



Board of Behavioral Sciences



1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830
www.bbs.ca.gov

Gavin Newsom, Governor
State of California

Business, Consumer Services and Housing Agency
Department of Consumer Affairs

BOARD MEETING Notice and Agenda

May 9-10, 2019

**The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501**

While the Board intends to webcast this meeting, it may not be possible to webcast the entire meeting due to technical difficulties or limitations on resources. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at the physical location.

AGENDA

**Thursday, May 9, 2019
8:30 a.m.**

Location: The Galleria

OPEN SESSION

- I. Call to Order and Establishment of Quorum
- II. Public Comment for Items Not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Gov. Code §§ 11125, 1125.7(a)]
- III. Suggestions for Future Agenda Items
- IV. Petition for Modification of Probation for Alyssa Renee Bradley, LMFT 106426
- V. Petition for Modification of Probation for Donald Lewis, ASW 80267
- VI. Petition for Early Termination of Probation for Chelsea Salas, LMFT 85487
- VII. Petition for Early Termination of Probation for Barek Sharif, LMFT 100734

CLOSED SESSION

VIII. Pursuant to Section 11126(c)(3) of the Government Code, the Board Will Meet in Closed Session for Discussion and to Take Action on Disciplinary Matters, Including the Above Petitions

RECONVENE IN OPEN SESSION

IX. Recess Until 8:30 a.m., Friday, May 10, 2019

AGENDA
Friday, May 10, 2019
8:30 a.m.

Location: The Grand Parisian Ballroom

OPEN SESSION

- X. Call to Order, Establishment of Quorum, and Introductions*
- XI. Department of Consumer Affairs Update
 - a. Status of Executive Officer Salary Study
 - b. Other Departmental Activities
- XII. Consent Calendar
 - a. Approval of the February 28 – March 1, 2019 Board Meeting Minutes
- XIII. Board Chair Report
 - a. Board Member Activities
- XIV. Executive Officer Report
 - a. Budget Report
 - b. Operations Report
 - c. Personnel Report
 - d. Strategic Plan Update
- XV. Election of Board Chair and Vice Chair
- XVI. Discussion and Possible Action Regarding Board Fee Audit
- XVII. Update on Exam Vendor Contract
- XVIII. Discussion and Possible Action Regarding the Policy and Advocacy Committee Recommendations
 - a. Recommendation #1: Support Assembly Bill 613 (Low) Professions and Vocations: Regulatory Fees
 - b. Recommendation #2: Support Assembly Bill 769 (Smith) Federally Qualified Health Centers and Rural Health Clinics: Licensed Professional Clinical Counselor
 - c. Recommendation #3: Support Assembly Bill 1145 (Garcia) Child Abuse: Reportable Conduct

- d. Recommendation #4: Neutral on Assembly Bill 1540 (Holden) Music Therapy
 - e. Recommendation #5: Support if Amended Assembly Bill 1651 (Medina) Licensed Educational Psychologists: Supervision of Associates and Trainees
 - f. Recommendation #6: Support Senate Bill 10 (Beall) Mental Health Services: Peer, Parent, Transition-Age, and Family Support Specialist Certification
 - g. Recommendation #7: Support Senate Bill 163 (Portantino) Healthcare Coverage: Pervasive Developmental Disorder or Autism
 - h. Recommendation #8: Support Senate Bill 601 (Morrell) State Agencies: Licensees: Fee Waiver
 - i. Recommendation #9: Support if Amended Senate Bill 660 (Pan) Postsecondary Education: Mental Health Counselors
- XIX. Discussion and Possible Action Regarding Assembly Bill 184 (Mathis) Board of Behavioral Sciences: Registrants and Licensees
- XX. Discussion and Possible Action Regarding Senate Bill 425 (Hill) Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct
- XXI. Discussion and Possible Action Regarding Assembly Bill 8 (Chu) Pupil Health: Mental Health Professionals
- XXII. Discussion and Possible Action Regarding Assembly Bill 544 (Brough) Professions and Vocations: Inactive License Fees and Accrued and Unpaid Renewal Fees
- XXIII. Discussion and Possible Action Regarding Assembly Bill 1529 (Low) Telephone Medical Advice Services
- XXIV. Update on Board Sponsored Legislation
- a. Assembly Bill 630 (Low) Board of Behavioral Sciences: Marriage and Family Therapists: Clinical Social Workers: Educational Psychologists: Professional Clinical Counselors: Required Notice
 - b. Senate Bill 679 (Bates) Healing Arts: Therapists and Counselors: Licensing
 - c. Senate Bill 786 (Committee on Business, Professions, and Economic Development) Healing Arts
- XXV. Update on Board Rulemaking Proposals

XXVI. Public Comment for Items Not on the Agenda

Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Gov. Code §§ 11125, 1125.7(a)]

XXVII. Suggestions for Future Agenda Items

XXVIII. Adjournment

**Introductions are voluntary for members of the public.*

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Times and order of items are approximate and subject to change. Action may be taken on any item listed on the Agenda.

This agenda as well as Board meeting minutes can be found on the Board of Behavioral Sciences website at www.bbs.ca.gov.

NOTICE: The meeting is accessible to persons with disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Christina Kitamura at (916) 574-7835 or send a written request to Board of Behavioral Sciences, 1625 N. Market Blvd., Suite S-200, Sacramento, CA 95834. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

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Executive Office

1625 North Market Blvd., Suite S-308, Sacramento, CA 95834
P (916) 574-8200 F (916) 574-8613 | www.dca.ca.gov



April 30, 2019

Kim Madsen
Executive Officer
Board of Behavioral Sciences
1625 North Market Blvd., Suite 200
Sacramento, CA 95834

Executive Officer Madsen:

Thank you for this opportunity to submit a written update from the Department of Consumer Affairs (DCA) to the Board of Behavioral Sciences. You will find below an update on recent activities at the Department:

DEPARTURE OF THE DCA DIRECTOR

As many of you are aware, Director Dean R. Grafilo left his post as DCA's Director on April 19th. Director Grafilo has been a steadfast mentor and friend to so many of us here at the Department, and his presence will be dearly missed. I know that I am not alone in expressing my gratitude to serve under his leadership at DCA. We wish him the best of luck as he starts a new chapter in his career. Our executive team looks forward to working with the Governor's Office to ensure a smooth transition as we prepare for new leadership at the department.

