five dollars ($45).
(c) A branch office registration fee and branch office renewal fee may not exceed thirty-five dollars ($35).
(d) Notwithstanding Section 163.5, the reinstatement fee as required by Section 6980.28 is the amount equal to the renewal fee plus a penalty of 50 percent thereof.
(e) An initial registration fee for an employee may not exceed twenty dollars ($20).
(f) A registration renewal fee for an employee performing the services of a locksmith may not exceed twenty dollars ($20).
(g) The fingerprint processing fee is that amount charged the bureau by the Department of Justice.
(h) All applicants seeking a license pursuant to this chapter shall also remit to the bureau the fingerprint fee that is charged to the bureau by the Department of Justice.
(i) The fee for a “Certificate of Licensure” may not exceed twenty dollars ($20).
(j) A delinquency fee is the amount equal to the renewal fee plus a penalty of 50 percent thereof.

(k) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 15. Section 6980.79 is added to the Business and Professions Code, to read:

6980.79. The fees prescribed by this chapter are those fixed in the following schedule:

(a) A locksmith license application fee shall be at least two hundred fifty dollars ($250) and may be increased to an amount not to exceed two hundred seventy-five dollars ($275).

(b) An original license fee for a locksmith license shall be at least two hundred fifty dollars ($250) and may be increased to an amount not to exceed two hundred seventy-five dollars ($275), and a renewal fee for a locksmith license shall be at least five hundred dollars ($500) and may be increased to an amount not to exceed five hundred fifty dollars ($550).

(c) A branch office initial registration fee shall be at least two hundred fifty dollars ($250) and may be increased to an amount not to exceed two hundred seventy-five dollars ($275), and a branch office renewal fee shall be at least one hundred fifty dollars ($150) and may be increased to an amount not to exceed one hundred sixty-five dollars ($165).

(d) Notwithstanding Section 163.5, the reinstatement fee as required by Section 6980.28 is the amount equal to the renewal fee plus a penalty of 50 percent thereof.

(e) An initial registration fee for an employee performing the services of a locksmith shall be at least fifty-five dollars ($55) and may be increased to an amount not to exceed sixty dollars ($60).

(f) A registration renewal fee for an employee performing the services of a locksmith shall be at least forty dollars ($40) and may be increased to an amount not to exceed forty-four dollars ($44).

(g) The fingerprint processing fee is that amount charged to the bureau by the Department of Justice.

(h) All applicants seeking a license pursuant to this chapter shall also remit to the bureau the fingerprint fee that is charged to the bureau by the Department of Justice.

(i) The fee for a Certificate of Licensure, as specified in Section 6980.24, shall be at least twenty-five dollars ($25).
(j) A delinquency fee is the amount equal to the renewal fee plus a penalty of 50 percent thereof.

(k) The fee for an endorsed verification of licensure or registration shall be twenty-five dollars ($25). The verification document shall include the license or registration number, the date of issuance and expiration of the license or registration, the current license or registration status, the date of the endorsement, an embossed seal, and the signature of the chief.

(l) The fee for the replacement of a lost or destroyed registration card, license, or certificate authorized by this chapter shall be twenty-five dollars ($25). The request for a replacement of a registration card, license, or certificate shall be made in the manner prescribed by the bureau.

(m) This section shall become operative on July 1, 2018.

SEC. 12.

SEC. 16. Section 7332 of the Business and Professions Code is amended to read:

7332. (a) An apprentice is any person who is licensed by the board to engage in learning or acquiring a knowledge of barbering, cosmetology, skin care, nail care, or electrology, in a licensed establishment under the supervision of a licensee approved by the board.

(b) For purposes of this section, “under the supervision of a licensee” means that the apprentice shall be supervised at all times by a licensee approved by the board while performing services in a licensed establishment. At no time shall an apprentice be the only individual working in the establishment. An apprentice that is not being supervised by a licensee, that has been approved by the board to supervise an apprentice, shall be deemed to be practicing unlicensed under this chapter.

SEC. 17. Section 7506.10 of the Business and Professions Code is amended to read:

7506.10. (a) Every initial registration shall expire one year following the date of issuance, unless renewed as provided in this section, except for those registrations issued on or after January 1, 1984, which shall expire on December 31, 1985, and every year thereafter, unless renewed as provided in this section. A renewal registration shall expire two years following the date of renewal, unless renewed as provided in this section.
(b) At least 60 days prior to the expiration, the bureau shall mail a renewal form to the registrant at the licensee’s place of business. A registrant who desires to renew his or her registration shall forward to the bureau for each registration the properly completed renewal form obtained from the bureau, with the renewal fee prescribed by this chapter, for renewal of his or her registration. Until the registration renewal certificate is issued, a registrant may continue to work with a temporary registration renewal certificate on a secure form prescribed by the chief and issued by the qualified certificate holder that has been embossed by the bureau with the state seal for a period not to exceed 120 days from the date of expiration of the registration.

(c) A licensee shall provide to his or her registrants information regarding procedures for renewal of registration.

(d) A registration that is not renewed within 60 days after its expiration may not be renewed. If the registration is renewed within 60 days after its expiration, the registrant, as a condition precedent to renewal, shall pay the renewal fee and also pay the delinquency fee prescribed in this chapter. Registrants working with expired registrations shall pay all accrued fees and penalties prior to renewal or reregistration.

(e) The delinquency fee is 50 percent of the renewal fee in effect on the date of expiration, but not less than twenty-five dollars ($25).

(f) Upon renewal, evidence of renewal, as the director may prescribe, shall be issued to the registrant. If evidence of renewal has not been delivered to the registrant prior to the date of expiration, the registrant may present evidence of renewal to substantiate continued registration for a period not to exceed 60 days after the date of expiration or a temporary registration renewal certificate as described in subdivision (b).

(g) A registration shall not be renewed until any and all fines assessed pursuant to this chapter and not resolved in accordance with this chapter have been paid.

(h) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 18. Section 7506.10 is added to the Business and Professions Code, to read:

7506.10. (a) Every initial registration shall expire one year following the date of issuance, unless renewed as provided in this
section, except for those registrations issued on or after January
1, 1984, which shall expire on December 31, 1985, and every year
thereafter, unless renewed as provided in this section. A renewal
registration shall expire two years following the date of renewal,
unless renewed as provided in this section.

(b) At least 60 days prior to the expiration, the bureau shall
mail a renewal form to the registrant at the licensee’s place of
business. A registrant who desires to renew his or her registration
shall forward to the bureau for each registration the properly
completed renewal form obtained from the bureau, with the
renewal fee prescribed by this chapter, for renewal of his or her
registration. Until the registration renewal certificate is issued, a
registrant may continue to work with a temporary registration
renewal certificate on a secure form prescribed by the chief and
issued by the qualified certificate holder that has been embossed
by the bureau with the state seal for a period not to exceed 120
days from the date of expiration of the registration.

(c) A licensee shall provide to his or her registrants information
regarding procedures for renewal of registration.

(d) A registration that is not renewed within 60 days after its
expiration may not be renewed. If the registration is renewed within
60 days after its expiration, the registrant, as a condition precedent
to renewal, shall pay the renewal fee and also pay the delinquency
fee prescribed in this chapter. Registrants working with expired
registrations shall pay all accrued fees and penalties prior to
renewal or reregistration.

(e) Upon renewal, evidence of renewal, as the director may
prescribe, shall be issued to the registrant. If evidence of renewal
has not been delivered to the registrant prior to the date of
expiration, the registrant may present evidence of renewal to
substantiate continued registration for a period not to exceed 60
days after the date of expiration or a temporary registration
renewal certificate, as described in subdivision (b).

(f) A registration shall not be renewed until any and all fines
assessed pursuant to this chapter and not resolved in accordance
with this chapter have been paid.

(g) This section shall become operative on July 1, 2018.

SEC. 19. Section 7511 of the Business and Professions Code
is amended to read:
Effective July 1, 1998, the bureau shall establish and assess fees and penalties for licensure and registration as displayed in this section. The fees prescribed by this chapter are as follows:

(a) The application fee for an original repossession agency license may not exceed eight hundred twenty-five dollars ($825).

(b) The application fee for an original qualification certificate may not exceed three hundred twenty-five dollars ($325).

(c) The renewal fee for a repossession agency license may not exceed seven hundred fifteen dollars ($715) biennially.

(d) The renewal fee for a license as a qualified certificate holder may not exceed four hundred fifty dollars ($450) biennially.

(e) Notwithstanding Section 163.5, the reinstatement fee for a repossession agency license required pursuant to Sections 7503.11 and 7505.3 is the amount equal to the renewal fee plus a penalty of 50 percent thereof.

(f) Notwithstanding Section 163.5, the reinstatement fee for a license as a qualified certificate holder required pursuant to Sections 7504.7 and 7503.11 is the amount equal to the renewal fee plus a penalty of 50 percent thereof.

(g) A fee for reexamination of an applicant for a qualified manager may not exceed thirty dollars ($30).

(h) An initial registrant registration fee may not exceed seventy-five dollars ($75), a registrant reregistration fee may not exceed thirty dollars ($30), and a registrant biennial renewal fee may not exceed sixty dollars ($60) per registration.

Notwithstanding Section 163.5 and this subdivision, the reregistration fee for a registrant whose registration expired more than one year prior to the filing of the application for reregistration may not exceed seventy-five dollars ($75).

(i) The delinquency fee is 50 percent of the renewal fee in effect on the date of expiration, but not less than twenty-five dollars ($25).

(j) The fingerprint processing fee is that amount charged the bureau by the Department of Justice.

(k) The director shall furnish one copy of any issue or edition of the licensing law and rules and regulations to any applicant or licensee without charge. The director shall charge and collect a fee not to exceed ten dollars ($10) plus sales tax for each additional copy which may be furnished on request to any applicant or
licensee, and for each copy furnished on request to any other
person.

(l) The processing fee for the assignment of a repossession
agency license pursuant to Section 7503.9 may not exceed one
hundred twenty-five dollars ($125).

This section shall become operative July 1, 1998, except that
the changes to this section enacted during the first year of the
1999-2000 Regular Session shall become operative January 1,
2000. Notwithstanding the operative date of this section, before,
on, or after July 1, 1998, the bureau may adopt regulations
specifying the fees authorized by this section. Inoperative July 1,
2018, and, as of January 1, 2019, is repealed.

SEC. 20. Section 7511 is added to the Business and Professions
Code, to read:

7511. The bureau shall establish and assess fees and penalties
for licensure and registration as displayed in this section. The fees
prescribed by this chapter are as follows:

(a) The application fee for an original repossession agency
license shall be at least nine hundred seventy dollars ($970) and
may be increased to an amount not to exceed one thousand
sixty-seven dollars ($1,067).

(b) The application fee for an original qualified manager
certificate shall be at least three hundred fifty dollars ($350) and
may be increased to an amount not to exceed three hundred
eighty-five dollars ($385).

(c) The renewal fee for a repossession agency license shall be
at least seven hundred fifty dollars ($750) and may be increased
to an amount not to exceed eight hundred twenty-five dollars ($825)
biennially.

(d) The renewal fee for a qualified manager certificate shall be
at least two hundred twenty-five dollars ($225) and may be
increased to an amount not to exceed two hundred forty-eight
dollars ($248) biennially.

(e) Notwithstanding Section 163.5, the reinstatement fee for a
repossession agency license required pursuant to Sections 7503.11
and 7505.3 is the amount equal to the renewal fee plus a penalty
of 50 percent thereof.

(f) Notwithstanding Section 163.5, the reinstatement fee for a
qualified manager certificate required pursuant to Sections 7503.11
and 7504.7 is the amount equal to the renewal fee plus a penalty
of 50 percent thereof.

(g) A fee for reexamination of an applicant for a qualified
manager shall be at least sixty dollars ($60) and may be increased
to an amount not to exceed sixty-six dollars ($66).

(h) An initial registrant registration fee shall be at least
seventy-five dollars ($75) and may be increased to an amount not
to exceed eighty-two dollars ($82), a registrant reregistration fee
shall be at least seventy-five dollars ($75) and may be increased
to an amount not to exceed eighty-two dollars ($82), and a
registrant biennial renewal fee shall be at least forty dollars ($40)
and may be increased to an amount not to exceed forty-four dollars
($44) per registration. Notwithstanding Section 163.5 and this
subdivision, the reregistration fee for a registrant whose
registration expired more than one year prior to the filing of the
application for reregistration shall be at least seventy-five dollars
($75) and may be increased to an amount not to exceed eighty-two
dollars ($82).

(i) The delinquency fee is 50 percent of the renewal fee in effect
on the date of expiration, but not less than twenty-five dollars
($25).

(j) The fingerprint processing fee is that amount charged to the
bureau by the Department of Justice.

(k) The director shall furnish one copy of any issue or edition
of the licensing law and rules and regulations to any applicant or
licensee without charge. The director shall charge and collect a
fee not to exceed ten dollars ($10) plus sales tax for each additional
copy, which may be furnished on request to any applicant or
licensee, and for each copy furnished on request to any other
person.

(l) The processing fee for the assignment of a repossession
agency license pursuant to Section 7503.9 shall be at least four
hundred dollars ($400) and may be increased to an amount not
to exceed four hundred forty dollars ($440).

(m) The fee for an endorsed verification of licensure,
certification, or registration shall be twenty-five dollars ($25).
The verification document shall include the license, certificate, or
registration number, the date of issuance and expiration of the
license, certificate, or registration, the current license, certificate,
or registration status, the date of the endorsement, an embossed
seal, and the signature of the chief.

(n) The fee for the replacement of a lost or destroyed registration
card, license, or certificate authorized by this chapter shall be
twenty-five dollars ($25). The request for a replacement of a
registration card, license, or certificate shall be made in the
manner prescribed by the bureau.

(o) This section shall become operative on July 1, 2018.

SEC. 21. Section 7574.11 of the Business and Professions Code
is amended to read:

7574.11. (a) An applicant seeking registration as a proprietary
private security officer shall apply to the department on forms
provided by the department.

(b) An application for registration as a proprietary private
security officer shall include, but not be limited to, the following:

(1) Submission of fingerprints for submission to the Department
of Justice.

(A) The department shall submit to the Department of Justice
fingerprint images and related information required by the
Department of Justice for all proprietary private security officer
registration applicants, as defined by subdivision (f) of Section
7574.01, for the purposes of obtaining information as to the
existence and content of a record of state or federal convictions
and state or federal arrests and also information as to the existence
and content of a record of state or federal arrests for which the
Department of Justice establishes that the person is free on bail or
on his or her own recognizance pending trial or appeal.

(B) When received, the Department of Justice shall forward to
the Federal Bureau of Investigation requests for federal summary
criminal history information received pursuant to this section. The
Department of Justice shall review the information returned from
the Federal Bureau of Investigation and compile and disseminate
a response to the department.

(C) The Department of Justice shall provide a state and federal
level response to the department pursuant to paragraph (1) of
subdivision (p) of Section 11105 of the Penal Code.

(D) The department shall request from the Department of Justice
subsequent arrest notification service, as provided pursuant to
Section 11105.2 of the Penal Code, for persons described in
subdivision (a).
(E) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section.

(2) A fee of fifty dollars ($50).

(c) Upon approval of an application for registration as a proprietary private security officer by the director, the chief shall cause to be issued to the applicant a registration card in a form approved by the director. A registration card shall be valid for two years from the date of issue.

(d) A person may work as a proprietary private security officer pending receipt of the registration card if he or she has been approved by the director and carries on his or her person a hard copy printout of the bureau’s approval from the bureau’s Internet Web site and either a valid driver’s license issued pursuant to Section 12811 of the Vehicle Code or a valid identification card issued pursuant to Section 13000 of the Vehicle Code.

(e) In the event of the loss or destruction of a registration card, the registrant may apply to the bureau on a form provided by the bureau for a certified replacement of the card, stating the circumstances surrounding the loss, and pay a replacement fee of ten dollars ($10), whereupon the bureau shall issue a replacement of the card.

(f) A registered proprietary private security officer shall apply for renewal biennially with the department on forms provided by the department. The department shall charge a renewal fee of thirty-five dollars ($35).

(g) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 22. Section 7574.11 is added to the Business and Professions Code, to read:

7574.11. (a) An applicant seeking registration as a proprietary private security officer shall apply to the department on forms provided by the department.

(b) An application for registration as a proprietary private security officer shall include, but not be limited to, the following:

(1) Submission of fingerprints for submission to the Department of Justice.

(A) The department shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice for all proprietary private security officer registration applicants, as defined by subdivision (f) of Section 96.
7574.01, for the purposes of obtaining information as to the
existence and content of a record of state or federal convictions
and state or federal arrests and also information as to the existence
and content of a record of state or federal arrests for which the
Department of Justice establishes that the person is free on bail
or on his or her own recognizance pending trial or appeal.