During this transition, the Department is still planning to host a Director's Quarterly meeting with all Executive Officers and Bureau Chiefs on **June 3, 2019 from 1:30-3:00PM in the DCA Headquarters 2 Hearing Room.**

EXECUTIVE OFFICER SALARY STUDY

As previously reported, the Department retained KH Consulting to conduct the executive officer salary study. The study aims to provide an in-depth analysis of programmatic and operational complexities of DCA Boards, as well as a salary comparison survey from other states. The project was expected to take approximately 6 months – with an initial estimated completion date of March 2019.

There has been a slight delay due to some challenges receiving timely responses from other states as part of our benchmark survey. In the interest of incorporating as much data as possible about salaries from similar positions in other states, the timeline has been extended.

We are aiming for an end of April release of the final report to our programs. We appreciate your patience as we work toward finalizing this important project.

DCA's OPEN DATA PORTAL

In January, DCA's Office of Information Services (OIS) announced the launch of the [DCA's Open Data Portal](#), a publicly accessible, one-stop shop for licensing statistics and information where users can see trends and changes in licensing data going back three years, filtered by individual board or bureau, even by individual license type.

This month, the OIS Data Governance Team announced the incorporation of enforcement and application data into the Open Data Portal. In the Enforcement Statistics section, users can access information on the number of complaints received and referred for investigation. Also available is data on case aging, including cases that end with or without disciplinary action. In the Application Statistics section, users can access information on the average application processing time of initial exam and license applications, as well as processing times for incomplete applications.

For questions about the Open Data Portal, please contact Sean O'Connor, Chief of OIS's Project Delivery and Administrative Services.

FUTURE LEADERSHIP DEVELOPMENT PROGRAM

Later in May, this year's cohort, consisting of eight individuals will be graduating and celebrating their accomplishments. Over the past eight months, participants have been developed by their mentors, exposed to pertinent qualities and characteristics of executive leadership, completed and presented a team project that directly impacts DCA as a whole, and networked with internal and external leaders.

We would like to thank you, Ms. Madsen, for your support of this program and being a mentor this year.

Thank you again for your valued partnership. Please let us know if the Department can be of service to your board. If you have any questions, feel free to contact Christopher.Castrillo@DCA.ca.gov.

All the best,



Christopher Castrillo
Deputy Director, Board and Bureau Services
Department of Consumer Affairs



Board of Behavioral Sciences

Memo

1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830, (916) 574-8625 Fax
www.bbs.ca.gov

To: Board Members

Date: May 2, 2019

From: Christina Kitamura
Administrative Analyst

Telephone: (916) 574-7830

Subject: **Agenda Item XII: Consent Calendar**

Agenda item XII (Approval of February 28 – March 1, 2019 Board Meeting Minutes) will be provided in a supplemental package and will be posted on the website at that time.

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2018/2019 Budget

The Board's budget for fiscal year (FY) 2018/2019 is \$12,547,000. This amount includes an augmentation to support Enforcement operations.

The attached expenditure log reflects the information currently available to the Board.

| Expense Category | Amount | Percentage |
|-------------------------|---------------------|-------------------|
| Personnel | \$3,630,699 | 29% |
| OE&E | \$ 3,315,049 | 26% |
| Enforcement | \$ 1,145,664 | 6% |
| Total Expenses | \$ 8,091,382 | 64% |

At the February 2019 Board meeting, DCA's fiscal office indicated year end reporting for 2018 would be completed by March 2019. Recently, DCA's fiscal office provided an update regarding the FI\$Cal system. Due to additional reconciliation requirements, the 2018-year end report will be concluded after June 2019. A copy of the update from DCA is included for your review.

General Fund Loans

The Board's Fund Condition report reflects a \$3.3 million loan repayment in FY 2018/2019. This is the final payment of the \$12.3 million dollars previously loaned to the General Fund.

Board Fund Condition

The Board's Fund Condition for FY 2018/2019 reflects a 4.5-month reserve.

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MEMORANDUM

| | |
|----------------|--|
| DATE | April 18, 2019 |
| TO | ALL Board Executive Officers / Bureau Chiefs |
| FROM | Janice Shintaku-Enkoji, Chief Fiscal Operations |
| SUBJECT | DCA FI\$Cal Status Update (April 2019) |

This memo provides an update on DCA's efforts implementing the FI\$Cal system, the new statewide system for budgets, accounting, and procurement that the State of California has implemented for all state departments.

DCA transitioned to FI\$Cal in July 2017. While DCA has experienced one full fiscal year using the system and is fast approaching the end of a second year, the transition continues to pose challenges in the reconciliation and closing of fiscal year 2017-18.

In DCA's previous FI\$Cal update memo from last February, it was projected that year-end financial statements would start being produced in March 2019. Since that time, DCA has learned of additional reconciliation requirements that have impacted the previous estimated timeline. Specifically, while DCA has completed its fund reconciliation between FI\$Cal and the State Controller's Office, additional reconciliation steps must occur within submodules of the FI\$Cal system itself.

A significant number of issues between the modules within FI\$Cal have been uncovered as DCA has progressed in this additional reconciliation effort. Each item requires extensive research to diagnose, and individual tickets must be submitted to FI\$Cal staff for correction. The final year-end reconciling process in FI\$Cal is considerably more complex than originally anticipated and DCA now projects the preparation of final financial reports for FY 2017-18 after June 30, 2019.

DCA acknowledges this setback in the budget process and is working diligently in partnership with the Department of Finance and FI\$Cal to complete the reconciliation and year-end process as quickly as possible.

We appreciate your continued patience and understanding as we work to complete these additional technical and workload challenges.