(B) When received, the Department of Justice shall forward to
the Federal Bureau of Investigation requests for federal summary
criminal history information received pursuant to this section. The
Department of Justice shall review the information returned from
the Federal Bureau of Investigation and compile and disseminate
a response to the department.

(C) The Department of Justice shall provide a state and federal
level response to the department pursuant to paragraph (1) of
subdivision (p) of Section 11105 of the Penal Code.

(D) The department shall request from the Department of Justice
subsequent arrest notification service, as provided pursuant to
Section 11105.2 of the Penal Code, for persons described in
subdivision (a).

(E) The Department of Justice shall charge a fee sufficient to
cover the cost of processing the request described in this section.

(2) A fee that shall be at least fifty-five dollars ($55) and may
be increased to an amount not to exceed sixty dollars ($60).

(c) Upon approval of an application for registration as a
proprietary private security officer by the director, the chief shall
cause to be issued to the applicant a registration card in a form
approved by the director. A registration card shall be valid for
two years from the date of issue.

(d) A person may work as a proprietary private security officer
pending receipt of the registration card if he or she has been
approved by the director and carries on his or her person a
hardcopy printout of the bureau’s approval from the bureau’s
Internet Web site and either a valid driver’s license issued pursuant
to Section 12811 of the Vehicle Code or a valid identification card
issued pursuant to Section 13000 of the Vehicle Code.

(e) The fee for a lost or destroyed registration card shall be
twenty-five dollars ($25). The request for a replacement of a
registration card, license, or certificate shall be made in the
manner prescribed by the bureau.
(f) A registered proprietary private security officer shall apply for renewal biennially with the department on forms provided by the department. The department shall charge a renewal fee that shall be at least forty dollars ($40) and may be increased to an amount not to exceed forty-four dollars ($44).

(g) This section shall become operative on July 1, 2018.

SEC. 23. Section 7574.13 of the Business and Professions Code is amended to read:

7574.13. (a) An applicant seeking registration as a proprietary private security employer shall apply to the department on forms provided by the department.

(b) An application for registration as a proprietary private security employer shall include, but not be limited to, a fee of seventy-five dollars ($75).

(c) Upon approval of an application for registration as a proprietary private security employer, the chief shall cause to be issued to the applicant a registration certificate in a form approved by the director. A registration certificate shall be valid for two years from the date of issue.

(d) A registered proprietary private security employer shall apply for renewal biennially with the department on forms provided by the department. The department shall charge a renewal fee of thirty-five dollars ($35).

(e) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 24. Section 7574.13 is added to the Business and Professions Code, to read:

7574.13. (a) An applicant seeking registration as a proprietary private security employer shall apply to the department on forms provided by the department.

(b) An application for registration as a proprietary private security employer shall include, but not be limited to, a fee that shall be at least three hundred fifty dollars ($350) and may be increased to an amount not to exceed three hundred eighty-five dollars ($385).

(c) Upon approval of an application for registration as a proprietary private security employer, the chief shall cause to be issued to the applicant a registration certificate in a form approved by the director. A registration certificate shall be valid for two years from the date of issue.
(d) A registered proprietary private security employer shall apply for renewal biennially with the department on forms provided by the department. The department shall charge a renewal fee that shall be at least three hundred fifty dollars ($350) and may be increased to an amount not to exceed three hundred eighty-five dollars ($385).

(e) The fee for the replacement of a lost or destroyed registration card shall be twenty-five dollars ($25). The request for a replacement of a registration card, license, or certificate shall be made in the manner prescribed by the bureau.

(f) This section shall become operative on July 1, 2018.

SEC. 25. Section 7574.35 is added to the Business and Professions Code, to read:

7574.35. (a) The fee for an endorsed verification of registration shall be twenty-five dollars ($25). The verification document shall include the registration number, the date of issuance and expiration of the registration, the current registration status, the date of the endorsement, an embossed seal, and the signature of the chief.

(b) This section shall become operative on July 1, 2018.

SEC. 26. Section 7582.11 of the Business and Professions Code is amended to read:

7582.11. (a) The chief shall issue a license, the form and content of which shall be determined by the chief in accordance with Section 164. In addition, the chief shall issue a “Certificate of Licensure” to any licensee, upon request and upon the payment of a fee of fifty dollars ($50).

(b) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 27. Section 7582.11 is added to the Business and Professions Code, to read:

7582.11. (a) The chief shall issue a license, the form and content of which shall be determined by the chief in accordance with Section 164. In addition, the chief shall issue a “Certificate of Licensure” to any licensee, upon request and upon the payment of the fee prescribed in this chapter:

(b) This section shall become operative on July 1, 2018.

SEC. 28. Section 7582.17 of the Business and Professions Code is amended to read:
7582.17. (a) No licensee shall conduct a business under a fictitious or other business name unless and until he or she has obtained the written authorization of the bureau to do so.

(b) The bureau shall not authorize the use of a fictitious or other business name which is so similar to that of a public officer or agency or of that used by another licensee that the public may be confused or misled thereby.

(c) The authorization shall require, as a condition precedent to the use of any fictitious name, that the licensee comply with Chapter 5 (commencing with Section 17900) of Part 3 of Division 7.

(d) A licensee desiring to conduct his or her business under more than one fictitious business name shall obtain the authorization of the bureau in the manner prescribed in this section for the use of each name.

(e) The licensee shall pay a fee of twenty-five dollars ($25) for each authorization to use an additional fictitious business name and for each change in the use of a fictitious business name. If the original license is issued in a nonfictitious name and authorization is requested to have the license reissued in a fictitious business name, the licensee shall pay a fee of twenty-five dollars ($25) for the authorization.

(f) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 29. Section 7582.17 is added to the Business and Professions Code, to read:

7582.17. (a) No licensee shall conduct a business under a fictitious or other business name unless and until he or she has obtained the written authorization of the bureau to do so.

(b) The bureau shall not authorize the use of a fictitious or other business name which is so similar to that of a public officer or agency or of that used by another licensee that the public may be confused or misled thereby.

(c) The authorization shall require, as a condition precedent to the use of any fictitious name, that the licensee comply with
Chapter 5 (commencing with Section 17900) of Part 3 of Division 7.

(d) A licensee desiring to conduct his or her business under more than one fictitious business name shall obtain the authorization of the bureau in the manner prescribed in this section for the use of each name.

(e) The licensee shall pay a fee of at least seventy-five dollars ($75) that may be increased to an amount not to exceed eighty-two dollars ($82) for each authorization to use an additional fictitious business name and for each change in the use of a fictitious business name. If the original license is issued in a nonfictitious name and authorization is requested to have the license reissued in a fictitious business name, the licensee shall pay a fee of at least seventy-five dollars ($75) that may be increased to an amount not to exceed eighty-two dollars ($82) for the authorization.

(f) This section shall become operative on July 1, 2018.

SEC. 30. Section 7583.12 of the Business and Professions Code is amended to read:

7583.12. (a) An employee of a licensee shall not carry or use a firearm unless the employee has in his or her possession both of the following:

(1) A valid guard registration card issued pursuant to this chapter.

(2) A valid firearm qualification card issued pursuant to this chapter.

(b) An employee of a licensee may carry or use a firearm while working as a security guard or security patrolperson pending receipt of a firearm qualification card if he or she has been approved by the bureau and carries on his or her person a hardcopy printout of the bureau’s approval from the bureau’s Internet Web site and a valid picture identification.

(c) In the event of the loss or destruction of the firearm qualification card, the cardholder may apply to the bureau for a certified replacement of the card, stating the circumstances surrounding the loss, and pay a ten-dollar ($10) certification fee, whereupon the bureau shall issue a certified replacement of the card.

(d) Paragraph (2) of subdivision (a) and subdivision (b) shall not apply to a duly appointed peace officer, as defined in Chapter...
4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, who meets all of the following:

(1) He or she has successfully completed a course of study in the use of firearms.

(2) He or she is authorized to carry a concealed firearm in the course and scope of his or her employment pursuant to Article 2 (commencing with Section 25450) of Chapter 2 of Division 5 of Title 4 of Part 6 of the Penal Code.

(3) He or she has proof that he or she has applied to the bureau for a firearm qualification card.

(e) (1) This section shall not apply to a duly appointed peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, or a federal qualified law enforcement officer, as defined in Section 926B of Title 18 of the United States Code, who has written approval from his or her primary employer, as defined in paragraph (2) of subdivision (i) of Section 7583.9, to carry a firearm while working as a security guard.

(2) A peace officer exempt under this subdivision shall carry on his or her person a letter of approval from his or her primary employer authorizing him or her to carry a firearm while working as a security guard.

(f) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 31. Section 7583.12 is added to the Business and Professions Code, to read:

7583.12. (a) An employee of a licensee shall not carry or use a firearm unless the employee has in his or her possession both of the following:

(1) A valid guard registration card issued pursuant to this chapter.

(2) A valid firearm qualification card issued pursuant to this chapter.

(b) An employee of a licensee may carry or use a firearm while working as a security guard or security patrolperson pending receipt of a firearm qualification card if he or she has been approved by the bureau and carries on his or her person a hardcopy printout of the bureau’s approval from the bureau’s Internet Web site and a valid picture identification.
Paragraph (2) of subdivision (a) and subdivision (b) shall not apply to a duly appointed peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, who meets all of the following:

1. He or she has successfully completed a course of study in the use of firearms.
2. He or she is authorized to carry a concealed firearm in the course and scope of his or her employment pursuant to Article 2 (commencing with Section 25450) of Chapter 2 of Division 5 of Title 4 of Part 6 of the Penal Code.
3. He or she has proof that he or she has applied to the bureau for a firearm qualification card.

(d) (1) This section shall not apply to a duly appointed peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, or a federal qualified law enforcement officer, as defined in Section 926B of Title 18 of the United States Code, who has written approval from his or her primary employer, as defined in paragraph (2) of subdivision (i) of Section 7583.9, to carry a firearm while working as a security guard.

(2) A peace officer exempt under this subdivision shall carry on his or her person a letter of approval from his or her primary employer authorizing him or her to carry a firearm while working as a security guard.

(e) This section shall become operative on July 1, 2018.

SEC. 32. Section 7583.17 of the Business and Professions Code is amended to read:

7583.17. (a) Upon approval of an application for registration, the chief shall cause to be issued to the applicant at his or her last known residential address a registration card in a form approved by the director.

(b) A person may work as a security guard or security patrolperson pending receipt of the registration card if he or she has been approved by the bureau and carries on his or her person a hardcopy printout of the bureau’s Internet approval from the bureau’s Web site and a valid picture identification.

(c) In the event of the loss or destruction of the card, the cardholder may apply to the bureau for a certified replacement of the card, stating the circumstances surrounding the loss, and pay
a ten dollar ($10) certification fee, whereupon the bureau shall
issue a certified replacement of the card.

(d) This section shall become inoperative on July 1, 2018, and,
as of January 1, 2019, is repealed.

SEC. 33. Section 7583.17 is added to the Business and
Professions Code, to read:

7583.17. (a) Upon approval of an application for registration,
the chief shall cause to be issued to the applicant at his or her last
known residential address a registration card in a form approved
by the director.

(b) A person may work as a security guard or security
patrolperson pending receipt of the registration card if he or she
has been approved by the bureau and carries on his or her person
a hardcopy printout of the bureau's approval from the bureau's
Internet Web site and a valid picture identification.

(c) This section shall become operative on July 1, 2018.

SEC. 34. Section 7583.20 of the Business and Professions Code
is amended to read:

7583.20. (a) A registration issued under this chapter expires
two years following the date of issuance or on the assigned renewal
date. Every security guard issued a registration under this chapter
that expires on or after January 1, 1997, and who is also issued or
renews a firearms qualification card on or after January 1, 1997,
shall be placed on a cyclical renewal so that the registration expires
on the expiration date of the firearms qualification card.
Notwithstanding any other provision of law, the bureau is
authorized to extend or shorten the first term of registration
following January 1, 1997, and to prorate the required registration
fee in order to implement this cyclical renewal. At least 60 days
prior to the expiration, a registrant seeking to renew a security
guard registration shall forward to the bureau a completed
registration renewal application and the renewal fee. The renewal
application shall be on a form prescribed by the director, dated
and signed by the applicant, certifying under penalty of perjury
that the information in the application is true and correct.

(b) The licensee shall provide to any employee information
regarding procedures for renewal or registration.

(c) In the event a registrant fails to request a renewal of his or
her registration as provided for in this chapter, the registration
shall expire as indicated on the registration. If the registration is
renewed within 60 days after its expiration, the registrant, as a
condition precedent to renewal, shall pay the renewal fee and the
delinquency fee.
(d) The delinquency fee is 50 percent of the renewal fee in effect
on the date of expiration, but not less than twenty-five dollars ($25).
(e) If the renewed registration card has not been delivered to
the registrant prior to the expiration of the prior registration, the
registrant may present evidence of renewal to substantiate
continued registration for a period not to exceed 90 days after the
date of expiration.
(f) A registration may not be renewed or reinstated unless a
registrant meets both of the following requirements:
(1) All fines assessed pursuant to Section 7587.7 and not
resolved in accordance with the provisions of that section have
been paid.
(2) On and after July 1, 2005, the registrant certifies, on a form
prescribed by the bureau, that he or she has completed the 32 hours
of the training required by subdivision (b) of Section 7583.6.
(g) This section shall become inoperative on July 1, 2018, and,
as of January 1, 2019, is repealed.
SEC. 35. Section 7583.20 is added to the Business and
Professions Code, to read:
7583.20. (a) A registration issued under this chapter expires
two years following the date of issuance or on the assigned renewal
date. Every security guard issued a registration under this chapter
that expires on or after January 1, 1997, and who is also issued
or renews a firearms qualification card on or after January 1,
1997, shall be placed on a cyclical renewal so that the registration
expires on the expiration date of the firearms qualification card.
Notwithstanding any other law, the bureau is authorized to extend
or shorten the first term of registration following January 1, 1997,
and to prorate the required registration fee in order to implement
this cyclical renewal. At least 60 days prior to the expiration, a
registrant seeking to renew a security guard registration shall
forward to the bureau a completed registration renewal application
and the renewal fee. The renewal application shall be on a form
prescribed by the director, dated and signed by the applicant,
certifying under penalty of perjury that the information in the
application is true and correct.
(b) The licensee shall provide to any employee information regarding procedures for renewal or registration.

(c) In the event a registrant fails to request a renewal of his or her registration as provided for in this chapter, the registration shall expire as indicated on the registration. If the registration is renewed within 60 days after its expiration, the registrant, as a condition precedent to renewal, shall pay the renewal fee and the delinquency fee.

(d) If the renewed registration card has not been delivered to the registrant prior to the expiration of the prior registration, the registrant may present evidence of renewal to substantiate continued registration for a period not to exceed 90 days after the date of expiration.

(e) A registration may not be renewed or reinstated unless a registrant meets both of the following requirements:

(1) All fines assessed pursuant to Section 7587.7 and not resolved in accordance with the provisions of that section have been paid.

(2) On and after July 1, 2005, the registrant certifies, on a form prescribed by the bureau, that he or she has completed the 32 hours of the training required by subdivision (b) of Section 7583.6.

(f) This section shall become operative on July 1, 2018.

SEC. 36. Section 7583.23 of the Business and Professions Code is amended to read:

7583.23. The bureau shall issue a firearms permit when all of the following conditions are satisfied:

(a) The applicant is a licensee, a qualified manager of a licensee, or a registered security guard subject to the following:

(1) The firearms permit may only be associated with the following:

(A) A sole owner of a sole ownership licensee, pursuant to Section 7582.7 or 7525.1.

(B) A partner of a partnership licensee, pursuant to Section 7582.7 or 7525.1.

(C) A qualified manager of a licensee, pursuant to Section 7536 or 7582.22.

(D) A security guard registrant.

(2) If the firearms permit is associated with a security guard registration, he or she is subject to the provisions of Section
7583.47, regardless of any other license possessed or associated
with the firearms permit.

(b) A certified firearms training instructor has certified that the
applicant has successfully completed a written examination
prepared by the bureau and training course in the carrying and use
of firearms approved by the bureau.

(c) The applicant has filed with the bureau a classifiable
fingerprint card, a completed application for a firearms permit on
a form prescribed by the director, dated and signed by the applicant,
certifying under penalty of perjury that the information in the
application is true and correct. In lieu of a classifiable fingerprint
card, the applicant may submit fingerprints into an electronic
fingerprinting system administered by the Department of Justice.
An applicant who submits his or her fingerprints by electronic
means shall have his or her fingerprints entered into the system
through a terminal operated by a law enforcement agency or other
facility authorized by the Department of Justice to conduct
electronic fingerprinting. The terminal operator may charge a fee
sufficient to reimburse it for the costs incurred in providing this
service.

(d) The bureau has determined, after investigation, that the
carrying and use of a firearm by the applicant, in the course of his
or her duties, presents no apparent threat to the public safety, or
that the carrying and use of a firearm by the applicant is not in
violation of the Penal Code.

(e) The applicant has produced evidence to the firearm training
facility that he or she is a citizen of the United States or has
permanent legal alien status in the United States. Evidence of
citizenship or permanent legal alien status shall be that deemed
sufficient by the bureau to ensure compliance with federal laws
prohibiting possession of firearms by persons unlawfully in the
United States and may include, but not be limited to, United States
Department of Justice, Immigration and Naturalization Service
Form I-151 or I-551, Alien Registration Receipt Card,
naturalization documents, or birth certificates evidencing lawful
residence or status in the United States.

(f) The application is accompanied by the application fees
prescribed in this chapter.

(g) Beginning January 1, 2018, or on a date to be determined
by the bureau, but no later than July 1, 2018, the applicant is a
registered security guard and he or she has been found capable of
exercising appropriate judgment, restraint, and self-control, for
the purposes of carrying and using a firearm during the course of
his or her duties, pursuant to Section 7583.47.

SEC. 37. Section 7583.24 of the Business and Professions Code
is amended to read:

7583.24. (a) The bureau shall not issue a firearm permit if the
applicant is prohibited from possessing, receiving, owning, or
purchasing a firearm pursuant to state or federal law.

(b) Before issuing an initial firearm permit the bureau shall
provide the Department of Justice with the name, address, social
security number, and fingerprints of the applicant.

(c) The Department of Justice shall inform the bureau, within
60 days from receipt of the information specified in subdivision
(b), of the applicant’s eligibility to possess, receive, purchase, or
own a firearm pursuant to state and federal law.

(d) An applicant who has been denied a firearm permit based
upon subdivision (a) may reapply for the permit after the
prohibition expires. The bureau shall treat this application as an
initial application and shall follow the required screening process
as specified in this section.

(e) Beginning January 1, 2018, the bureau shall not issue
a firearm permit pursuant to this chapter to a registered security
guard if the applicant has been found incapable, at the time of
application, of exercising appropriate judgment, restraint, and
self-control for the purposes of carrying and using a firearm during
the course of his or her duties, pursuant to Section 7583.47. An
applicant who has been denied a firearm permit pursuant to this
subdivision may reapply for the permit after 12 months from the
date of denial. The bureau shall treat the application as an initial
application and the applicant must satisfy all the requirements
specified in Section 7583.23.

(f) Beginning January 1, 2018, the bureau shall not issue a
firearm permit pursuant to this chapter to a licensee or a qualified
manager of a licensee who, within the past 12 months, has been
found incapable of exercising appropriate judgment, restraint, and
self-control, for the purposes of carrying and using a firearm during
the course of his or her duties, pursuant to the assessment required
under Section 7583.47 for a permit associated with a security guard
registration.
SEC. 38. Section 7583.47 of the Business and Professions Code is amended to read:

7583.47. (a) As used in this section, “assessment” means the application of a testing instrument identified by the bureau that evaluates whether an applicant for a firearms permit who is a registered security guard, at the time of the assessment, possesses appropriate judgment, restraint, and self-control for the purposes of carrying and using a firearm during the course of his or her security guard duties.

(b) Beginning January 1, 2018, or on a date to be determined by the bureau, but no later than July 1, 2018, the applicant shall complete the assessment, as specified in this section.

(c) (1) The bureau shall implement a process to administer the assessment specified in this section by January 1, 2018. The establishment of the assessment and the process for administering the assessment shall not be subject to the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) The bureau shall consult with a California licensed psychologist, psychologists, or other persons with subject matter expertise, whose minimum duties shall include, but are not limited to, assisting the bureau with all of the following:

(A) Establishing criteria for a contract with a vendor to administer the assessment.

(B) Identifying minimum standards for the assessment.

(C) Evaluating currently available assessments.

(D) Providing consultative services on the bids received by the bureau from third-party vendors seeking to administer and interpret the assessment, to ensure both of the following:

(i) Compliance with the applicable standards of care for the administration and interpretation of such assessments.

(ii) The assessment will be administered in accordance with the assessment manufacturer’s requirements.

(3) The bureau shall contract with a third-party vendor to administer the assessment. All third-party vendors seeking to administer the assessment must meet the minimum standards established by the bureau, its consultants, and the assessment manufacturer’s requirements for administering the assessment. Considerations for the third-party vendor contract shall include, but are not limited to, all of the following:
(A) Cost to the applicant to complete the assessment.
(B) Geographic accessibility statewide of the assessment to applicants.
(C) Assessment compliance with the established minimum standards for the assessment and assessment process.
(D) Ensuring an assessment carried out on an applicant complies with the applicable professional standards of care for such assessments, as well as the assessment manufacturer’s requirements for administering the assessment.
(d) Upon the bureau’s verification that the applicant has satisfied subdivisions (a) to (f), inclusive, of Section 7583.23 and upon the applicant’s clearance of a background check by the Department of Justice and the Federal Bureau of Investigation to possess a firearm, the bureau shall notify the applicant that he or she is to contact the bureau’s vendor to complete the assessment. The applicant, or his or her designee or employer if the employer voluntarily chooses, shall bear the cost of the assessment.
(e) Within 30 days of administering an applicant’s assessment, the vendor shall directly provide the bureau, on a form and in a manner prescribed by the bureau, the applicant’s assessment results. If the results of the applicant’s assessment indicate that he or she is incapable of exercising appropriate judgment, restraint, and self-control for the purposes of carrying and using a firearm during the course of his or her duties, at the point in time of the evaluation, the bureau shall not issue a firearms permit.
(f) The application shall be deemed incomplete until the bureau receives the applicant’s results of his or her assessment.
(g) The bureau may prescribe, adopt, and enforce emergency regulations, and promulgate regulations to implement this section. Any emergency regulation prescribed, adopted, or enforced pursuant to this section shall be adopted in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, and for purposes of that chapter, including Section 11349.6 of the Government Code, the adoption of the regulation is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, and general welfare.
(h) The assessment required pursuant to this section shall be subject to review by the appropriate policy committees of the
Legislature. The review shall be performed as if this section was
scheduled to be repealed as of January 1, 2020.

SEC. 39. Section 7585.16 of the Business and Professions Code
is amended to read:

7585.16. (a) In the event of the loss, theft, or destruction of a
baton permit, a permitholder may request the bureau to issue a
replacement permit. The request shall be in writing, shall state the
circumstances surrounding the loss, theft, or destruction of the
permit and the name of the instructor, training facility, and date
of instruction relating to the issuance of the original baton permit.
The request shall be accompanied by a five dollar ($5) replacement
fee. The bureau may issue a replacement baton permit upon
verification of successful baton training.

(b) This section shall become inoperative on July 1, 2018, and,
as of January 1, 2019, is repealed.

SEC. 40. Section 7585.16 is added to the Business and
Professions Code, to read:

7585.16. (a) In the event of the loss, theft, or destruction of a
baton permit, a permitholder may request the bureau to issue a
replacement permit. The request shall be in writing, shall state the
circumstances surrounding the loss, theft, or destruction of the
permit and the name of the instructor, training facility, and date
of instruction relating to the issuance of the original baton permit.
The request shall be accompanied by a fee prescribed in this
chapter. The bureau may issue a replacement baton permit upon
verification of successful baton training.

(b) This section shall become operative on July 1, 2018.

SEC. 41. Section 7588 of the Business and Professions Code
is amended to read:

7588. The fees prescribed by this chapter are as follows:
(a) The application and examination fee for an original license
for a private patrol operator may not exceed five hundred dollars
($500).

(b) The application fee for an original branch office certificate
for a private patrol operator may not exceed two hundred fifty
dollars ($250).

(c) The fee for an original license for a private patrol operator
may not exceed seven hundred dollars ($700).

(d) The renewal fee is as follows:
For a license as a private patrol operator, the fee may not exceed seven hundred dollars ($700).

(2) For a branch office certificate for a private patrol operator, the fee may not exceed seventy-five dollars ($75).

(e) The delinquency fee is 50 percent of the renewal fee in effect on the date of expiration.

(f) A reinstatement fee is equal to the amount of the renewal fee plus the regular delinquency fee.

(g) The fee for reexamination of an applicant or his or her manager shall be the actual cost to the bureau for developing, purchasing, grading, and administering each examination.

(h) Registration fees pursuant to this chapter are as follows:

(1) A registration fee for a security guard shall not exceed fifty dollars ($50).

(2) A security guard registration renewal fee shall not exceed thirty-five dollars ($35).

(i) Fees to carry out other provisions of this chapter are as follows:

(1) A firearms qualification fee may not exceed eighty dollars ($80).

(2) A firearms requalification fee may not exceed sixty dollars ($60).

(3) An initial baton certification fee may not exceed fifty dollars ($50).

(4) An application fee and renewal fee for certification as a firearms training facility or a baton training facility may not exceed five hundred dollars ($500).

(5) An application fee and renewal fee for certification as a firearms training instructor or a baton training instructor may not exceed two hundred fifty dollars ($250).

(j) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 42. Section 7588 is added to the Business and Professions Code, to read:

7588. The fees prescribed by this chapter are as follows:

(a) The application and examination fee for an original license for a private patrol operator shall be at least five hundred fifty dollars ($550) and may be increased to an amount not to exceed six hundred fifty dollars ($605).
(b) The application fee for an original branch office certificate for a private patrol operator shall be at least two hundred fifty dollars ($250) and may be increased to an amount not to exceed two hundred seventy-five dollars ($275).

(c) The fee for an original license for a private patrol operator shall be at least seven hundred seventy dollars ($770) and may be increased to an amount not to exceed eight hundred forty-seven dollars ($847).

(d) The renewal fee is as follows:

1. For a license as a private patrol operator, the fee shall be at least nine hundred dollars ($900) and may be increased to an amount not to exceed nine hundred ninety dollars ($990).
2. For a branch office certificate for a private patrol operator, the fee shall be at least one hundred fifty dollars ($150) and may be increased to an amount not to exceed one hundred sixty-five dollars ($165).

(e) The delinquency fee is 50 percent of the renewal fee in effect on the date of expiration but not less than twenty-five dollars ($25).

(f) A reinstatement fee is equal to the amount of the renewal fee plus the regular delinquency fee.

(g) The fee for reexamination of an applicant or his or her manager shall be at least sixty dollars ($60) and may be increased to an amount not to exceed sixty-six dollars ($66).

(h) Registration fees pursuant to this chapter are as follows:

1. A registration fee for a security guard shall be at least fifty-five dollars ($55) and may be increased to an amount not to exceed sixty dollars ($60).
2. A security guard registration renewal fee shall be at least forty dollars ($40) and may be increased to an amount not to exceed forty-four dollars ($44).

(i) Fees to carry out other provisions of this chapter are as follows:

1. A firearms permit fee shall be at least one hundred dollars ($100) and may be increased to an amount not to exceed one hundred ten dollars ($110).
2. A firearms permit renewal fee shall be at least eighty dollars ($80) and may be increased to an amount not to exceed eighty-eight dollars ($88).
(3) An initial baton permit fee shall be sixty dollars ($60) and may be increased to an amount not to exceed sixty-six dollars ($66).

(4) An application fee for certification as a firearms training facility shall be at least eight hundred dollars ($800) and may be increased to an amount not to exceed eight hundred eighty dollars ($880).

(5) A renewal fee for certification as a firearms training facility shall be at least seven hundred fifty dollars ($750) and may be increased to an amount not to exceed eight hundred twenty-five dollars ($825).

(6) An application fee for certification as a baton training facility shall be at least seven hundred dollars ($700) and may be increased to an amount not to exceed seven hundred seventy dollars ($770).

(7) A renewal fee for certification as a baton training facility shall be at least five hundred fifty dollars ($550) and may be increased to an amount not to exceed six hundred five dollars ($605).

(8) An application fee for certification as a firearms or baton training instructor shall be at least three hundred fifty dollars ($350) and may be increased to an amount not to exceed three hundred eighty-five dollars ($385).

(9) A renewal fee for certification as a firearms training instructor shall be at least three hundred dollars ($300) and may be increased to an amount not to exceed three hundred thirty dollars ($330).

(10) A renewal fee for certification as a baton training instructor shall be at least two hundred seventy-five dollars ($275) and may be increased to an amount not to exceed three hundred three dollars ($303).

(11) The fee for the replacement of a lost or destroyed registration card, license, certificate, or permit authorized by this chapter shall be twenty-five dollars ($25). The request for a replacement of a registration card, license, certificate, or permit shall be made in the manner prescribed by the bureau.

(12) The fee for a Certificate of Licensure, as specified in Section 7582.11, shall be twenty-five dollars ($25).

(j) The fee for an endorsed verification of registration, licensure, certification, or permit shall be twenty-five dollars ($25).
verification document shall include the registration, license, certificate, or permit number, the date of issuance and expiration of the registration, license, certificate, or permit, the current registration, license, certificate, or permit status, the date of the endorsement, an embossed seal, and the signature of the chief.

(k) This section shall become operative on July 1, 2018.

SEC. 43. Section 7596.5 of the Business and Professions Code is amended to read:

7596.5. (a) The firearms qualification card shall be mailed to the applicant at the address which appears on the application. In the event of the loss or destruction of the card, the cardholder may apply to the bureau for a certified replacement of the card, stating the circumstances surrounding the loss, and pay a ten dollar ($10) certification fee, whereupon, the bureau shall issue a certified replacement of the card.

(b) This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 44. Section 7596.5 is added to the Business and Professions Code, to read:

7596.5. (a) The firearms qualification card shall be mailed to the applicant at the address that appears on the application.

(b) This section shall become operative on July 1, 2018.

SEC. 45. Section 7598.14 of the Business and Professions Code is amended to read:

7598.14. (a) Upon approval of an application for registration, the chief shall cause to be issued to the applicant, at his or her last known address, a registration card in a form approved by the director. A photo identification card shall be issued upon written request of the applicant, submission of two recent photographs of the applicant, and payment of the fee. The applicant may request to be issued an enhanced pocket card that shall be composed of a durable material and may incorporate technologically advanced security features. The bureau may charge a fee sufficient to reimburse the department’s costs for furnishing the enhanced license. The fee charged may not exceed the actual costs for system development, maintenance, and processing necessary to provide this service, and may not exceed six dollars ($6). If the applicant does not request an enhanced card, the department shall issue a standard card at no cost to the applicant. In the event of the loss or destruction of the card, the cardholder may apply to the bureau
for a certified replacement of the card, stating the circumstances
surrounding the loss, and pay a ten dollar ($10) certification fee,
whereupon the bureau shall issue a certified replacement of the
card. Every person, while engaged in any activity for which
registration is required, shall display their valid pocket card as
provided by regulation.
(b) This section shall become inoperative on July 1, 2018, and,
as of January 1, 2019, is repealed.

SEC. 46. Section 7598.14 is added to the Business and
Professions Code, to read:
7598.14. (a) Upon approval of an application for registration,
the chief shall cause to be issued to the applicant, at his or her
last known address, a registration card in a form approved by the
director. A photo identification card shall be issued upon written
request of the applicant, submission of two recent photographs of
the applicant, and payment of the fee. The applicant may request
to be issued an enhanced pocket card that shall be composed of a
durable material and may incorporate technologically advanced
security features. The bureau may charge a fee sufficient to
reimburse the department’s costs for furnishing the enhanced
license. The fee charged may not exceed the actual costs for system
development, maintenance, and processing necessary to provide
this service, and may not exceed six dollars ($6). If the applicant
does not request an enhanced card, the department shall issue a
standard card at no cost to the applicant. Every person, while
engaged in any activity for which registration is required, shall
display their valid pocket card as provided by regulation.
(b) This section shall become operative on July 1, 2018.

SEC. 47. Section 7598.17 of the Business and Professions Code
is amended to read:
7598.17. (a) A registration issued under this chapter expires
two years following the date of issuance or on the assigned renewal
date. Every alarm agent issued a registration under this chapter
that expires on or after January 1, 1997, and who is also issued or
renews a firearms qualification card on or after January 1, 1997,
shall be placed on a cyclical renewal so that the registration expires
on the expiration date of the firearms qualification card.
Notwithstanding any other provision of law, the bureau is
authorized to extend or shorten the first term of registration
following January 1, 1997, and to prorate the required registration
fee in order to implement this cyclical renewal. At least 60 days
prior to the expiration of a registration, a registrant who desires to
renew his or her registration shall forward to the bureau a copy of
his or her current registration card, along with the renewal fee as
set forth in this chapter, to the bureau for renewal of his or her
registration.