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BOARD OF BEHAVIORAL SCIENCES
FY 2018-19 BUDGET REPORT
FM6

Based on 3/20 Activity Log - with
AG/OAH Augmentation

| OBJECT DESCRIPTION | FY 2017-18 | FY 2018-19 | | | |
|--|---|---------------------------------|---|----------------------------|-------------------------|
| | ACTUAL EXPENDITURES (Prelim FM12) | CY REVISED BUDGET 2018-19 | CURRENT YEAR EXPENDITURES (3/20 Activity Log) | PROJECTIONS TO YEAR END | UNENCUMBERED BALANCE |
| PERSONNEL SERVICES | | | | | |
| Salary & Wages (Staff) | 2,772,619 | 3,288,000 | 2,022,933 | 3,040,000 | 248,000 |
| Temp Help | 282,247 | 0 | 166,210 | 246,000 | (246,000) |
| Statutory Exempt (EO) | 108,288 | 91,000 | 75,080 | 113,000 | (22,000) |
| Board Member Per Diem | 16,600 | 13,000 | 6,800 | 12,000 | 1,000 |
| Overtime/Flex Elect | 104,857 | 2,000 | 2,803 | 14,000 | (12,000) |
| Staff Benefits | 1,758,138 | 2,038,000 | 1,356,843 | 2,037,000 | 1,000 |
| TOTALS, PERSONNEL SVC | 5,042,749 | 5,432,000 | 3,630,669 | 5,462,000 | (30,000) |
| OPERATING EXPENSE AND EQUIPMENT | | | | | |
| General Expense | 151,532 | 81,000 | 207,639 | 250,000 | (169,000) |
| Printing | 110,545 | 26,000 | 47,996 | 70,000 | (44,000) |
| Communication | 22,060 | 18,000 | 3,144 | 6,000 | 12,000 |
| Postage | 76,370 | 70,000 | 18,362 | 38,000 | 32,000 |
| Insurance | 17,250 | 0 | 0 | 0 | 0 |
| Travel In State | 60,481 | 59,000 | 8,297 | 30,000 | 29,000 |
| Travel, Out-of-State | 607 | 72,000 | 767 | 2,000 | 70,000 |
| Training | 2,702 | 28,000 | 1,250 | 3,000 | 25,000 |
| Facilities Operations | 441,988 | 228,000 | 288,441 | 356,000 | (128,000) |
| Utilities | 0 | 4,000 | 0 | 0 | 4,000 |
| C & P Services - Interdept. | 0 | 15,000 | 0 | 0 | 15,000 |
| Attorney General | 1,123,302 | 1,370,000 | 685,354 | 1,370,000 | 0 |
| Office of Administrative Hearings | 310,425 | 589,000 | 245,310 | 589,000 | 0 |
| C & P Services - External | 891,833 | 1,210,000 | 1,267,771 | 997,000 | 213,000 |
| DCA Pro Rata | 2,576,648 | 2,627,000 | 1,313,500 | 2,627,000 | 0 |
| DOI - Investigations | 555,300 | 430,000 | 215,000 | 430,000 | 0 |
| Interagency Services | 0 | 1,000 | 0 | 0 | 1,000 |
| IA w/ OPES | 323,944 | 325,000 | 157,426 | 325,000 | 0 |
| Consolidated Data Center | 16,909 | 29,000 | 1 | 17,000 | 12,000 |
| Information Technology | 2,769 | 14,000 | 0 | 3,000 | 11,000 |
| Equipment | 39,980 | 20,000 | 455 | 22,000 | (2,000) |
| Other Items of Expense | 1,125 | 0 | 0 | 0 | 0 |
| Vehicle Operations | 0 | 19,000 | 0 | 0 | 19,000 |
| TOTALS, OE&E | 6,725,770 | 7,235,000 | 4,460,713 | 7,135,000 | 100,000 |
| TOTAL EXPENSE | 11,768,519 | 12,667,000 | 8,091,382 | 12,597,000 | 70,000 |
| Sched. Reimb. - Fingerprints | (10,535) | (24,000) | (11,856) | (24,000) | 0 |
| Sched. Reimb. - Other | (574) | (26,000) | 0 | (26,000) | 0 |
| Unsched. Reimb. - Other | (242,086) | 0 | (184,108) | 0 | 0 |
| NET APPROPRIATION | 11,515,324 | 12,617,000 | 7,895,418 | 12,547,000 | 70,000 |

0773 - Behavioral Science
Analysis of Fund Condition
(Dollars in Thousands)

Prepared 1.24.2018

Governor's Budget

| | Governor's Budget | | | | | |
|--|--------------------------|----------------|----------------|----------------|----------------|----------------|
| | PY | CY | BY | BY+1 | BY+2 | BY+3 |
| | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
| BEGINNING BALANCE | \$ 5,647 | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ -2,461 | \$ -6,456 |
| Prior Year Adjustment | \$ - | \$ - | \$ - | \$ - | \$ - | \$ 2 |
| Adjusted Beginning Balance | \$ 5,647 | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ (2,461) | \$ (6,454) |
| REVENUES AND TRANSFERS | | | | | | |
| Revenues: | | | | | | |
| 4129200 Other regulatory fees | \$ 176 | \$ 221 | \$ 228 | \$ 228 | \$ 228 | \$ 228 |
| 4129400 Other regulatory licenses and permits | \$ 3,770 | \$ 3,637 | \$ 3,637 | \$ 3,637 | \$ 3,637 | \$ 3,637 |
| 4127400 Renewal fees | \$ 5,213 | \$ 5,268 | \$ 5,268 | \$ 5,268 | \$ 5,268 | \$ 5,268 |
| 4121200 Delinquent fees | \$ 100 | \$ 93 | \$ 93 | \$ 93 | \$ 93 | \$ 93 |
| 4163000 Income from surplus money investments | \$ 9 | \$ 14 | \$ 19 | \$ 40 | \$ 31 | \$ 19 |
| 4172500 Miscellaneous revenues | \$ 4 | \$ 11 | \$ 11 | \$ 11 | \$ 11 | \$ 11 |
| Totals, Revenues | \$ 9,272 | \$ 9,244 | \$ 9,256 | \$ 9,277 | \$ 9,268 | \$ 9,256 |
| Transfers from Other Funds | | | | | | |
| F00001 GF loan repayment per item 1110-011-0773 BA of 2008 | \$ 3,000 | \$ - | \$ - | \$ - | \$ - | \$ - |
| F00001 GF loan repayment per item 1110-011-0773 BA of 2011 | \$ - | \$ 3,300 | \$ - | \$ - | \$ - | \$ - |
| Totals, Revenues and Transfers | \$ 12,272 | \$ 12,544 | \$ 9,256 | \$ 9,277 | \$ 9,268 | \$ 9,256 |
| Totals, Resources | \$ 17,919 | \$ 17,709 | \$ 14,070 | \$ 10,561 | \$ 6,807 | \$ 2,802 |
| EXPENDITURES | | | | | | |
| Disbursements: | | | | | | |
| 1111 Department of Consumer Affairs Regulatory Boards, Bureaus, Divisions (State Operations) | \$ 12,047 | \$ 11,837 | \$ 11,823 | \$ 12,059 | \$ 12,300 | \$ 12,546 |
| 8880 Financial Information System for California (State Operations) | \$ 15 | \$ 1 | \$ -3 | \$ -3 | \$ -3 | \$ -3 |
| 9892 Supplemental Pension Payment (State Operations) | \$ - | \$ 100 | \$ 212 | \$ 212 | \$ 212 | \$ 212 |
| 9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations) | \$ 692 | \$ 957 | \$ 754 | \$ 754 | \$ 754 | \$ 754 |
| Total Disbursements | \$ 12,754 | \$ 12,895 | \$ 12,786 | \$ 13,022 | \$ 13,263 | \$ 13,509 |
| FUND BALANCE | | | | | | |
| Reserve for economic uncertainties | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ -2,461 | \$ -6,456 | \$ -10,707 |
| Months in Reserve | 4.8 | 4.5 | 1.2 | -2.2 | -5.7 | -9.3 |



Board Statistics

Attached for your review are the quarterly performance statistics for the third quarter of FY 2018/2019.

Licensing Program

Overall, application volumes increased 18% in the third quarter of FY 2018/2019.

Application Volumes

| Application Type | 3rd Quarter 1/10/19-3/31/19 | 2nd Quarter 10/1/18-12/31/18 | Difference |
|--|---|--|-------------------|
| AMFT Registration | 644 | 465 | +38% |
| AMFT Registration Subsequent Number | 186 | 160 | +16% |
| LMFT Examination | 753 | 673 | +12% |
| ASW Registration | 433 | 413 | +1% |
| ASW Registration Subsequent Number | 76 | 121 | -37% |
| LCSW Examination | 622 | 514 | +21% |
| LEP Examination | 32 | 32 | 0 |
| APCC Registration | 249 | 174 | +43% |
| APCC Registration Subsequent Number | 4 | 1 | +3% |
| LPCC Examination | 69 | 55 | +25% |
| Total Applications | 3068 | 2608 | +18% |

Days to Process Applications

| License Type | 3rd Quarter 1/1/19-3/31/19 | 2nd Quarter 10/1/18-12/31/18 | Difference |
|-------------------|-------------------------------|---------------------------------|------------|
| AMFT Registration | 15 days | 11 days | +4 days |
| LMFT Examination | 49 days | 43 days | +6 days |
| ASW Registration | 13 days | 9 days | +4 days |
| LCSW Examination | 31 days | 25 days | +7 days |
| LEP Examination | 16 days | 9 days | +7 days |
| APCC Registration | 16 days | 11 days | +5 days |
| LPCC Examination | 20 days | 13 days | +7 days |

A total of 1,418 initial licenses were issued in the third quarter. As of April 9, 2019, the Board has 115,753 licensees and registrants. This figure includes all licenses that have been issued that are current and/or eligible to renew.

| LICENSE POPULATION (As of 4/09/2019) | | | | |
|--------------------------------------|---------------|----------------------|---------------|---------------------|
| License Type | Active | Current In-Active | Delinquent | Total Population |
| Registrants | | | | |
| AMFT | 12,891 | N/A | 3,944 | 16,835 |
| ASW | 11,922 | N/A | 3,905 | 15,827 |
| APCC | 2,674 | N/A | 1,379 | 4,053 |
| Total Registrant | 27,487 | N/A | 9,228 | 36,715 |
| Licensees | | | | |
| LMFT | 38,571 | 4,321 | 3,004 | 45,896 |
| LCSW | 25,028 | 2,467 | 1,710 | 29,205 |
| LEP | 1,395 | 431 | 269 | 2,059 |
| LPCC | 1,679 | 137 | 62 | 1,878 |
| Total Licensee | 66,673 | 7,356 | 5,045 | 79,038 |
| Total Population | 94,160 | 7,356 | 14,273 | 115,753 |

Examination Program

Attached for your review are the examination statistics by school. A total 3,873 examinations were administered in the third quarter of FY 2018/2019.

| | 3rd Qtr | | | | 2nd Qtr | | | |
|-----------------------|----------------|--------|------------|--------|-------------------|--------|------------|--------|
| | 1/1/19-3/31/19 | | | | 10/01/18-12/31/18 | | | |
| | Total Exams | Pass % | First Time | Pass % | Total Exams | Pass % | First Time | Pass % |
| LMFT L/E* | 922 | 71% | 639 | 78% | 1,136 | 82% | 735 | 87% |
| LMFT Clinical* | 1,068 | 66% | 694 | 76% | 1,182 | 60% | 787 | 70% |
| LCSW L/E* | 775 | 76% | 585 | 79% | 953 | 74% | 692 | 77% |
| LCSW ASWB | 843 | 61% | 585 | 75% | 881 | 61% | 609 | 75% |
| LPCC L/E* | 241 | 74% | 167 | 79% | 250 | 68% | 175 | 70% |
| LPCC NCMHCE | 38 | 61% | 26 | 65% | 79 | 58% | 62 | 58% |
| LEP* | 41 | 54% | 23 | 74% | 49 | 53% | 29 | 69% |

*^Total includes paper/pencil exams *Board developed examination*

Ten examination development workshops were conducted from January 1, 2019 to March 31, 2019.

OPES continues work on the LMFT Occupational Analysis. The occupational analysis is a study of the profession and provides the bases for the LMFT Written Clinical licensing examination. As part of the process, a survey will be available online at the end of August 2019.

The input of licensees is very important to the occupational analysis process, and the Board is inviting all LMFT licensees who are interested to participate. All LMFT licensees who have an email on file with the Board will be sent a link to the survey. If a LMFT would like to participate, please update or add your email address with the Board before July 1, 2019. Additionally, the link will be available on the Board's website.

Administration Program

The Board received 8,163 applications in the second quarter, a 1% increase since last quarter. This figure does not include renewal applications. The chart below reflects the total renewal activity for the third quarter.

| RENEWAL ACTIVITY | | |
|-------------------------|---------------------------|-------------------|
| | Number of Renewals | Percentage |
| BBS Processed | 475 | 4% |
| Online Renewal | 12,933 | 96% |
| Total | 13,408 | |

Enforcement Program

During the third quarter, the Enforcement staff received 391 consumer complaints and 252 criminal convictions. A total of 550 cases were closed and 28 cases were referred to the Attorney General's office for formal discipline. As of March 31, 2019, there were 442 cases pending at the Attorney General's Office. A total of 28 Accusations and 12 Statement of Issues were filed this quarter. The number of final citations for the third quarter was 32.