The

(b) The licensee shall provide to any employee information
regarding procedures for renewal of registration.

An

(c) An expired registration may be renewed provided the
registrant files a renewal application on a form prescribed by the
director and the renewal and delinquency fees prescribed by this
chapter are returned to the bureau within 60 days of the expiration
date of the registration. A firearms permit is not valid while the
registration is expired.

A

(d) A registration not renewed within 60 days following its
expiration may not be renewed thereafter. The holder of the expired
registration may obtain a new registration only on compliance with
all of the provisions of this chapter relating to the issuance of an
original registration. The delinquency fee is 50 percent of the
renewal fee in effect on the date of expiration, but not less than
twenty-five dollars ($25).

A

(e) The holder of an expired registration shall not engage in the
activity for which a registration is required until the bureau issues
a renewal registration.

A

(f) If the renewed registration card has not been delivered to the
registrant, prior to the date of expiration of the prior registration,
the registrant may present evidence of renewal to substantiate
continued registration, for a period not to exceed 90 days after the
date of expiration.

A

(g) A registration may not be renewed or reinstated until all
fines assessed pursuant to Section 7591.9 and not resolved in
accordance with the provisions of that section have been paid.

A
(h) A new registration shall be issued subject to payment of all fines assessed pursuant to Section 7591.9 and not resolved in accordance with the provisions of Section 7591.9 and payment of all applicable fees.

This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 48. Section 7598.17 is added to the Business and Professions Code, to read:

7598.17. (a) A registration issued under this chapter expires two years following the date of issuance or on the assigned renewal date. Every alarm agent issued a registration under this chapter that expires on or after January 1, 1997, and who is also issued or renews a firearms qualification card on or after January 1, 1997, shall be placed on a cyclical renewal so that the registration expires on the expiration date of the firearms qualification card. Notwithstanding any other law, the bureau is authorized to extend or shorten the first term of registration following January 1, 1997, and to prorate the required registration fee in order to implement this cyclical renewal. At least 60 days prior to the expiration of a registration, a registrant who desires to renew his or her registration shall forward to the bureau a copy of his or her current registration card, along with the renewal fee as set forth in this chapter, to the bureau for renewal of his or her registration.

(b) The licensee shall provide to any employee information regarding procedures for renewal of registration.

(c) An expired registration may be renewed provided the registrant files a renewal application on a form prescribed by the director and the renewal and delinquency fees prescribed by this chapter are returned to the bureau within 60 days of the expiration date of the registration. A firearms permit is not valid while the registration is expired.

(d) A registration not renewed within 60 days following its expiration may not be renewed thereafter. The holder of the expired registration may obtain a new registration only on compliance with all of the provisions of this chapter relating to the issuance of an original registration.

(e) The holder of an expired registration shall not engage in the activity for which a registration is required until the bureau issues a renewal registration.
(f) If the renewed registration card has not been delivered to the registrant prior to the date of expiration of the prior registration, the registrant may present evidence of renewal to substantiate continued registration, for a period not to exceed 90 days after the date of expiration.

(g) A registration may not be renewed or reinstated until all fines assessed pursuant to Section 7591.9 and not resolved in accordance with the provisions of that section have been paid.

(h) A new registration shall be issued subject to payment of all fines assessed pursuant to Section 7591.9 and not resolved in accordance with the provisions of Section 7591.9 and payment of all applicable fees.

(i) This section shall become operative on July 1, 2018.

SEC. 49. Section 7599.70 of the Business and Professions Code is amended to read:

> 7599.70. (a) Effective July 1, 1998, the bureau shall establish and assess fees and penalties for licensure and registration as follows:

(1) A company license application fee may not exceed thirty-five dollars ($35).

(2) An original license fee for an alarm company operator license may not exceed two hundred eighty dollars ($280). A renewal fee for an alarm company operator license may not exceed three hundred thirty-five dollars ($335).

(3) A qualified manager application and examination fee may not exceed one hundred five dollars ($105).

(4) A renewal fee for a qualified manager may not exceed one hundred twenty dollars ($120).

(5) An original license fee and renewal fee for a branch office certificate may not exceed thirty-five dollars ($35).

(6) Notwithstanding Section 163.5, the reinstatement fee as required by Sections 7593.12 and 7598.17 is the amount equal to the renewal fee plus a penalty of 50 percent thereof.
A fee for reexamination of an applicant for a qualified manager may not exceed two hundred forty dollars ($240).

An initial registration fee for an alarm agent may not exceed seventeen dollars ($17).

A registration renewal fee for an alarm agent may not exceed seven dollars ($7).

A firearms qualification fee may not exceed eighty dollars ($80) and a firearms requalification fee may not exceed sixty dollars ($60).

The fingerprint processing fee is that amount charged the bureau by the Department of Justice.

The processing fee required pursuant to Sections 7593.7 and 7598.14 is the amount equal to the expenses incurred to provide a photo identification card.

The fee for a “Certificate of Licensure” may not exceed fifty dollars ($50).

The delinquency fee is 50 percent of the renewal fee in effect on the date of expiration, but not less than twenty-five dollars ($25).

The processing fee for the assignment of an alarm company operator license pursuant to Section 7593.15 may not exceed one hundred twenty-five dollars ($125).

This section shall become inoperative on July 1, 2018, and, as of January 1, 2019, is repealed.

SEC. 50. Section 7599.70 is added to the Business and Professions Code, to read:

7599.70. (a) The bureau shall establish and assess fees and penalties for licensure and registration as follows:

(1) An alarm company operator license application fee shall be at least three hundred seventy dollars ($370) and may be increased to an amount not to exceed four hundred seven dollars ($407).
(2) An original license fee for an alarm company operator license shall be at least six hundred dollars ($600) and may be increased to an amount not to exceed six hundred sixty dollars ($660). A renewal fee for an alarm company operator license shall be seven hundred fifty dollars ($750) and may be increased to an amount not to exceed eight hundred twenty-five dollars ($825).

(3) A qualified manager certificate application and examination fee shall be at least three hundred fifty dollars ($350) and may be increased to an amount not to exceed three hundred eighty-five dollars ($385).

(4) A renewal fee for a qualified manager certificate shall be at least two hundred twenty-five dollars ($225) and may be increased to an amount not to exceed two hundred forty-eight dollars ($248).

(5) An original license fee for a branch office certificate shall be at least two hundred fifty dollars ($250) and may be increased to an amount not to exceed two hundred seventy-five dollars ($275). A renewal fee for a branch office certificate shall be at least one hundred fifty dollars ($150) and may be increased to an amount not to exceed one hundred sixty-five dollars ($165).

(6) Notwithstanding Section 163.5, the reinstatement fee as required by Sections 7593.12 and 7598.17 is the amount equal to the renewal fee plus a penalty of 50 percent thereof.

(7) A fee for reexamination of an applicant for a qualified manager shall be at least sixty dollars ($60) and may be increased to an amount not to exceed sixty-six dollars ($66).

(8) An initial registration fee for an alarm agent shall be at least fifty-five dollars ($55) and may be increased to an amount not to exceed sixty dollars ($60).

(9) A registration renewal fee for an alarm agent shall be at least forty dollars ($40) and may be increased to an amount not to exceed forty-four dollars ($44).

(10) A firearms permit fee shall be at least one hundred dollars ($100) and may be increased to an amount not to exceed one hundred ten dollars ($110), and a firearms permit renewal fee shall be at least eighty dollars ($80) and may be increased to an amount not to exceed eighty-eight dollars ($88).

(11) The fingerprint processing fee is that amount charged the bureau by the Department of Justice.
(12) The processing fee required pursuant to Sections 7593.7 and 7598.14 is the amount equal to the expenses incurred to provide a photo identification card.

(13) The fee for a Certificate of Licensure, as specified in Section 7593.8, shall be twenty-five dollars ($25).

(14) The delinquency fee is 50 percent of the renewal fee in effect on the date of expiration, but not less than twenty-five dollars ($25).

(15) The processing fee for the assignment of an alarm company operator license pursuant to Section 7593.15 shall be at least four hundred dollars ($400) and may be increased to an amount not to exceed four hundred forty dollars ($440).

(16) The fee for the replacement of a lost or destroyed registration card, license, certificate, or permit authorized by this chapter shall be twenty-five dollars ($25). The request for a replacement of a registration card, license, certificate, or permit shall be made in the manner prescribed by the bureau.

(17) The fee for an endorsed verification of licensure, certification, registration, or permit shall be twenty-five dollars ($25). The verification document shall include the license, certificate, registration, or permit number, the date of issuance and expiration of the license, certificate, registration, or permit, the current license, certificate, registration, or permit status, the date of the endorsement, an embossed seal, and the signature of the chief.

(b) This section shall become operative on July 1, 2018.

SEC. 13. Section 7635 of the Business and Professions Code is amended to read:

7635. (a) Any person employed by, or an agent of, a licensed funeral establishment, who consults with the family or representatives of a family of a deceased person for the purpose of arranging for services as set forth in subdivision (a) of Section 7615, shall receive documented training and instruction, at least once every three years, that results in a demonstrated knowledge of all applicable federal and state laws, rules, and regulations including those provisions dealing with vital statistics, the coroner, anatomical gifts, and other laws, rules, and regulations pertaining to the duties of a funeral director. A written outline of the training program, including documented evidence of the training time,
place, and participants, shall be maintained in the funeral
establishment and shall be available for inspection and comment
by an inspector of the bureau.
(b) This section shall not apply to anyone who has successfully
passed the funeral director’s examination pursuant to Section 7622.

SEC. 14.
SEC. 52. Section 11302 of the Business and Professions Code
is amended to read:
11302. For the purpose of applying this part, the following
terms, unless otherwise expressly indicated, shall mean and have
the following definitions:
(a) “Affiliate” means any entity that controls, is controlled by,
or is under common control with another entity.
(b) “Appraisal” means the act or process of developing an
opinion of value for real property.
The term “appraisal” does not include an opinion given by a real
estate licensee or engineer or land surveyor in the ordinary course
of his or her business in connection with a function for which a
license is required under Chapter 7 (commencing with Section
6700) or Chapter 15 (commencing with Section 8700) of Division
3, or Chapter 3 (commencing with Section 10130) or Chapter 7
(commencing with Section 10500) and the opinion shall not be
referred to as an appraisal. This part does not apply to a probate
referee acting pursuant to Sections 400 to 408, inclusive, of the
Probate Code unless the appraised transaction is federally related.
(c) “Appraisal Foundation” means the Appraisal Foundation
that was incorporated as an Illinois not-for-profit corporation on
(d) (1) “Appraisal management company” means any person
or entity that satisfies all of the following conditions:
(A) Provides appraisal management services to creditors or to
secondary mortgage market participants, including affiliates.
(B) Provides those services in connection with valuing a
consumer’s principal dwelling as security for a consumer credit
transaction or incorporating such transactions into securitizations.
(C) Within a given 12 calendar month period oversees an
appraiser panel of more than 15 state-certified or state-licensed
State licensed appraisers in a state or 25 or more
State certified appraisers or—State licensed
appraisers in two or more States, as described in Section 11345.5.
(2) An appraisal management company does not include a department or division of an entity that provides appraisal management services only to that entity.
(3) An appraisal management company that is a subsidiary of an insured depository institution and regulated by a federal financial institution is not required to register with the bureau.
(e) “Appraisal management services” means one or more of the following:
(1) Recruiting, selecting, and retaining appraisers.
(2) Contracting with state-certified or state-licensed appraisers to perform appraisal assignments.
(3) Managing the process of having an appraisal performed, including providing administrative services such as receiving appraisal orders and appraisal reports, submitting completed appraisal reports to creditors and secondary market participants, collecting fees from creditors and secondary market participants for services provided, and paying appraisers for services performed.
(4) Reviewing and verifying the work of appraisers.
(f) “Appraiser panel” means a network, list, or roster of licensed or certified appraisers approved by an appraisal management company to perform appraisals as independent contractors for the appraisal management company. Appraisers on an appraisal management company’s “appraiser panel” under this part include both appraisers accepted by the appraisal management company for consideration for future appraisal assignments in covered transactions or for secondary mortgage market participants in connection with covered transactions, and appraisers engaged by the appraisal management company to perform one or more appraisals in covered transactions or for secondary mortgage market participants in connection with covered transactions. An appraiser is an independent contractor for purposes of this part if the appraiser is treated as an independent contractor by the appraisal management company for purposes of federal income taxation.
(g) “Appraisal Subcommittee” means the Appraisal Subcommittee of the Federal Financial Institutions Examination Council.
(h) “Consumer credit” means credit offered or extended to a consumer primarily for personal, family, or household purposes.

(i) “Controlling person” means one or more of the following:

(1) An officer or director of an appraisal management company, or an individual who holds a 10 percent or greater ownership interest in an appraisal management company.

(2) An individual employed, appointed, or authorized by an appraisal management company that has the authority to enter into a contractual relationship with clients for the performance of appraisal services and that has the authority to enter into agreements with independent appraisers for the completion of appraisals.

(3) An individual who possesses the power to direct or cause the direction of the management or policies of an appraisal management company.

(j) “Course provider” means a person or entity that provides educational courses related to professional appraisal practice.

(k) “Covered transaction” means any consumer credit transaction secured by the consumer's principal dwelling.

(l) “Creditor” means:

(1) A person who regularly extends consumer credit that is subject to a finance charge or is payable by written agreement in more than four installments, not including a down payment, and to whom the obligation is initially payable, either on the face of the note or contract, or by agreement when there is no note or contract.

(2) A person regularly extends consumer credit if, in any 12–month period, the person originates more than one credit extension for transactions secured by a dwelling.

(m) “Department” means the Department of Consumer Affairs.

(n) “Director” or “chief” means the Chief of the Bureau of Real Estate Appraisers.

(o) “Dwelling” means:

(1) A residential structure that contains one to four units, whether or not that structure is attached to real property. The term includes an individual condominium unit, cooperative unit, mobile home, mobilehome, and trailer, if it is used as a residence.

(2) A consumer can have only one “principal” dwelling at a time. Thus, a vacation or other second home is not a principal dwelling. However, if a consumer buys or builds a new dwelling
that will become the consumer’s principal dwelling within a year or upon the completion of construction, the new dwelling is considered the principal dwelling for purposes of this section.

(p) “Federal financial institutions regulatory agency” means the Federal Reserve Board, Federal Deposit Insurance Corporation, Office of the Comptroller of the Currency, Federal Home Loan Bank System, National Credit Union Administration, and any other agency determined by the director to have jurisdiction over transactions subject to this part.

(q) “Federally regulated appraisal management company” means an appraisal management company that is owned and controlled by an insured depository institution, as defined in Section 1813 of Title 12 of the United States Code and regulated by the Office of the Comptroller of the Currency, the Board of Governors of the Federal Reserve System, or the Federal Deposit Insurance Corporation.

(r) “Federally related real estate appraisal activity” means the act or process of making or performing an appraisal on real estate or real property in a federally related transaction and preparing an appraisal as a result of that activity.

(s) “Federally related transaction” means any real estate-related financial transaction which a federal financial institutions regulatory agency engages in, contracts for or regulates and which requires the services of a state licensed real estate appraiser regulated by this part. This term also includes any transaction identified as such by a federal financial institutions regulatory agency.

(t) “License” means any license, certificate, permit, registration, or other means issued by the bureau authorizing the person to whom it is issued to act pursuant to this part within this state.

(u) “Licensure” means the procedures and requirements a person shall comply with in order to qualify for issuance of a license and includes the issuance of the license.

(v) “Office” or “bureau” means the Bureau of Real Estate Appraisers.

(w) “Registration” means the procedures and requirements with which a person or entity shall comply in order to qualify to conduct business as an appraisal management company.

(x) “Secondary mortgage participant” means a guarantor or insurer of mortgage-backed securities, or an underwriter or issuer
of mortgage-backed securities. Secondary mortgage market participant only includes an individual investor in a mortgage-backed security if that investor also serves in the capacity of a guarantor, insurer, underwriter, or issuer for the mortgage-backed security.

(y) “State licensed real estate appraiser” is a person who is issued and holds a current valid license under this part.

(z) “Uniform Standards of Professional Appraisal Practice” are the standards of professional appraisal practice established by the Appraisal Foundation.

SEC. 15.

SEC. 53. Section 11320.5 of the Business and Professions Code is amended to read:

11320.5. No person or entity shall act in the capacity of an appraisal management company or represent itself to the public as an appraisal management company, either in its advertising or through its business name, without a certificate of registration from the office.

SEC. 16.