A total of 19 decisions were adopted. The average number of days to complete Formal Discipline in the third quarter was 370 days. The year to date average is 345 days. This statistic is measured from the date the Board receives the complaint to the date the discipline becomes effective. The DCA Performance Measure to complete Formal Discipline is 540 days.

The average number of days the case is with the Attorney General's Office in the third quarter was 528. The year to date average is 513 days. This statistic is measured from the date the Board refers the matter to the Attorney General's to the date the case is complete. The average number of days to complete all Board investigations in the third quarter was 194 days. The year to date average is 131 days.

Continuing Education Audits

Due to operational needs, the Board temporarily suspended continuing education audits from February to April.

Outreach Activity

Board staff either physically attended the following events or participated via a phone conference.

| | |
|-------------------|----------------------------------|
| December 14, 2018 | Orange County MFT Consortium |
| February 1, 2019 | Sacramento MFT Consortium |
| February 8, 2019 | Central Valley MFT Consortium |
| March 2, 2019 | Greater LA County MFT Consortium |
| March 11, 2019 | Central Coast MFT Consortium |
| March 14, 2019 | Inland Empire MFT Consortium |
| March 20, 2019 | Orange County MFT Consortium |
| March 28, 2019 | Chico School of Social Work |
| April 7, 2019 | NASW Lobby Days |
| April 25-27, 2019 | CAMFT Annual Conference |
| May 3, 2019 | Orange County MFT Consortium |

Board Move Update

Construction on the new suite was completed early March. During the week of March 11, 2019, Board staff moved into the new suite.

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Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

LICENSE TYPE: LCSW

EXAM: LCSW Clinical Exam (ASWB)

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Azusa Pacific University, Azusa | 103 | 18 | 10 | 56% | 8 | 44% | 12 | 8 | 67% | 4 | 33% |
| California State University, Bakersfield | 002 | 15 | 10 | 67% | 5 | 33% | 9 | 9 | 100% | 0 | 0% |
| California State University, Chico | 003 | 20 | 11 | 55% | 9 | 45% | 13 | 10 | 77% | 3 | 23% |
| California State University, Dominguez Hills | 004 | 24 | 11 | 46% | 13 | 54% | 15 | 10 | 67% | 5 | 33% |
| California State University, Fresno | 005 | 23 | 6 | 26% | 17 | 74% | 13 | 5 | 38% | 8 | 62% |
| California State University, Fullerton | 006 | 15 | 9 | 60% | 6 | 40% | 11 | 8 | 73% | 3 | 27% |
| California State University, Hayward | 007 | 34 | 13 | 38% | 21 | 62% | 26 | 12 | 46% | 14 | 54% |
| California State University, Long Beach | 008 | 76 | 36 | 47% | 40 | 53% | 48 | 30 | 62% | 18 | 38% |
| California State University, Los Angeles | 009 | 32 | 19 | 59% | 13 | 41% | 17 | 12 | 71% | 5 | 29% |
| California State University, Northridge | 010 | 40 | 23 | 58% | 17 | 42% | 28 | 17 | 61% | 11 | 39% |
| California State University, Sacramento | 011 | 46 | 28 | 61% | 18 | 39% | 32 | 20 | 62% | 12 | 38% |
| California State University, San Bernardino | 012 | 17 | 9 | 53% | 8 | 47% | 9 | 6 | 67% | 3 | 33% |
| California State University, Stanislaus | 013 | 21 | 12 | 57% | 9 | 43% | 13 | 9 | 69% | 4 | 31% |
| Humboldt State University, Arcata | 014 | 4 | 3 | 75% | 1 | 25% | 3 | 2 | 67% | 1 | 33% |
| Loma Linda University, Orinda | 125 | 16 | 5 | 31% | 11 | 69% | 8 | 3 | 38% | 5 | 62% |
| OUT-OF-COUNTRY | 400 | 4 | 2 | 50% | 2 | 50% | 2 | 2 | 100% | 0 | 0% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|-----|--------------|-----|------|----|-----|-------------|-----|------|----|-----|
| | | | | | | | | | | | |
| Out-of-State | 300 | 92 | 68 | 74% | 24 | 26% | 75 | 63 | 84% | 12 | 16% |
| San Diego State University | 015 | 21 | 17 | 81% | 4 | 19% | 18 | 16 | 89% | 2 | 11% |
| San Francisco State University | 016 | 17 | 10 | 59% | 7 | 41% | 8 | 8 | 100% | 0 | 0% |
| San Jose State University | 017 | 46 | 27 | 59% | 19 | 41% | 29 | 23 | 79% | 6 | 21% |
| San Marcos University | 019 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| UC, Berkeley | 050 | 29 | 25 | 86% | 4 | 14% | 26 | 25 | 96% | 1 | 4% |
| UC, Los Angeles | 052 | 22 | 19 | 86% | 3 | 14% | 19 | 18 | 95% | 1 | 5% |
| University of Southern California, Los Angeles | 145 | 210 | 144 | 69% | 66 | 31% | 150 | 121 | 81% | 29 | 19% |