SEC. 54. Section 11321 of the Business and Professions Code is amended to read:

11321. (a) No person other than a state licensed real estate appraiser may assume or use that title or any title, designation, or abbreviation likely to create the impression of state licensure as a real estate appraiser in this state.

(b) No person other than a licensee may sign an appraisal in a federally related transaction. A trainee licensed pursuant to Section 11327 may sign an appraisal in a federally related transaction if it is also signed by a licensee.

(c) No person other than a licensee holding a current valid license at the residential level issued under this part to perform, make, or approve and sign an appraisal may use the abbreviation SLREA in his or her real property appraisal business.

(d) No person other than a licensee holding a current valid license at a certified level issued under this part to perform, make, or approve and sign an appraisal may use the term “state certified real estate appraiser” or the abbreviation SCREA in his or her real property appraisal business.
SEC. 17.

SEC. 55. Section 11323 of the Business and Professions Code is amended to read:

11323. No licensee shall engage in any appraisal activity if his or her compensation is dependent on or affected by the value conclusion generated by the appraisal.

SEC. 18.

SEC. 56. Section 11324 of the Business and Professions Code is amended to read:

11324. An individual who is not a licensee may assist in the preparation of an appraisal in a federally related transaction under the following conditions:

(a) The assistance is under the direct supervision of an individual who is a licensed appraiser and the final conclusion as to value is made by a licensed appraiser.

(b) The final appraisal document in a federally related transaction is approved and signed, with acceptance of full responsibility, by the supervising individual who is licensed by the state pursuant to this part, identifies the assisting individual, and identifies the scope of work performed by the individual who assisted in preparation of the appraisal in a federally related transaction.

SEC. 19.

SEC. 57. Section 11345 of the Business and Professions Code is amended to read:

11345. The director shall adopt regulations governing the process and procedure of applying for registration as an appraisal management company. Applications for a certificate of registration shall require, at a minimum, all of the following:

(a) The name of the person or entity seeking registration.

(b) The business address and telephone number of the person or entity seeking registration.

(c) If the applicant is not a person or entity domiciled in this state, the name and contact number of a person or entity acting as agent for service of process in this state, along with an irrevocable consent to service of process in favor of the office.

(d) The name, address, and contact information for each controlling person of the applicant who has operational authority to direct the management of, and establish policies for, the applicant.
SEC. 20.  
SEC. 58. Section 11345.2 of the Business and Professions Code is amended to read:

11345.2. (a) An individual shall not act as a controlling person for a registrant if any of the following apply:

(1) The individual has entered a plea of guilty or no contest to, or been convicted of, a felony. Notwithstanding subdivision (c) of Section 480, if the individual’s felony conviction has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code, the bureau may allow the individual to act as a controlling person.

(2) The individual has had a license or certificate to act as an appraiser or to engage in activities related to the transfer of real property refused, denied, canceled, or revoked in this state or any other state.

(b) Any individual who acts as a controlling person of an appraisal management company and who enters a plea of guilty or no contest to, or is convicted of, a felony, or who has a license or certificate as an appraiser refused, denied, canceled, or revoked in any other state shall report that fact or cause that fact to be reported to the office, in writing, within 10 days of the date he or she has knowledge of that fact.

SEC. 21.  
SEC. 59. Section 11345.3 of the Business and Professions Code is repealed.

SEC. 22.  
SEC. 60. Section 11345.3 is added to the Business and Professions Code, to read:

11345.3. All appraisal management companies shall do all of the following:

(a) Ensure that all contracted appraisal panel members possess all required licenses and certificates from the office.

(b) Establish and comply with processes and controls reasonably designed to ensure that the appraisal management company, in engaging an appraiser, selects an appraiser who is independent of the transaction and who has the requisite license, education, expertise, and experience necessary to competently complete the appraisal assignment for the particular market and property type.
(c) Direct the appraiser to perform the assignment in accordance with the Uniform Standards of Professional Appraisal Practice.

(d) Establish and comply with processes and controls reasonably designed to ensure that the appraisal management company conducts its appraisal management services in accordance with the requirements of Section 129E(a) through (i) of the Truth in Lending Act, 15 U.S.C. 1639e(a) through (i), and regulations thereunder.

(e) Engage appraisal panel members with an engagement letter that shall include terms of payment.

(f) Appraisal management companies shall maintain all of the following records for each service request:

1. Date of receipt of the request.
2. Name of the person from whom the request was received.
3. Name of the client for whom the request was made, if different from the name of the person from whom the request was received.
4. The appraiser or appraisers assigned to perform the requested service.
5. Date of delivery of the appraisal product to the client.
6. Client contract.
8. The appraisal report.

SEC. 23.

SEC. 61. Section 11345.5 is added to the Business and Professions Code, to read:

11345.5. For purposes of subdivision (d) of Section 11302 and determining whether, within a 12-month period, an appraisal management company oversees an appraiser panel of more than 15 State-certified or State-licensed appraisers in a State or 25 or more State-certified or State-licensed appraisers in two or more States:

(a) An appraiser is deemed part of the appraisal management company’s appraiser panel as of the earliest date on which the appraisal management company does either of the following:

1. Accepts the appraiser for the appraisal management company’s consideration for future appraisal assignments in

SEC. 23.
covered transactions or for secondary mortgage market participants
in connection with covered transactions.

(2) Engages the appraiser to perform one or more appraisals on
behalf of a creditor for a covered transaction or secondary mortgage
market participant in connection with covered transactions.

(b) An appraiser who is deemed part of the appraisal
management company’s appraiser panel pursuant to subdivision
(a) is deemed to remain on the panel until the date on which the
appraisal management company does either of the following:

(1) Sends written notice to the appraiser removing the appraiser
from the appraiser panel, with an explanation of its action.

(2) Receives written notice from the appraiser asking to be
removed from the appraiser panel or notice of the death or
incapacity of the appraiser.

(c) If an appraiser is removed from an appraisal management
company’s appraiser panel pursuant to subdivision (b), but the
appraisal management company subsequently accepts the appraiser
for consideration for future assignments or engages the appraiser
at any time during the 12 months after the appraisal management
company’s removal, the removal will be deemed not to have
occurred, and the appraiser will be deemed to have been part of
the appraisal management company’s appraiser panel without
interruption.

SEC. 24.
SEC. 62. Section 11345.6 of the Business and Professions Code
is amended to read:

11345.6. (a) No appraisal management company may alter,
modify, or otherwise change a completed appraisal report submitted
by an appraiser.

(b) No appraisal management company may require an appraiser
to provide it with the appraiser’s digital signature or seal. However,
nothing in this subdivision shall be deemed to prohibit an appraiser
from voluntarily providing his or her digital signature or seal to
another person, to the extent permissible under the Uniform
Standards of Professional Appraisal Practice.

SEC. 25.
SEC. 63. Section 11345.8 is added to the Business and
Professions Code, to read:

11345.8. A federally regulated appraisal management company
operating in California shall report to the bureau the information
the bureau is required to submit to the Appraisal Subcommittee, pursuant to the Appraisal Subcommittee’s policies regarding the determination of the Appraisal Management Company Registry fee. The bureau may charge the federally regulated appraisal management company a state fee in an amount not to exceed the reasonable regulatory cost to the board for processing and submitting the information. This fee shall be deposited in the Real Estate Appraisers Regulation Fund.

SEC. 26.
SEC. 64. Section 11422 of the Business and Professions Code is amended to read:

11422. The office shall, on or before February 1, 1994, and at least annually thereafter, transmit to the appraisal subcommittee specified in subdivision (g) of Section 11302 a roster of persons licensed pursuant to this part.

SEC. 27.
SEC. 65. Section 12241 of the Business and Professions Code is amended to read:

12241. The secretary shall establish by regulation an annual administrative fee to recover reasonable administrative and enforcement costs incurred by the department for exercising supervision over and performing investigations in connection with the activities performed pursuant to Sections 12210 and 12211 and to recover reasonable costs incurred by the department for the safekeeping and certification of the state standards pursuant to Section 12304 and for certification services provided pursuant to Sections 12305 and 12310. This administrative fee shall be collected for every device registered with each county office of weights and measures, and paid to the Department of Food and Agriculture Fund.

SEC. 28.
SEC. 66. Section 12304 of the Business and Professions Code is amended to read:

12304. The department shall keep the standards of the state in a suitable laboratory location or, if transportable, shall maintain the standards under environmental conditions appropriate for maintaining the integrity of the unit of measure represented by the standard. The department shall have the standards directly certified by the National Institute of Standards and Technology or by any
measurement assurance procedures approved by the National
Institute of Standards and Technology.

SEC. 29.

SEC. 67. Section 12305 of the Business and Professions Code
is amended to read:

12305. The department shall use the standards of the state to
certify similar standards and any dissimilar standards that are
dependent on the values represented by the state standards. Copies
of the standards that have been compared and certified against the
state standards shall become working standards that shall be used
in the certification, calibration, and sealing of county field
standards, and in the certification, calibration, and sealing of
measurement devices submitted by state and local government
agencies or by industry.

SEC. 30.

SEC. 68. Section 12310 of the Business and Professions Code
is amended to read:

12310. The department, or a laboratory designated by the
department that has been certified pursuant to Section 12314, shall
certify the standards of the county sealers as often as may be
deemed by the secretary to be necessary, based upon a review of
statistical data resulting from previous certifications, but in no
event shall the period of time between certifications exceed 10
years. In the absence of statistical data, standards shall be certified
at least every two years. Sealers shall, upon the request of the
department, deliver for testing those standards in their possession
that are used in the discharge of their duties. Direct expenses
incurred in the certification process shall be borne by the state or
recovered pursuant to Section 12241, while any incidental expense,
such as the cost of transportation, shall be borne by the county
whose standards have been certified.

SEC. 31.

SEC. 69. Section 12500 of the Business and Professions Code
is amended to read:

12500. As used in this chapter the following terms mean:
(a) “Weighing instrument” means any device, contrivance,
apparatus, or instrument used, or designed to be used, for
ascertaining weight and includes any tool, appliance, or accessory
used or connected therewith.
(b) “Measuring instrument” means any device, contrivance, apparatus, or instrument used, or designed to be used, for ascertaining measure and includes any tool, appliance, or accessory used or connected therewith.

(c) “Correct” means any weight or measure or weighing, measuring, or counting instrument which meet all of the tolerance and specification requirements established by the director pursuant to Section 12107.

(d) “Incorrect” means any instrument which fails to meet all of the requirements of Section 12107.

(e) “Commercial purposes” include the determination of the weight, measure, or count of any commodity or thing which is sold on the basis of weight, measure, or count; or the determination of the weight, measure, or count of any commodity or thing upon which determination a charge for service is based. Devices used in a determination upon which a charge for service is based include, but are not limited to, taximeters, odometers, timing devices, parcel scales, shipping scales, and scales used in the payment of agricultural workers.

“Commercial purposes” do not include the determination of the weight, measure, or count of any commodity or thing which is performed within a plant or business as a part of the manufacturing, processing, or preparing for market of that commodity or thing, or the determination of charges for the transmission of letters or parcels of less than 150 pounds, except when that determination is made in the presence of the customer charged for the service, or the determination of the weight of any animal or human by a qualified health provider, licensed doctor of veterinary medicine, California-licensed veterinarian, licensed physician and surgeon, or staff members within the business operations of, and under the supervision of, a licensed doctor of veterinary medicine California-licensed veterinarian or licensed physician and surgeon for the purposes of determining the appropriate dosage of any medication or medical treatment or the volume, duration, or application of any medical procedure.

SEC. 70. Section 1 of Chapter 539 of the Statutes of 2010 is amended to read:

SECTION 1. Section 12 of the act cited in this title is amended to read:

See 12—
Sec. 12. (a) Licenses issued under the provisions of this section expire at 12 midnight on the last day of the month of birth of licentiates of the board.

(b) The board shall establish regulations for the administration of a birth month renewal program. Each person practicing chiropractic within this state shall, on or before the last day of their the person’s month of birth of each year, after a license is issued to them as herein provided, the person under this act, pay to the Board of Chiropractic Examiners a renewal fee of two hundred fifty dollars ($250). The renewal fee specified under subdivision (d).

(d) (1) Until January 1, 2019, the renewal fee shall be three hundred dollars ($300).

(2) On and after January 1, 2019, the renewal fee shall be two hundred fifty dollars ($250).

(e) The secretary shall mail to all a licensed chiropractor in this state, on or before 60 days prior to the last day of their the licensee’s birth each year, a notice that the renewal fee will be due on or before the last day of the next month of their birth next following, following the licensee’s birth. Nothing in this act shall be construed to require the receipts to be recorded in like manner as original licenses. The

(f) The failure, neglect or refusal of any a person holding a license or certificate to practice under this act in the State of California to pay the annual fee during the time their the license remains in force shall, after a period of 60 days from the last day of their the licensee’s birth, automatically work a forfeiture of his or her the license or certificate, and it shall not be restored except upon the written application therefor and the payment to the board of a fee of twice the annual amount of the renewal fee in effect at the time the restoration application is filed except that a-licentiate licensee who fails, refuses refuses, or neglects to pay the annual tax within a period of 60 days after the last day of the month of his or her the licensee’s birth of each year shall not be required to submit to an examination for the reissuance of the certificate.

SEC. 32.

SEC. 71. No reimbursement is required by this act pursuant to Section 6 of Article XIIIIB 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.
SUMMARY:
This bill requires Department of Consumer Affairs (DCA) to review the existing criteria set for Uniform Standard 4 regarding substance testing and determine whether the existing criteria should be updated to reflect recent developments in testing research and technology.

ANALYSIS:

Existing law:
- Establishes the Substance Abuse Coordination Committee (Committee) within DCA to formulate uniform specific standards, which each healing arts board is required to use in dealing with substance-abusing licensees.
- Requires the Committee to formulate uniform standards by January 1, 2010 in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees. This includes standards governing all aspects of required drug testing.

This bill would:
- Require the Committee to review the existing criteria for those standards governing all aspects of substance testing to determine whether the existing criteria should be updated to reflect recent developments in testing research and technology.

Fiscal Impact:
- No significant costs anticipated

Comments:
- BRN monitors about 956 substance abusing RNs (either in the Probation Program or in the Intervention Program), who are all required to submit to substance testing.
- BRN has submitted for DCA’s review a proposed regulatory packet, which includes amendments to incorporate the Uniform Standards into the “Recommended Guidelines for Disciplinary Orders and Conditions of Probation.”
**BOARD POSITION:** Not previously considered

**LEGISLATIVE COMMITTEE RECOMMENDED POSITION:** Watch (8/9/2017)

**SUPPORT:**
- Bastyr University
- California Naturopathic Doctors Association
- Respiratory Care Board of California
- Naturopathic Medicine Committee
- Southern California University of Health Sciences
- State of Utah Division of Occupational and Professional Licensing
- State of Washington Board of Naturopathy

**OPPOSE:**
- American Naturopathic Medical Association
- California Health Freedom Coalition
- California Naturopathic Association
- Natural Health Freedom Action
- Natural Healing Institute of Naturopathy, Inc.
- Sunshine Health Freedom Foundation
- Numerous individuals
An act to amend Sections 315, 2450.3, 3621, 3630, 3635, 3644, 3660, 3680, 3686, 3710, 3716, and 3772 of, to add Sections 3635.1 and 3635.2 to, and to repeal Section 3645 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST


(1) The Department of Consumer Affairs is comprised of healing arts boards that are responsible for the licensure and regulation of healing arts licensees. Under existing law, the Substance Abuse Coordination Committee is created within the department and the committee is required to formulate uniform and specific standards in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees. Existing law, by January 1, 2010, requires the committee to formulate uniform and specific standards in specified areas, including standards governing all aspects of required testing, that each healing arts board is required to use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program.
This bill, by January 1, 2019, would require the committee to review the existing criteria for those standards governing all aspects of required testing to determine whether the existing criteria should be updated to reflect recent developments in testing research and technology.

(2) Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee within the Osteopathic Medical Board of California for the licensure and regulation of naturopathic doctors. Existing law requires the committee to consist of 9 members appointed by the Governor, including 2 public members. Existing law requires a public member to be a citizen of the state for at least 5 years preceding his or her appointment.

This bill would instead require 7 professional members to be appointed by the Governor, one public member to be appointed by the Senate Committee on Rules, and one public member to be appointed by the Speaker of the Assembly. The bill would instead require a public member to be a resident of the state for at least 5 years preceding his or her appointment.

Existing law repeals the act on January 1, 2018. Existing law also specifies that the committee is subject to review by the appropriate policy committees of the Legislature on January 1, 2018.

This bill would instead repeal the act and subject the committee to legislative review on January 1, 2022.