LCSW Clinical Exam (ASWB) TOTAL: 843 518 61% 325 39% 585 438 75% 147 25%

EXAM: LCSW Law and Ethics

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Azusa Pacific University, Azusa | 103 | 16 | 14 | 88% | 2 | 12% | 10 | 8 | 80% | 2 | 20% |
| California State University, Bakersfield | 002 | 18 | 12 | 67% | 6 | 33% | 10 | 6 | 60% | 4 | 40% |
| California State University, Chico | 003 | 11 | 8 | 73% | 3 | 27% | 10 | 7 | 70% | 3 | 30% |
| California State University, Dominguez Hills | 004 | 12 | 8 | 67% | 4 | 33% | 3 | 3 | 100% | 0 | 0% |
| California State University, Fresno | 005 | 11 | 4 | 36% | 7 | 64% | 8 | 2 | 25% | 6 | 75% |
| California State University, Fullerton | 006 | 11 | 10 | 91% | 1 | 9% | 11 | 10 | 91% | 1 | 9% |
| California State University, Hayward | 007 | 35 | 25 | 71% | 10 | 29% | 19 | 15 | 79% | 4 | 21% |
| California State University, Long Beach | 008 | 38 | 30 | 79% | 8 | 21% | 25 | 20 | 80% | 5 | 20% |
| California State University, Los Angeles | 009 | 19 | 12 | 63% | 7 | 37% | 11 | 7 | 64% | 4 | 36% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Angeles | | | | | | | | | | | |
| California State University, Northridge | 010 | 30 | 25 | 83% | 5 | 17% | 27 | 22 | 81% | 5 | 19% |
| California State University, Sacramento | 011 | 21 | 16 | 76% | 5 | 24% | 12 | 10 | 83% | 2 | 17% |
| California State University, San Bernardino | 012 | 22 | 17 | 77% | 5 | 23% | 19 | 14 | 74% | 5 | 26% |
| California State University, Stanislaus | 013 | 15 | 10 | 67% | 5 | 33% | 11 | 8 | 73% | 3 | 27% |
| Humboldt State University, Arcata | 014 | 8 | 6 | 75% | 2 | 25% | 6 | 5 | 83% | 1 | 17% |
| Loma Linda University, Orinda | 125 | 9 | 6 | 67% | 3 | 33% | 6 | 5 | 83% | 1 | 17% |
| Monterey Bay State University | 018 | 7 | 4 | 57% | 3 | 43% | 6 | 3 | 50% | 3 | 50% |
| OUT-OF-COUNTRY | 400 | 7 | 4 | 57% | 3 | 43% | 1 | 1 | 100% | 0 | 0% |
| Out-of-State | 300 | 174 | 128 | 74% | 46 | 26% | 147 | 114 | 78% | 33 | 22% |
| San Diego State University | 015 | 31 | 27 | 87% | 4 | 13% | 28 | 25 | 89% | 3 | 11% |
| San Francisco State University | 016 | 11 | 7 | 64% | 4 | 36% | 7 | 5 | 71% | 2 | 29% |
| San Jose State University | 017 | 26 | 21 | 81% | 5 | 19% | 21 | 19 | 90% | 2 | 10% |
| San Marcos University | 019 | 3 | 3 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| UC, Berkeley | 050 | 15 | 9 | 60% | 6 | 40% | 13 | 8 | 62% | 5 | 38% |
| UC, Los Angeles | 052 | 16 | 15 | 94% | 1 | 6% | 16 | 15 | 94% | 1 | 6% |
| University of Southern California, Los Angeles | 145 | 209 | 167 | 80% | 42 | 20% | 155 | 128 | 83% | 27 | 17% |

LCSW Law and Ethics TOTAL: 775 588 76% 187 24% 585 463 79% 122 21%

LICENSE TYPE: LEP

EXAM: LEP Standard Written Exam

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

LCSW Law and Ethics TOTAL: 775 588 76% 187 24% 585 463 79% 122 21%

LICENSE TYPE: LEP

EXAM: LEP Standard Written Exam

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | |
|---|-----|--------------|---|------|---|------|-------------|---|------|---|
| | | | | | | | | | | |
| Alliant International University (aka CSPP) | 112 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 |
| Alliant International University (aka US International) | 139 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 |
| Azusa Pacific University, Azusa | 103 | 2 | 1 | 50% | 1 | 50% | 1 | 1 | 100% | 0 |
| Biola University, La Mirada(Rosemead School of Psy) | 104 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 |
| California Baptist University, Riverside | 105 | 2 | 0 | 0% | 2 | 100% | 1 | 0 | 0% | 1 |
| California State University, Dominguez Hills | 004 | 3 | 1 | 33% | 2 | 67% | 0 | 0 | | 0 |
| California State University, Hayward | 007 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 |
| California State University, Long Beach | 008 | 2 | 1 | 50% | 1 | 50% | 1 | 0 | 0% | 1 |
| California State University, Los Angeles | 009 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 |
| California State University, Sacramento | 011 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 |
| Chapman University, Orange | 113 | 4 | 3 | 75% | 1 | 25% | 3 | 3 | 100% | 0 |
| Fresno Pacific University | 153 | 3 | 3 | 100% | 0 | 0% | 3 | 3 | 100% | 0 |
| Loyola Marymount University, Los Angeles | 126 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 |
| National University | 129 | 4 | 2 | 50% | 2 | 50% | 0 | 0 | | 0 |
| OUT-OF-COUNTRY | 400 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 |
| Out-of-State | 300 | 7 | 5 | 71% | 2 | 29% | 5 | 4 | 80% | 1 |
| Pepperdine University, Malibu | 135 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 |
| San Diego State University | 015 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 |
| UC, Berkeley | 050 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 |
| UC, Santa Barbara | 056 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 |
| University of La Verne, La Verne | 140 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 |
| University of the Pacific, Stockton | 146 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 |

LEP Standard Written Exam TOTAL: 41 22 54% 19 46% 23 17 74% 6 26%

LICENSE TYPE: LMFT

EXAM: LMFT Clinical Exam

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| FAILED PERCENT | | | | | | | | | | |
|----------------|--|--|--|--|--|--|--|--|--|--|
| 100% | | | | | | | | | | |
| 100% | | | | | | | | | | |
| 0% | | | | | | | | | | |
| 0% | | | | | | | | | | |
| 100% | | | | | | | | | | |
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| 0% | | | | | | | | | | |
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| 0% | | | | | | | | | | |
| 100% | | | | | | | | | | |
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| 20% | | | | | | | | | | |
| | | | | | | | | | | |
| 0% | | | | | | | | | | |
| 0% | | | | | | | | | | |
| | | | | | | | | | | |
| 0% | | | | | | | | | | |

| | | | | | | | | | | |
|----------------------------------|----|----|-----|----|-----|----|----|-----|---|-----|
| LEP Standard Written Exam TOTAL: | 41 | 22 | 54% | 19 | 46% | 23 | 17 | 74% | 6 | 26% |
|----------------------------------|----|----|-----|----|-----|----|----|-----|---|-----|