Existing law requires an applicant for a license as a naturopathic doctor to file a written application with the committee, as specified. Existing law requires the committee to establish the amount of the fee assessed to conduct activities of the committee, including the amount of fees for applicant licensure, licensure renewal, late renewal, and childbirth certification. Existing law requires the committee to require the satisfactory completion of 60 hours of approved continuing education biennially, as specified, for licensure renewal.

This bill would remove the requirement that an application be written. The bill would specify the amount or maximum amount for each of the fees. The bill would require a licensee to retain certificates of continuing education course completion for 6 years. The bill would authorize the committee to audit licensees’ continuing education records to ensure that continuing education requirements are met. The bill would specify that furnishing false or misleading information to the committee regarding continuing education constitutes unprofessional conduct.

Existing law requires the committee to approve a specified naturopathic medical education program. Existing law requires boards
within the Department of Consumer Affairs to adopt rules and regulations to provide for methods of evaluating education, training, and experience obtained in the armed services, if applicable to the requirements of the business, occupation, or profession regulated, and to specify how this education, training, and experience may be used to meet the licensure requirements for the particular business, occupation, or profession regulated. Existing law also requires these boards to consult with the Department of Veterans Affairs and the Military Department before adopting these rules and regulations.

This bill would require that the naturopathic medical program, pursuant to those provisions, evaluate an applicant’s education, training, and experience obtained in the armed services, and provide course credit where applicable.

Existing law requires the satisfactory completion of specified hours of approved continuing education biennially in order to renew a license. Existing law requires the continuing education to meet certain requirements and to be provided by an approved continuing education provider.

This bill would additionally require the course content to pertain to the practice of naturopathic, osteopathic, or allopathic medicine. The bill would require continuing education providers to comply with certain conflict-of-interest requirements. The bill would also require these providers to submit a related annual declaration to the committee. The bill would require the committee to maintain a list of these providers meeting those requirements on its Internet Web site.

Existing law does not prevent or restrict the practice, services, or activities of a person who makes recommendations regarding or is engaged in the sale of, among other things, food or vitamins.

This bill would authorize an unlicensed person to represent that he or she “practices naturopathy” if certain requirements related to restrictions on services provided and specified disclosures and acknowledgments are met.

Existing law requires that a person be licensed to use the professional abbreviation “N.D.” or other titles, words, letters, or symbols with the intent to represent that he or she practices, is authorized to practice, or is able to practice naturopathic medicine as a naturopathic doctor, except as specified. Existing law makes a violation of this provision a crime. Existing law also specifies that the Naturopathic Doctors Act permits, and does not restrict the use of, the titles “naturopath,” “naturopathic practitioner,” and “traditional naturopathic practitioner” by persons
who are educated and trained for those positions. Existing law specifies that the Naturopathic Doctors Act permits, and does not restrict, the education of these persons, and does not require these persons to be licensed under the act.

This bill would repeal the provisions restricting the scope of the act, and instead would require that a person be licensed to use the title “naturopath,” “naturopathic practitioner,” or “traditional naturopathic practitioner” with the intent to represent that he or she practices, is authorized to practice, or is able to practice naturopathic medicine as a naturopathic doctor, except as specified. Until January 1, 2020, the bill would authorize the use of the terms “naturopath,” “naturopathic practitioner,” and “traditional naturopathic practitioner” to be used in certain materials by persons who are educated and trained, but not licensed, to practice naturopathy pursuant to this act. By expanding the definition of a crime, this bill would impose a state-mandated local program.

Existing law, the Respiratory Care Practice Act, establishes the Respiratory Care Board of California for the licensure and regulation of respiratory care practitioners. Existing law specifies that the board is subject to review by the appropriate policy committees of the Legislature upon repeal of the provision establishing the board. Existing law also authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2018.

This bill would instead repeal those provisions on January 1, 2022.

Existing law establishes the Respiratory Care Fund in the State Treasury to carry out the purposes of the act, and requires all collections from persons licensed or seeking to be licensed under the Respiratory Care Act to be paid into the fund, as specified.

This bill would make the availability of the moneys in the fund contingent upon appropriation by the Legislature.

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

SECTION 1. Section 315 of the Business and Professions Code is amended to read:

315. (a) For the purpose of determining uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, there is established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. The committee shall be comprised of the executive officers of the department’s healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Health Care Services. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee.

(b) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Division 3 of Title 2 of the Government Code).

(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in paragraph (1) and any treatment recommended by the evaluator described in paragraph (1) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.
(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee’s employer about the licensee’s status and condition.

(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomness, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

(8) Procedures to be followed when a licensee tests positive for a banned substance.

(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a “deferred prosecution” stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.

(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.
(13) If a board uses a private-sector vendor that provides diversion services, standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; standards for the vendor’s approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and standards for a licensee’s termination from the program and referral to enforcement.

(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor’s performance in adhering to the standards adopted by the committee.

(16) Measurable criteria and standards to determine whether each board’s method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

(d) Notwithstanding any other law, by January 1, 2019, the committee shall review the existing criteria for Uniform Standard #4 established pursuant to paragraph (4) of subdivision (c). The committee’s review and findings shall determine whether the existing criteria for Uniform Standard #4 should be updated to reflect recent developments in testing research and technology. The committee shall consider information from, but not limited to, the American Society of Addiction Medicine, and other sources of best practices.

SEC. 2. 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, 2022, and as of that date is repealed. 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. 3. Section 3621 of the Business and Professions Code is
amended to read:

3621. (a) The committee shall consist of nine members,
consisting of seven professional members appointed by the
Governor, one public member appointed by the Senate Committee
on Rules, and one public member appointed by the Speaker of the
Assembly. Members of the committee shall include five members
who are California licensed naturopathic doctors, two members
who are California licensed physicians and surgeons, and two
public members.

(b) A member of the committee shall be appointed for a
four-year term. A person shall not serve as a member of the
committee for more than two consecutive terms. A member shall
hold office until the appointment and qualification of his or her
successor, or until one year from the expiration of the term for
which the member was appointed, whichever first occurs.

Vacancies shall be filled by appointment for unexpired terms.

(c) (1) A public member of the committee shall be a resident
of this state for at least five years preceding his or her appointment.

(2) A person shall not be appointed as a public member if the
person or the person’s immediate family in any manner owns an
interest in a college, school, or institution engaged in naturopathic
education, or the person or the person’s immediate family has an
economic interest in naturopathy or has any other conflict of
interest. “Immediate family” means the public member’s spouse,
parents, children, or his or her children’s spouses.

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

(e) The committee 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
committee and vested in him or her by this chapter.

SEC. 4. Section 3623 of the Business and Professions Code is
amended to read:

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

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

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

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

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

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

SEC. 5. Section 3630 of the Business and Professions Code is
amended to read:

3630. An applicant for a license as a naturopathic doctor shall
file an application with the committee on a form provided by the
committee that shows, to the committee’s satisfaction, compliance
with all of the following requirements:
(a) The applicant has not committed an act or crime that constitutes grounds for denial of a license under Section 480, and has complied with the requirements of Section 144.

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

SEC. 6. Section 3635 of the Business and Professions Code is amended to read:

3635. (a) In addition to any other qualifications and requirements for licensure renewal, the committee shall require the satisfactory completion of 60 hours of approved continuing education biennially. This requirement is waived for the initial license renewal. The continuing education shall meet the following requirements:

1. At least 20 hours shall be in pharmacotherapeutics.
2. No more than 15 hours may be in naturopathic medical journals or osteopathic or allopathic medical journals, or audio or videotaped presentations, slides, programmed instruction, or computer-assisted instruction or preceptorships.
3. No more than 20 hours may be in any single topic.
4. No more than 15 hours of the continuing education requirements for the specialty certificate in naturopathic childbirth attendance shall apply to the 60 hours of continuing education requirement.
5. Course content shall pertain to the practice of naturopathic, osteopathic, or allopathic medicine.

(b) The continuing education requirements of this section may be met through continuing education courses approved by the committee, the California Naturopathic Doctors Association, the American Association of Naturopathic Physicians, the California State Board of Pharmacy, the State Board of Chiropractic Examiners, or other courses that meet the standards for continuing education for licensed physicians and surgeons in California. All continuing education providers shall comply with Section 3635.2. Continuing education providers shall submit an annual declaration to the committee that their educational activities satisfy the requirements described in Section 3635.2 and the committee shall maintain a list of these providers on its Internet Web site.
SEC. 7. Section 3635.1 is added to the Business and Professions Code, to read:

3635.1. (a) A licensee shall retain certificates of continuing education course completion for six years.
(b) The committee may audit licensees’ continuing education records to ensure that continuing education requirements are met.
(c) It shall be unprofessional conduct for a licensee to furnish false or misleading information to the committee regarding continuing education.

SEC. 8. Section 3635.2 is added to the Business and Professions Code, to read:

3635.2. In addition to complying with subdivision (b) of Section 3635, the following shall apply to providers of continuing education:
(a) The content of continuing education courses and related materials shall provide balance, independence, objectivity, and scientific rigor. All patient care recommendations from continuing education courses involving clinical medicine shall be based on evidence accepted by naturopathic doctors. All scientific research used to support patient care recommendations shall conform to generally accepted standards of experimental design, data collection, and analysis.
(b) A conflict of interest is created when an individual in a position to control the content of a continuing education course, or his or her spouse or partner, has a relevant personal financial relationship within the past 12 months with a commercial entity that produces, markets, resells, or distributes health care goods or services consumed by, or used on patients that benefits the individual in any financial amount and therefore, may bias his or her opinions and teachings with respect to the content of continuing education courses. This may include receiving a salary, royalty, intellectual property rights, consulting fee, honoraria, ownership interest such as stocks, stock options or other ownership interest, excluding diversified mutual funds, or other financial benefit. Financial benefits are generally associated with roles such as employment, a management position, or an independent contractor position, including contracted research and clinical trials, consulting, speaking and teaching, membership on advisory committees or review panels, board membership, and other activities for which remuneration is received or expected.
(c) Prior to a course being presented, continuing education providers shall identify, disclose, and resolve all conflicts of interest. Individuals who fail or refuse to disclose relevant financial relationships shall not be approved as a provider of continuing education as described in subdivision (b) of Section 3635.

(d) Conflicts of interests shall be resolved by one of the following mechanisms:

1. Altering financial relationships. Individuals may change their relationships with commercial interests, such as discontinuance of contracted services, thereby eliminating any conflict of interest related to the continuing education content.

2. Altering control over content. An individual’s control of continuing education content may be altered in several ways to remove the opportunity to affect content related to the products and services of a commercial interest. These include the following:

   A. Choose someone else to control that part of the content. If a proposed presenter or planner has a conflict of interest related to the content, someone else who does not have a relationship to the commercial interests related to the content may present or plan that part of the content.

   B. Change the focus of the continuing education activity so that the content is not about products or services of the commercial interest that is the basis of the conflict of interest.

   C. Change the content of the individual’s assignment so that it is no longer about products or services of the commercial interest. For example, an individual with a conflict of interest regarding products for treatment of a condition could address the pathophysiology or diagnosis of the condition, rather than therapeutics.

   D. Limit the content to a report without recommendations. If an individual has been funded by a commercial entity to perform research, the individual’s presentation may be limited to the data and results of the research. Someone else may be assigned to address broader implications and recommendations.

   E. Limit the sources for recommendations. Rather than having a person with a conflict of interest present personal recommendations or personally select the evidence to be presented, limit the role of the person to reporting recommendations based on formal structured reviews of the literature with the inclusion and exclusion criteria stated “evidence-based.”
3 Conflict of interest may be resolved if the continuing education material is peer reviewed and both of the following are met:
4 (A) All the recommendations involving clinical medicine are based on evidence that is accepted within the profession of naturopathic medicine as adequate justification for indications and contraindications in the care of patients.
5 (B) All scientific research referred to, reported, or used in the continuing education activity in support or justification of patient care recommendations conforms to the generally accepted standards of experimental design, data collection, and analysis.

SEC. 9. Section 3644 of the Business and Professions Code is amended to read:

3644. This chapter does not prevent or restrict the practice, services, or activities of any of the following:
(a) A person licensed, certified, or otherwise recognized in this state by any other law or regulation if that person is engaged in the profession or occupation for which he or she is licensed, certified, or otherwise recognized.
(b) A person employed by the federal government in the practice of naturopathic medicine while the person is engaged in the performance of duties prescribed by laws and regulations of the United States.
(c) A person rendering aid to a family member or in an emergency, if no fee or other consideration for the service is charged, received, expected, or contemplated.
(d)(1) A person who makes recommendations regarding or is engaged in the sale of food, extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and their extracts, botanical medicines, homeopathic medicines, dietary supplements, and nonprescription drugs or other products of nature, the sale of which is not otherwise prohibited under state or federal law.
(2) An unlicensed person described in this subdivision may represent that he or she “practices naturopathy” if he or she complies with Section 2053.6. However, an unlicensed person may not use the title “naturopathic doctor” unless he or she has been issued a license by the committee.
(e) A person engaged in good faith in the practice of the religious
tenets of any church or religious belief without using prescription
drugs.
(f) A person acting in good faith for religious reasons as a matter
of conscience or based on a personal belief, while obtaining or
providing information regarding health care and the use of any
product described in subdivision (d).
(g) A person who provides the following recommendations
regarding the human body and its function:

(1) Nonprescription products.
(2) Natural elements such as air, heat, water, and light.
(3) Class I or class II nonprescription, approved medical devices,
as defined in Section 360c of Title 21 of the United States Code.
(4) Vitamins, minerals, herbs, homeopathics, natural food
products and their extracts, and nutritional supplements.
(h) A person who is licensed in another state, territory, or the
District of Columbia to practice naturopathic medicine if the person
is incidentally called into this state for consultation with a
naturopathic doctor.
(i) A student enrolled in an approved naturopathic medical
program whose services are performed pursuant to a course of
instruction under the supervision of a naturopathic doctor.

SEC. 10. Section 3645 of the Business and Professions Code
is repealed.

SEC. 10. Section 3645 of the Business and Professions Code
is amended to read:
3645. (a) This chapter permits, and does not restrict, the use of
the following titles by persons who comply with
subdivision (c) and are educated and trained as any of the
following:

(1) “Naturopath.”
(2) “Naturopathic practitioner.”
(3) “Traditional naturopathic practitioner.”
(b) This chapter permits, and does not restrict, the education of
persons as described in paragraphs (1) to (3), inclusive, of
subdivision (a). Those persons are not required to be licensed under
this chapter.
(c) An unlicensed person may use the titles specified in
subdivision (a) if the unlicensed person does all of the following:

(1) Complies with Section 2053.6.
(2) Provides a conspicuous disclosure in all marketing, advertisements, and other related materials that states, in plain language, that the person is not licensed by the Naturopathic Medicine Committee as a naturopathic doctor.

(3) Obtains verbal confirmation that the client understands that the person is not licensed as a naturopathic doctor prior to providing advice or arranging for services related to the practice of naturopathy over the phone.

SEC. 11. Section 3660 of the Business and Professions Code is amended to read:

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

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

(b) To use the professional designation “N.D.;” “naturopath;” “naturopathic practitioner;” “traditional naturopathic practitioner;” “N.D.” or other titles, words, letters, or symbols with the intent to represent that he or she practices, is authorized to practice, or is able to practice naturopathy as a naturopathic doctor.

(e) Until January 1, 2020, the use of the terms “naturopath;” “naturopathic practitioner;” and “traditional naturopathic practitioner” may be used in marketing, advertisements, and other related materials by persons who are educated and trained, but not licensed, to practice naturopathy pursuant to this chapter. Individuals shall not be disciplined for the misuse of titles not under their control.

SEC. 12. Section 3680 of the Business and Professions Code is amended to read:

3680. (a) The application fee for a doctor of naturopathic medicine shall be no more than four hundred dollars ($400).

(b) The initial license fee shall be no more than eight hundred dollars ($800).

(c) The renewal fee for a license shall be no more than eight hundred dollars ($800).

(d) The late renewal fee for a license shall be no more than one hundred fifty dollars ($150).

(e) The fee for processing fingerprint cards shall be the current fee charged by the Department of Justice.
(f) The fee for a duplicate or replacement license shall be no more than twenty-five dollars ($25).

SEC. 13. Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 14. 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, 2022, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 15. Section 3716 of the Business and Professions Code is amended to read:

3716. (a) 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.

(b) This section shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 16. Section 3772 of the Business and Professions Code is amended to read:

3772. There is established in the State Treasury the Respiratory Care Fund. All collections from persons licensed or seeking to be licensed under this chapter shall be paid by the board into the fund after the report to the Controller at the beginning of each month of the amount and source of the collections. Moneys in the fund shall be available to the board, upon appropriation by the Legislature.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIIIIB 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.
SUMMARY:
This bill extends the Board’s sunset date to 2022. This bill provides for the investigation of registered nurses referred to the Intervention Program, increases the threshold for reporting liability insurance settlements, and makes changes to continuing education provisions. This bill also requires the California Research Bureau to assess to what degree employers report nurses to the BRN and to report its findings to the Legislature by January 1, 2019.