LICENSE TYPE: LMFT

EXAM: LMFT Clinical Exam

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Alliant International University (aka US International) | 139 | 17 | 12 | 71% | 5 | 29% | 8 | 6 | 75% | 2 | 25% |
| Antioch University, Los Angeles | 241 | 47 | 32 | 68% | 15 | 32% | 35 | 26 | 74% | 9 | 26% |
| Antioch University, Santa Barbara | 243 | 9 | 4 | 44% | 5 | 56% | 6 | 3 | 50% | 3 | 50% |
| Argosy University (aka American School of Prof. Psych. | 204 | 44 | 28 | 64% | 16 | 36% | 24 | 16 | 67% | 8 | 33% |
| Azusa Pacific University, Azusa | 103 | 29 | 23 | 79% | 6 | 21% | 18 | 14 | 78% | 4 | 22% |
| Bethany College | 157 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 | 100% |
| Bethel Theological Seminary | 152 | 4 | 2 | 50% | 2 | 50% | 2 | 2 | 100% | 0 | 0% |
| Brandman University | 253 | 45 | 23 | 51% | 22 | 49% | 32 | 19 | 59% | 13 | 41% |
| Calif. Polytechnic State University, San Luis Obispo - Cal Poly | 001 | 2 | 2 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| California Baptist University, Riverside | 105 | 35 | 20 | 57% | 15 | 43% | 19 | 13 | 68% | 6 | 32% |
| California Graduate Institute, Los Angeles | 203 | 2 | 1 | 50% | 1 | 50% | 0 | 0 | | 0 | |
| California Institute of Integral Studies, S.F. | 107 | 25 | 22 | 88% | 3 | 12% | 22 | 20 | 91% | 2 | 9% |
| California Lutheran University, Thousand Oaks | 108 | 17 | 13 | 76% | 4 | 24% | 13 | 11 | 85% | 2 | 15% |
| California Southern University | 246 | 5 | 5 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| California State Polytechnic University, Pomona | 019 | 5 | 5 | 100% | 0 | 0% | 5 | 5 | 100% | 0 | 0% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| California State University, Bakersfield | 002 | 3 | 2 | 67% | 1 | 33% | 3 | 2 | 67% | 1 | 33% |
| California State University, Chico | 003 | 3 | 2 | 67% | 1 | 33% | 3 | 2 | 67% | 1 | 33% |
| California State University, Dominguez Hills | 004 | 11 | 6 | 55% | 5 | 45% | 5 | 1 | 20% | 4 | 80% |
| California State University, Fresno | 005 | 17 | 9 | 53% | 8 | 47% | 12 | 7 | 58% | 5 | 42% |
| California State University, Fullerton | 006 | 18 | 8 | 44% | 10 | 56% | 12 | 8 | 67% | 4 | 33% |
| California State University, Hayward | 007 | 17 | 8 | 47% | 9 | 53% | 9 | 7 | 78% | 2 | 22% |
| California State University, Long Beach | 008 | 12 | 9 | 75% | 3 | 25% | 8 | 6 | 75% | 2 | 25% |
| California State University, Los Angeles | 009 | 7 | 5 | 71% | 2 | 29% | 4 | 4 | 100% | 0 | 0% |
| California State University, Northridge | 010 | 21 | 17 | 81% | 4 | 19% | 15 | 12 | 80% | 3 | 20% |
| California State University, Sacramento | 011 | 7 | 6 | 86% | 1 | 14% | 6 | 5 | 83% | 1 | 17% |
| California State University, San Bernardino | 012 | 3 | 3 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| California State University, Stanislaus | 013 | 3 | 3 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| Chapman University, Orange | 113 | 16 | 13 | 81% | 3 | 19% | 9 | 7 | 78% | 2 | 22% |
| Dominican University of California | 117 | 4 | 2 | 50% | 2 | 50% | 2 | 2 | 100% | 0 | 0% |
| Fresno Pacific Biblical Seminary, Fresno | 127 | 6 | 5 | 83% | 1 | 17% | 5 | 4 | 80% | 1 | 20% |
| Fuller Theological Seminary, Pasadena | 119 | 14 | 14 | 100% | 0 | 0% | 13 | 13 | 100% | 0 | 0% |
| Golden Gate | 151 | 4 | 1 | 25% | 3 | 75% | 3 | 1 | 33% | 2 | 67% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| University | | | | | | | | | | | |
| Holy Names University, Oakland | 122 | 3 | 1 | 33% | 2 | 67% | 1 | 1 | 100% | 0 | 0% |
| Hope International University | 131 | 13 | 5 | 38% | 8 | 62% | 7 | 3 | 43% | 4 | 57% |
| Humboldt State University, Arcata | 014 | 2 | 1 | 50% | 1 | 50% | 1 | 1 | 100% | 0 | 0% |
| John F. Kennedy University, Orinda | 124 | 42 | 23 | 55% | 19 | 45% | 25 | 16 | 64% | 9 | 36% |
| Loma Linda University, Orinda | 125 | 9 | 8 | 89% | 1 | 11% | 6 | 5 | 83% | 1 | 17% |
| Loyola Marymount University, Los Angeles | 126 | 10 | 10 | 100% | 0 | 0% | 9 | 9 | 100% | 0 | 0% |
| Mount St. Mary's College, Los Angeles | 128 | 12 | 8 | 67% | 4 | 33% | 9 | 5 | 56% | 4 | 44% |
| National University | 129 | 72 | 43 | 60% | 29 | 40% | 48 | 34 | 71% | 14 | 29% |
| New College of California, San Francisco | 130 | 2 | 1 | 50% | 1 | 50% | 1 | 0 | 0% | 1 | 100% |
| Northcentral University | 256 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| Notre Dame de Namur University | 116 | 23 | 17 | 74% | 6 | 26% | 17 | 14 | 82% | 3 | 18% |
| OUT-OF-COUNTRY | 400 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| Out-of-State | 300 | 24 | 18 | 75% | 6 | 25% | 19 | 17 | 89% | 2 | 11% |
| Pacific Oaks College, Pasadena | 133 | 18 | 9 | 50% | 9 | 50% | 8 | 6 | 75% | 2 | 25% |
| Pacifica Graduate Institute, Carpinteria | 154 | 20 | 14 | 70% | 6 | 30% | 15 | 13 | 87% | 2 | 13% |
| Palo Alto University | 258 | 11 | 9 | 82% | 2 | 18% | 9 | 7 | 78% | 2 | 22% |
| Pepperdine University, Malibu | 135 | 59 | 49 | 83% | 10 | 17% | 42 | 39 | 93% | 3 | 7% |
| Phillips | 106 | 27 | 22 | 81% | 5 | 19% | 17 | 15 | 88% | 2 | 12% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Graduate Institute | | | | | | | | | | | |
| Ryokan College, Los Angeles | 216 | 2 | 2 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| San Diego State University | 015 | 5 | 3 | 60% | 2 | 40% | 3 | 2 | 67% | 1 | 33% |
| San Francisco State University | 016 | 8 | 6 | 75% | 2 | 25% | 6 | 6 | 100% | 0 | 0% |
| San Jose State University | 017 | 2 | 2 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Santa Barbara Graduate Institute | 245 | 2 | 1 | 50% | 1 | 50% | 2 | 1 | 50% | 1 | 50% |
| Santa Clara University | 144 | 18 | 18 | 100% | 0 | 0% | 15 | 15 | 100% | 0 | 0% |
| Simpson University | 254 | 5 | 4 | 80% | 1 | 20% | 5 | 4 | 80% | 1 | 20% |
| Sofia University, San Jose | 155 | 9 | 8 | 89% | 1 | 11% | 4 | 4 | 100% | 0 | 0% |
| Sonoma State University | 018 | 4 | 3 | 75% | 1 | 25% | 2 | 2 | 100% | 0 | 0% |
| Southern California Seminary (aka Southern CA Bible College and Seminary) | 237 | 2 | 1 | 50% | 1 | 50% | 1 | 1 | 100% | 0 | 0% |
| St. Mary's College of CA, Moraga | 136 | 8 | 5 | 62% | 3 | 38% | 8 | 5 | 62% | 3 | 38% |
| The Chicago School of Professional Psychology at Los Angeles | 251 | 13 | 9 | 69% | 4 | 31% | 8 | 5 | 62% | 3 | 38% |
| UC, Santa Barbara | 056 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| University of La Verne, La Verne | 140 | 12 | 6 | 50% | 6 | 50% | 7 | 5 | 71% | 2 | 29% |
| University of Phoenix, Sacramento | 238 | 5 | 2 | 40% | 3 | 60% | 1 | 0 | 0% | 1 | 100% |
| University of Phoenix, San Diego | 236 | 107 | 45 | 42% | 62 | 58% | 43 | 20 | 47% | 23 | 53% |
| University of San Diego, San Diego | 142 | 9 | 9 | 100% | 0 | 0% | 8 | 8 | 100% | 0 | 0% |
| University of San Francisco, | 143 | 22 | 13 | 59% | 9 | 41% | 12 | 5 | 42% | 7 | 58% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| San Francisco | | | | | | | | | | | |
| University of Santa Monica | 240 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| University of Southern California, Los Angeles | 145 | 11 | 11 | 100% | 0 | 0% | 11 | 11 | 100% | 0 | 0% |
| University of the West | 255 | 3 | 1 | 33% | 2 | 67% | 2 | 1 | 50% | 1 | 50% |
| Vanguard University of Southern California | 156 | 4 | 3 | 75% | 1 | 25% | 3 | 3 | 100% | 0 | 0% |
| Webster University | 248 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| Western Seminary (Western Conservative Baptist Seminary) | 232 | 5 | 5 | 100% | 0 | 0% | 5 | 5 | 100% | 0 | 0% |
| Wright Institute, Berkeley | 150 | 5 | 5 | 100% | 0 | 0% | 5 | 5 | 100% | 0 | 0% |