ANALYSIS:
Existing law:
- The Nursing Practice Act (NPA) establishes the Board of Registered Nursing (BRN) within the Department of Consumer Affairs (DCA) to license and regulate the practice of registered nurses until January 1, 2018.
- Authorizes the BRN to take disciplinary action against a licensee or deny an application for licensure for various acts and offenses.
- Provides for an Intervention Program to rehabilitate registered nurses (RN) from abuse of alcohol, drugs, or mental illness.
- Requires BRN to close an investigation of an RN who voluntarily enters the Intervention Program if the reason for the current investigation is based primarily on the self-administration of any drug or alcohol and does not involve actual, direct harm to the public. The board shall reopen the investigation only if the RN withdraws or is terminated from the Intervention Program.
- Requires a person renewing his or her license to submit proof that, during the preceding 2-year period, he or she has been informed of the developments in the RN field or in any special area of practice engaged in by the licensee, occurring since the last renewal thereof, either by pursuing a course or courses of continuing education in the registered nurse field or relevant to the practice of the licensee, and approved by the board, or by other means deemed equivalent by the board.
- Requires the board to adopt regulations establishing standards for continuing education for licensees, as specified.
• Requires insurers that provide liability insurance to certain licensees, including persons licensed by the board, to report to the licensing agency certain settlement or arbitration awards over $3,000.

This bill would:
• Extend Board of Registered Nursing’s sunset date until January 1, 2022.

Amended analysis as of 5/1/2017:
This bill would:
• Extend Board of Registered Nursing’s sunset date until January 1, 2022.
• Require reporting of registered nurses to the board:
  o An RN who has knowledge that another person has committed any act listed as grounds for discipline or a denial of application shall make a written report to the board and cooperate with the board in furnishing information or assistance.
  o An RN employer shall report to the board any registered nurse who, as defined, is suspended, terminated, or resigned for cause.
  o An RN employer shall report to the board any registered nurse who, as defined, is rejected from assignment by a health facility or home health care provider for certain acts that would be cause for suspension or termination.
  o Authorize the BRN, to issue an administrative fine up to $10,000 per violation for any registered nurse or employer who fails to make a report as required by the bill.
• Require the BRN to investigate all complaints against registered nurses concurrently participating in the intervention program.
• Revise continuing education provisions:
  o Require that each person renewing his or her license to submit proof of completing at least 30 hours of continuing education in the registered nurse nursing field or relevant to the practice of the licensee.
  o Prohibit the board from renewing existing continuing education providers or approving individual continuing education providers or courses.
  o Permit continuing education courses from providers approved by the board before January 1, 2018, or approved by accrediting agencies or associations as deemed appropriate by the board, which shall include, but not be limited to American Association of Nurse Practitioners, American Association of Critical-Care Nurses, and the American Association of Nurse Anesthetists.
  o Require the board to promulgate emergency regulations to establish a list of approved entities based on the entities’ history of sanctioning learning opportunities appropriate to the practice of registered nursing.
  o Require the board to submit to the legislature by January 1, 2019, a report detailing a comprehensive plan for approving and disapproving continuing education opportunities.
• Increase the threshold from $3,000 to $10,000 for reporting certain settlement or arbitration awards.

Fiscal impact:
• Increase in costs for additional investigation and disciplinary actions related to additional reporting to the BRN.
• was amended to remove the term “evidence-based.”
Comments:
- This bill implements legislative changes as a result of the Joint Sunset Review Oversight Hearings.

Amended analysis as of 5/26/2017:
SB 799 was amended as follow:
- Further defines “insurer” for reporting of insurance settlements.
- Removes bill provision that required RNs to report other RNs who may have violated the NPA.
- Adds 30-day timeframe for employers to report RNs who may have violated the NPA.
- In bill provision related reporting of RNs rejected from assignment, changes the required reporting entity to the employment agency or nursing registry.
- In bill provision related to employer’s failure to report an RN, reduces fine amount from $10,000 to $5,000.
- Changes bill provision that requires investigation of RNs who participate in the intervention program. Instead, bill provisions would permit the Board to investigate these complaints at its discretion. Additionally, it is clarified that the Board will not take disciplinary action unless the RN withdraws or is terminated from the program.
- Deletes bill provision that prohibited Board from renewing existing CE providers or approving new CE providers or courses. Instead, adds provision that would require the Board report to the Legislature by January 1, 2020, its progress for approving or disapproving CE opportunities. Deletes from law, language that permitted board to include pain management course when establishing CE standards.
- Changes the Board’s Fund from continuous appropriation and instead makes it available upon appropriation by the Legislature.

Amended analysis as of 7/3/2017:
The term “evidence-based” was removed from bill provision pertaining to course content related to the scientific knowledge of nursing practice.

Amended analysis as of 8/24/2017:
The amended bill removes mandatory reporting provisions. Instead, the bill would require the California Research Bureau to prepare and deliver a report to the Legislature by January 1, 2019. The report will evaluate to what degree employers report disciplined nurses to the BRN and offer options for consistent and reasonable reporting mechanisms.

Comments:
On August 21st, BRN staff submitted a letter on behalf of the BRN Legislative Committee (see attached) urging the bill author to work with others in the Legislature to avoid sunset of the BRN.

The amended bill was heard by and passed the Assembly Business and Professions Committee on August 29th pursuant to suspension of Assembly Rule 56. The bill will move forward to the Assembly Committee on Appropriations for hearing on August 30th.

BOARD POSITION: “Support” position (as introduced), but “Watch” position on recent amendments (6/8/2017)
LEGISLATIVE COMMITTEE RECOMMENDED POSITION: “Support” position (as introduced), but “Watch” position on May 1, 2017 amendments (5/10/2017)

SUPPORT:
- California School Nurses Organization

OPPOSE:
- California Association for Health Services at Home
- California Nurses Association
- California State Council of the Service Employees International Union
- Service Employees International Union Local 1000
- United Nurses Associations of California/Union of Health Care Professionals
SUMMARY:
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  o Authorize the BRN, to issue an administrative fine up to $10,000 per violation for any registered nurse or employer who fails to make a report as required by the bill.
• Require the BRN to investigate all complaints against registered nurses concurrently participating in the intervention program.
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  o Require that each person renewing his or her license to submit proof of completing at least 30 hours of continuing education in the registered nurse nursing field or relevant to the practice of the licensee.
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  o Require the board to promulgate emergency regulations to establish a list of approved entities based on the entities’ history of sanctioning learning opportunities appropriate to the practice of registered nursing.
  o Require the board to submit to the legislature by January 1, 2019, a report detailing a comprehensive plan for approving and disapproving continuing education opportunities.
• Increase the threshold from $3,000 to $10,000 for reporting certain settlement or arbitration awards.

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- Changes bill provision that requires investigation of RNs who participate in the intervention program. Instead, bill provisions would permit the Board to investigate these complaints at its discretion. Additionally, it is clarified that the Board will not take disciplinary action unless the RN withdraws or is terminated from the program.
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- California Nurses Association
- California State Council of the Service Employees International Union
- Service Employees International Union Local 1000
- United Nurses Associations of California/Union of Health Care Professionals
August 18, 2017

Senator Jerry Hill  
Chair, Senate B&P Economic Committee  
State Capitol, Room 5035  
Sacramento, CA 95814

RE: SB 799: Support with proposed amendments by ASM B&P

Dear Senator Hill:

The BRN Legislative Committee appreciates and supports SB 799’s recommendation to extend the operation of the BRN until January 1, 2022. We also appreciate the sharing of information between our staff and your staff regarding the two versions of the Sunset Background Reports where many issues of concern could be explored and considered. As you know, we have already set up a process where two members of the BRN will work directly with BRN staff to focus on the charge in SB 799 to report back to the Legislature by January 2019 on the Continuing Education Provider program.

With respect, however, we have been very concerned about the amendments made in SB 799 regarding changing the Intervention Program and mandating employer reporting and our Legislative Committee chair met with you and your staff in June to further discuss those concerns and explore a resolution. We specifically discussed the concept of looking at existing complaints and providing analysis as to whether there is any data suggesting that the existing requirements on health care employers to file complaints with the BRN are inadequate.

We were also prepared to support SB 799 with the Assembly B&P Committee Analysis’ amendments whereby mandatory employer reporting was replaced by collection and analysis of data by the BRN with a January 1, 2019 report to the Legislature. We believe additional data and analysis is prudent on this subject and would better inform all parties on a subject that was not explored in depth as part of the Sunset Review and Report process.

However, we were unable to publicly express our position when you declined to present your bill and the bill subsequently failed to meet the deadline to move out of the Assembly thus putting the BRN sunset extension at risk. Of course, we urge you to work with others in the Legislature to avoid the disruptive and costly sunsetting of the BRN.

Therefore, this letter updates the BRN position regarding SB 799. Trande Phillips, President of the BRN is the contact person when the Legislature reconvenes in August.
Sincerely,

Donna Gerber
BRN Legislative Committee Chair, BRN Board Member

Cc: Assembly Member Evan Low, Chair of the Committee on Business and Professions
SB 799

Date of Hearing: August 29, 2017

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Evan Low, Chair
SB 799 (Hill) – As Amended August 24, 2017

SENATE VOTE: 40-0

SUBJECT: Nursing.

SUMMARY: Extends the operation of the Board of Registered Nursing (BRN) until January 1, 2022; increases the threshold for insurers that provide liability insurance to Registered Nurses (RNs) to report specified settlement or arbitration awards to the BRN; defines “insurer” to include a licensee or the licensee’s counsel; requires the California Research Bureau to prepare and deliver a report to the Legislature by January 1, 2019, that evaluates RN complaint reporting mechanisms; requires the BRN to report to the Legislature its plan for the approval of continuing education opportunities and its progress implementing the plan; and makes other technical and clarifying changes.

EXISTING LAW:

1) Regulates and licenses the practice of nursing under the Nursing Practice Act. (Business and Professions Code (BPC) §§ 2700-2718)

2) Establishes the BRN within the Department of Consumer Affairs (DCA) until January 1, 2018, to administer and enforce the Nursing Practice Act. (BPC § 2701)

3) Requires every insurer providing professional liability insurance to specified licensees, including RNs, to send a complete report to the relevant licensing agency as to any settlement or arbitration award over $3,000 of a claim or action for damages for death or personal injury caused by that person’s negligence, error, or omission in practice, or by the licensee’s rendering of unauthorized professional services, as specified. (BPC § 801(a))

4) Requires the BRN to establish criteria for the acceptance, denial, or termination of RNs in its intervention program, and specifies that only those registered nurses who have voluntarily requested to participate in the intervention program shall participate in the program. (BPC § 2770.7(a))

5) Provides the following relating to investigation and discipline of RNs who voluntarily enter the intervention program:

   a) Authorizes an RN under current investigation by the BRN to request entry into the intervention program by contacting the BRN. Prior to authorizing an RN to enter into the intervention program, the BRN may require the RN to execute a statement of understanding that states that the RN understands that his or her violations that would otherwise be the basis for discipline may still be investigated and may be the subject of disciplinary action. (BPC § 2770.7(b))

   b) Requires the BRN to close the investigation if the reasons for the investigation are based primarily on the self-administration of any controlled substance or dangerous drug or
alcohol, as specified, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, and the RN is accepted into, and successfully completes, the BRN’s intervention program. If the RN withdraws or is terminated from the program by an intervention evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the BRN. (BPC § 2770.7(c))

c) Provides that neither acceptance nor participation in the intervention program precludes the BRN from investigating or taking disciplinary action against an RN for any unprofessional conduct committed before, during, or after participation in the intervention program. (BPC § 2770.7(d))

d) Provides that an RN who is terminated from the intervention program for failure to comply with program requirements is subject to disciplinary action for acts committed before, during, and after participation in the intervention program. (BPC § 2770.7(f))

6) Requires an RN renewing a license to submit proof satisfactory that, during the preceding two-year period, the RN has been informed of the developments in the nursing field or in the RN’s special area of practice that have occurred since the last renewal, either by pursuing a course or continuing education (CE) in the RN field or relevant to the RN’s practice, and approved by the BRN, or by other means deemed equivalent by the BRN. (BPC § 2811.5(a))

7) Requires the employer of a licensed vocational nurse (LVN) or respiratory care practitioner (RCP) to report to the licensee’s board the suspension or termination for cause, or resignation for cause for LVNs, as specified. (BPC §§ 2878.1, 3758)

8) Defines, for purposes of the employer reporting requirements, “suspension, termination, or resignation for cause” or “rejection from assignment” as suspension, termination, or resignation from employment, or rejection from assignment, for any of the following reasons:

a) Use of controlled substances or alcohol to the extent that it impairs the licensee’s ability to safely practice vocational nursing.

b) Unlawful sale of a controlled substance or other prescription items.

c) Patient or client abuse, neglect, physical harm, or sexual contact with a patient or client.

d) Falsification of medical records.

e) Gross negligence or incompetence.

f) Theft from patients or clients, other employees, or the employer. (BPC §§ 2878.1(d), 3758(b))

9) Makes failure of an employer to make a report under the reporting requirements punishable by an administrative fine not to exceed ten thousand dollars ($10,000) per violation. (BPC §§ 2878.1(e), 3758(c))

10) Provides that, pursuant to Civil Code § 43.8, no employer shall incur a civil penalty for making the reports. (BPC §§ 2878.1, 3759)
THIS BILL:

1) Raises the threshold under BPC § 801 for reporting settlement or arbitration awards for an insurer providing professional liability insurance to an RN from $3,000 to $10,000.

2) Defines “insurer,” for purposes of the reporting requirement for all insurers providing professional liability insurance to licensees listed under BPC § 801, as follows:
   a) The insurer providing professional liability insurance to the licensee.
   b) The licensee, or the licensee’s counsel, if the licensee does not possess professional liability insurance.
   c) A state or local governmental agency, including, but not limited to, a joint powers authority that self-insures the licensee, as defined.

3) Extends operation of the BRN from January 1, 2018 until January 1, 2022.

4) Deletes the completed California State Auditor investigation provisions.

5) Declares that it is the intent of the Legislature to provide for a study of reporting mechanisms to the BRN so that it can identify methods of receiving timely information on nurses who may have violated the Nursing Practice Act.

6) Requires the California Research Bureau (CRB) to prepare and deliver a report to the Legislature by January 1, 2019, that evaluates to what extent employers voluntarily report disciplined nurses to the board and offers options for consistent and reasonable reporting mechanisms.

7) Requires the CRB report to include, at a minimum:
   a) A review of existing mandatory reporting requirements that alert the BRN to nurses who may have violated this chapter.
   b) A review of existing laws permitting, prohibiting, encouraging, or discouraging voluntary reporting to the BRN.
   c) An analysis of the number of employer reports to the BRN, the number of those reports investigated by the BRN, and the final action taken by the BRN for each report.
   d) Employer reporting requirements of other boards within the DCA.
   e) Nursing reporting requirements of other states.

8) Deletes provisions of law requiring the BRN to close investigations related to certain causes of action if an RN is accepted into the intervention program and instead authorizes the BRN to investigate, at its discretion, complaints against RNs participating in the intervention program.
9) Prohibits the BRN from taking disciplinary action with regard to acts committed before or during participation in the intervention program unless the RN withdraws or is terminated from the program.

10) Requires the BRN to deliver a report to the appropriate legislative policy committees detailing a comprehensive plan for approving and disapproving CE opportunities by January 1, 2019, and report on its progress by January 1, 2020.

11) Deletes the BRN Fund’s continuous appropriation and instead makes the funds available upon appropriation by the Legislature.

12) Makes technical changes and clarifying changes.

**FISCAL EFFECT:** According to the Senate Appropriations Committee, this bill will result in ongoing costs of $41 million per year for the continuing operation of the BRN.

**COMMENTS:**

**Purpose.** This bill is sponsored by the author. According to the author, “The Author’s office is proud to present a solution to concerns raised through the Sunset Process. Current law does too little to encourage reporting by those who are both closest to these dangerously unqualified licensees, as well as the most qualified to recognize an improper deviation from California nursing protocol. [This bill] is a calculated and measured response drafted as a result of considerable research, constituent and stakeholder interaction, and deliberation.”

**Background.** The BRN regulates the practice of nursing in California and implements and enforces the Nursing Practice Act, which contains the laws related to nursing education, licensure, practice, and discipline. The BRN regulates over 420,000 RNs.

**Sunset Review.** In February and March of this year, the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions and Economic Development (Committees) conducted joint oversight hearings to review various regulatory entities. During the sunset review hearings, the Committees heard testimony from the entities and stakeholders and evaluated entities scheduled to be repealed the following year. The reviewed entities will sunset unless the Legislature enacts a law to extend them.

This bill is one of the several sunset bills intended to implement legislative changes recommended in the respective background reports drafted by the Committees for the entities reviewed. Because this is the BRN’s supplemental sunset review report after a two-year extension (extensions are typically four years), this bill also addresses the outstanding issues from the BRN’s 2015 sunset review.

**California State Auditor Report.** In response to issues raised during the BRN’s 2015 sunset review, the BRN’s 2015 sunset bill (SB 466 (Hill), Chapter 489, Statutes of 2015) required the California State Auditor to conduct an audit of the BRN’s enforcement program. The State Auditor noted issues with the BRN’s complaint processing timelines, data collection and use, complaint referrals, and investigator training. It made a total of 25 recommendations, 3 of which were directed at the Legislature:
1) “To ensure that BRN receives timely and consistent notification of nurses’ alleged violations of the Nursing Act, the Legislature should require the employers of registered nurses to report to BRN the suspension, termination, or resignation of any registered nurse due to alleged violations of the Nursing Act.

2) If BRN does not develop and implement an action plan by March 1, 2017, to prioritize and resolve its deficiencies, as mentioned in the first recommendation to BRN, the Legislature should consider transferring BRN’s enforcement responsibilities to Consumer Affairs.

3) The Legislature should amend state law to require BRN to conduct investigations of complaints alleging substance abuse or mental illness against nurses who choose to enter the intervention program.”

*Mandatory Judgment and Settlement Reporting.* This bill changes the amount in a settlement or arbitration award that would require insurers of RNs to report to the BRN from $3,000 to $10,000. The BRN is currently collecting data to determine whether $3,000 is an appropriate amount. The $3,000 figure was set in 1975, and BRN gets many low-dollar reports that do not represent sufficiently egregious violations to warrant investigation.

Currently, the BRN indicates that 199 cases were reported from January 1, 2014 through October 24, 2016. Of those, 39 were between $3,000 and $29,999, and 150 were between $30,000 and $6,000,000, with the average being $345,908.

*CE Providers.* This bill requires the BRN to deliver a report to the appropriate legislative policy committees detailing a comprehensive plan for approving and disapproving continuing education opportunities by January 1, 2019, and update the Legislature on its progress the following year.

All licensees are required by statute to complete 30 hours of CE during each two-year renewal cycle to ensure continued competence. Statute requires that the BRN establish regulations ensuring that CE courses are either related to the scientific knowledge or technical skills required for the practice of nursing, or to direct or indirect patient care. The BRN promulgated regulations further specifying appropriate coursework, including the requirement that all content be relevant to the practice of nursing. According to the author, the BRN continues to be lax in its approval standards for CE providers.

*Response from the BRN.* The Board of Registered Nursing supports the sunset extension portion of this bill. The BRN “voted to support the version of the bill introduced on February 17, 2017, which extends the [BRN’s] sunset date until 2022, and to watch the subsequent amendments from the version of the bill amended May 26, 2017.”

Further, the BRN notes that while it “is in favor of the amendments we are extremely concerned about several issues expressed in the current revision of the Bill which include the following: 1) Although not explicitly stated, the potential cost associated with the California Research Board (CRB) conducting the research; 2) The accuracy of the data collecting, sharing, and reporting by the CRB and the need for the BRN to be involved in the process, and 3) The short time period allotted to collect sufficient data and provide a comprehensive report to the committee by 2019.

Respectfully, we request that these matters be considered by the [Assembly] B & P Committee members and that the Board be exempted from paying any cost associated with conducting the research mentioned in the amendments. However, the Board should be involved in the data
mining and reviewing the accuracy of the information prior to reporting to the Committee. Finally, we are suggesting that the final report be delivered by January 2020 instead of January 2019 which will allow additional time for the BRN to become better staffed in order to assign personnel to work collectively with the CRB staff with data collating and reporting.”

ARGUMENTS IN SUPPORT:

The California Hospital Association (CHA) writes in support, “California hospitals seek to employ the most qualified staff to ensure the highest quality of patient care. To this end, we will continue to support the BRN’s efforts to ensure that nurses who jeopardize quality care are held accountable as would be required by this bill. CHA supports this important step to provide research and ample time for the BRN to make successful changes. We will continue to underscore the need to highlight that the BRN act judiciously with the information provided, as the employer’s report is an administrative obligation on the employer without demonstrable benefits if there is not timely, efficient and effective processing of the reports.”

The California School Nurses Organization (CSNO) supports the sunset extension portion of this bill, stating “we are in strong support of the continuance of this board until 2022. The need for a nursing board to oversee and regulate the profession of nursing is paramount for the practitioners as well as to assure the health and safety of the consumers they serve.”

ARGUMENTS IN OPPOSITION:

The California Nurses Association (CNA) supports the sunset extension but requests amendments limiting the CRB reporting provisions and opposes the intervention provisions of this bill. CNA believes that the reporting provision is too broad and “presupposes a result by its underlying assumption that employers are supposed to be reporting ‘disciplined’ nurses.” Specifically, CNA requests that 1) the intent language be removed, 2) the report due date be delayed to January 1, 2020, 3) the scope of the report be narrowed to the listed subdivisions, 4) the analysis of the employer report be based solely on data from the BRN’s BreEZe system, and 5) the requirements of other boards within the DCA and other states be deleted.

On the intervention portion of the bill, CNA writes that it “removes the incentive to participate in the intervention program and does not promote recovery. The promise of no discipline is a way to get struggling nurses into treatment before they become a danger to patients.” With the limiting amendments and the deletion of the intervention provisions, CNA would support this measure.

The California State Council of the Service Employees International Union (SEIU) State Council), supports the sunset extension, is neutral on the CRB report so long as due process is factored into the report, opposes the intervention provision of this bill, and requests amendments to the continuing education portion of the bill.

On the intervention provisions, SEIU State Council notes that the “new requirement would impose a large amount of costs to the Board and would require the BRN to hire additional staff. It is unclear why this measure has proposed to overhaul the intervention program and imposes large costs for an issue that affects a scant amount of the licensee population and where there is no identified problem. We believe an unintended consequence of the proposed revisions would be to disincetivize voluntary treatment, which helps to keep patients safe.”
On the continuing education portions of the bill, “SEIU proposes to amend the sunset bill to require a report to the legislative policy committees by January 1, 2019 detailing the proposed changes in staffing and fees that will be required to comply with the existing CEU provider audit requirements contained in Business and Professions Code (BPC) Section 2811.5.

Any proposed policy change related to course content or provider criteria should be developed as part of a broader stakeholder process…. While the measure sought to address a real problem (i.e., the BRN has failed to adequately audit CEU providers and courses), as currently proposed, the BRN would unilaterally implement the new CEU approval process without any outside input.”

California Labor Federation, International Longshore and Warehouse Union, Local 29, and Northern California District Council – ILWU, support the sunset extension, were concerned about the mandatory reporting requirements, but are opposed unless amended to delete the provisions related to the intervention program. They write that, without the requirement that the BRN close any investigation on RNs entering the program, there will be a chilling effect on the number of RNs who may enter and complete the program.

The California Pharmacists Association opposes the intervention provisions of this bill. “For licensees already struggling with addiction issues, the discontinuation of a board investigation is a strong incentive to enter treatment and to stick with the program until completion.

The Board of Pharmacy has a similar intervention program in place, and CPhA believes that the current system is working well for licensees. It is important to note, similar to the BRN, the Board of Pharmacy only refers licensees into the intervention program when the complaint does not apply to allegations that involve actual or direct harm to the public. Moreover, the DCA’s Diversion Program average relapse rate is almost four times better than the expected relapse rate of the general public. Given this information, it is unclear why the proposed changes to the intervention program have been put forth in BRN sunset measure.”

The California Society of Addiction Medicine (CSAM) is opposed to this measure and writes, “[We oppose] provisions that would impede persons voluntarily going into treatment by allowing the board to activate an investigation of someone who has voluntarily entered treatment. This is the wrong way to attempt to keep the public safe.”

POLICY ISSUES:

Mandatory Employer Reporting. This bill explores the State Auditor recommendation of establishing employer reporting requirements for RNs like those for the employers of LVNs. This recommendation is one part of the broader goal of improving the BRN’s enforcement program. The State Auditor noted that the “BRN should improve its collaboration with other state agencies and health boards to ensure effective enforcement.” Specifically, the State Auditor noted that the “BRN’s relationship and sharing of information with other entities involved in the enforcement of complaints against nurses could be improved.” To that end, the State Auditor made three specific recommendations, two to the BRN and one to the Legislature:

1) To ensure that it has prompt access to adequate information that could affect the status of a nurse’s license, BRN should do the following by June 2017:
   a) Establish formal agreements with other agencies and other health boards that have information pertaining to a nurse’s misconduct.
b) Work with Consumer Affairs and other health boards to determine whether modifying BreEZe to include a capability that would allow it to promptly notify BRN when another health board receives a complaint or takes disciplinary action against a licensed nurse is cost-effective. If it is, add this functionality to BreEZe.

2) To ensure that BRN receives timely and consistent notification of nurses’ alleged violations of the Nursing Act, the Legislature should require the employers of registered nurses to report to BRN the suspension, termination, or resignation of any registered nurse due to alleged violations of the Nursing Act.

The BRN is currently implementing its two recommendations on this issue. This bill explores the legislative recommendation. The State Auditor’s reason for the recommendation was that state law does not require employers of RNs to report complaints or discipline to BRN. However, it requires employers of an LVN who resigns, is suspended, or terminated for cause. It also noted that “the [BRN’s] assistant executive officer stated that she does not know why BRN was excluded from this law, but she believes BRN would benefit greatly if employers were required to report to it nurses who violate the Nursing Act.”

According to the BRN’s 2016 Supplemental Sunset Report, it wrote that it “has been reviewing the language that has been included for [LVNs] in B&P Code section 2878.1” (page 14). The BRN also wrote that it has been “meeting with other healing arts boards to review their malpractice settlement and mandatory reporting practices.” The BRN stated that it will continue to review and move forward in the near future with these issues for possible legislative change proposals but, according to its Legislative Committee, it does not currently support it.

Still, as with all consumer protections, the benefits should be weighed against any potential burdens on the licensees. The author asserts that the BRN’s complaint data for the last two years shows that, when compared to public complaints, the BRN receives “only a fraction of those complaints from employers. Ideally, the complaint totals should be similar.”

However, it is not clear that the number of complaints from members of the public should match the number of complaints from employers or peers. A complaint is an unsubstantiated allegation. In general, a medical professional will have a better sense of the severity of a mistake (which is distinguished from harm) and who may be at fault than a patient or family member. As a result, the rate at which the average member of the public makes a complaint to the BRN will differ from the rate at which a hospital makes a complaint against its own employee or an RN makes a complaint against a colleague.

Ideally, the number of complaints from the public that result in formal discipline after an investigation would match or be lower than that of other comparison groups (given a lack of other confounding variables, such as variations in available evidence). However, the BRN aggregates enforcement data in a way that makes it difficult to perform this comparison (this is consistent across the DCA).

For example, page 44 of the BRN’s 2016 Supplemental Sunset Report provides a breakdown of complaint data:

<table>
<thead>
<tr>
<th>Complaints</th>
<th>FY 14/15</th>
<th>FY 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6,783</td>
<td>7,757</td>
</tr>
</tbody>
</table>
The table shows a total of 7,757 complaints in FY 15/16, of which 3,383 are complaints received which are not based on a conviction or arrest notice (intake/consumer). The complaints from outside sources are split between Public (1,015), Industry (622), Governmental Agencies (1,337 after subtracting arrest/conviction notices), and Other (251). Other is typically an “internal complaint,” or a complaint based on data already available to staff. Given this, the apparent comparison groups are Public, Industry (employers and peers), and Governmental Agencies (health boards, law enforcement, other oversight agencies, and potentially state employers). Between the comparison groups, those that could include employers appear to have reported about twice the number of complaints from the public. For example, health facilities licensed under the Department of Public Health may submit RN employee violations to the Department or to the Office of Statewide Health Planning and Development, and those agencies may then forward that on to the BRN.

Still, it is not clear from the data how many of the complaints are from the employers of the RN named in the complaint, whether there were cases in which an investigation would have benefited from an employer report, or whether there were cases in which no complaint was made at all where an employer should have reported. In addition, it is not clear which of the investigated complaints were serious enough to warrant formal discipline (as noted above, complaints from the public may not always merit discipline). While nearly all of the 7,757 total complaints were referred to investigation, the BRN only filed 1,113 accusations (101 of which were withdrawn, dismissed, or declined), but it is unclear what types of complaints resulted in the accusations. Therefore, this bill requires the CRB to review existing requirements and reports to determine whether there are additional reporting mechanisms that can provide the BRN consistent and timely complaint information.

BRN Investigations of RNs in the Intervention Program. This bill authorizes the BRN to investigate complaints against RNs participating in the intervention program. It also prohibits the BRN from taking disciplinary action against RNs who successfully complete the program (unless found to have committed unprofessional conduct as stated in existing law).

The State Auditor noted that state law requires the BRN to close the investigation of certain types of complaints against an RN if that RN chooses to participate in the BRN’s voluntary intervention program and the BRN determines that the RN qualifies. The investigation remains closed unless the RN exits the program early or fails to successfully complete it.

In the event the RN exits the program or fails to complete it, the BRN refers the complaint to the appropriate unit for investigation. However, depending on when the RN leaves the program, the
investigation may not start or be completed until several years after the BRN initially received the complaint, restricting BRN’s ability to access evidence. According to the BRN’s website, the “average length of time is 3 to 5 years for RNs to successfully complete the program” (http://www.rn.ca.gov/intervention/int-faqs.shtml, accessed July 5, 2017). In theory, if an RN is terminated from the program closer to 5 years, investigators may have to deal with the degradation of primary eye witness testimony, corroborating evidence, and authenticated documents. In one case provided by the BRN’s Legislative Committee, an RN was terminated from the intervention program for missing a random lab test after 4 years.

According to the State Auditor, if state law required BRN to conduct investigations of all complaints against nurses while they participate in the intervention program, it would increase the likelihood that investigators have access to the necessary evidence. As a result, the BRN would not have to spend more time in the field or seek stale evidence if an RN fails to complete the program. The BRN would already have collected the necessary evidence to pursue disciplinary action. While the RN will lose the incentive to participate in the program to halt an investigation, those RNs that do and see the program to completion will continue to be shielded from disciplinary action. This could still be a strong incentive for some RNs in the program. Further, if the BRN has the discretion to investigate, it can choose not to investigate cases where evidence would be available later on or where RN’s willingness to participate would be affected (the BRN is the one that accepts the RN into the program in the first place).

In terms of data, the BRN’s 2016 Supplemental Sunset Report showed the following (page 45):

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>FY 14/15</th>
<th>FY 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Participants</td>
<td>148</td>
<td>106</td>
</tr>
<tr>
<td>Successful Completions</td>
<td>97</td>
<td>93</td>
</tr>
<tr>
<td>Participants (close of FY)</td>
<td>430</td>
<td>400</td>
</tr>
<tr>
<td>Terminations</td>
<td>57</td>
<td>42</td>
</tr>
<tr>
<td>Terminations for Public Threat</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>Drug Tests Ordered</td>
<td>15,230</td>
<td>16,229</td>
</tr>
<tr>
<td>Positive Drug Tests</td>
<td>494</td>
<td>717</td>
</tr>
<tr>
<td>Relapses</td>
<td>36</td>
<td>42</td>
</tr>
</tbody>
</table>

In the past two FYs, the intervention program has had an annual average of 415 participants, 127 of which were new participants and 39 of which were relapses. It also had an average of 171 participants leaving, which included 95 successful completions and 76 terminations (including 26 for public threat). While the number of intervention participants is small compared to the BRN’s overall licensing population, the issue is whether completing the investigation ahead of time will benefit the BRN’s enforcement timelines and process overall.

In FY 15/16, there were a total of 7,607 complaints referred for investigation. The question is whether the 76 terminations from the program involved additional nursing violations (presumably at least 27 for public threat) and whether the inability to investigate the cases at the start of the program affected the BRN’s ability to impose discipline if warranted or close the investigation in a timely manner.

REGISTERED SUPPORT:

California Hospital Association
California School Nurses Organization
REGISTERED OPPOSITION:

California Nurses Association
California Pharmacists Association
California Labor Federation
California Society of Addiction Medicine
California State Council of the Service Employees International Union
International Longshore and Warehouse Union, Local 29
Northern California District Council - ILWU

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