LMFT Clinical Exam TOTAL: 1,068 710 66% 358 34% 694 524 76% 170 24%

EXAM: LMFT Law and Ethics

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Alliant International University (aka US International) | 139 | 24 | 15 | 62% | 9 | 38% | 17 | 11 | 65% | 6 | 35% |
| Antioch University, Los Angeles | 241 | 53 | 43 | 81% | 10 | 19% | 42 | 39 | 93% | 3 | 7% |
| Antioch University, Santa Barbara | 243 | 10 | 8 | 80% | 2 | 20% | 6 | 6 | 100% | 0 | 0% |
| Argosy University (aka American School of Prof. Psych.) | 204 | 37 | 24 | 65% | 13 | 35% | 24 | 17 | 71% | 7 | 29% |
| Azusa Pacific University, Azusa | 103 | 19 | 16 | 84% | 3 | 16% | 13 | 12 | 92% | 1 | 8% |
| Brandman University | 253 | 44 | 22 | 50% | 22 | 50% | 27 | 15 | 56% | 12 | 44% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Calif. Polytechnic State University, San Luis Obispo - Cal Poly | 001 | 6 | 6 | 100% | 0 | 0% | 6 | 6 | 100% | 0 | 0% |
| California Baptist University, Riverside | 105 | 28 | 16 | 57% | 12 | 43% | 22 | 12 | 55% | 10 | 45% |
| California Institute of Integral Studies, S.F. | 107 | 36 | 26 | 72% | 10 | 28% | 29 | 24 | 83% | 5 | 17% |
| California Lutheran University, Thousand Oaks | 108 | 13 | 10 | 77% | 3 | 23% | 11 | 9 | 82% | 2 | 18% |
| California Southern University | 246 | 7 | 5 | 71% | 2 | 29% | 6 | 5 | 83% | 1 | 17% |
| California State Polytechnic University, Pomona | 019 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| California State University, Bakersfield | 002 | 3 | 2 | 67% | 1 | 33% | 3 | 2 | 67% | 1 | 33% |
| California State University, Chico | 003 | 3 | 2 | 67% | 1 | 33% | 2 | 1 | 50% | 1 | 50% |
| California State University, Dominguez Hills | 004 | 9 | 4 | 44% | 5 | 56% | 7 | 3 | 43% | 4 | 57% |
| California State University, Fresno | 005 | 15 | 13 | 87% | 2 | 13% | 9 | 8 | 89% | 1 | 11% |
| California State University, Fullerton | 006 | 13 | 12 | 92% | 1 | 8% | 12 | 11 | 92% | 1 | 8% |
| California State University, Hayward | 007 | 9 | 5 | 56% | 4 | 44% | 5 | 4 | 80% | 1 | 20% |
| California State University, Long Beach | 008 | 14 | 10 | 71% | 4 | 29% | 11 | 10 | 91% | 1 | 9% |
| California State University, Los Angeles | 009 | 6 | 5 | 83% | 1 | 17% | 3 | 3 | 100% | 0 | 0% |
| California State University, Northridge | 010 | 25 | 22 | 88% | 3 | 12% | 21 | 19 | 90% | 2 | 10% |
| California State | 011 | 3 | 3 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| University, Sacramento | | | | | | | | | | | |
| California State University, San Bernardino | 012 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| California State University, Stanislaus | 013 | 4 | 4 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| Chapman University, Orange | 113 | 6 | 4 | 67% | 2 | 33% | 4 | 4 | 100% | 0 | 0% |
| Dominican University of California | 117 | 6 | 6 | 100% | 0 | 0% | 6 | 6 | 100% | 0 | 0% |
| Fuller Theological Seminary, Pasadena | 119 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| Golden Gate University | 151 | 2 | 0 | 0% | 2 | 100% | 2 | 0 | 0% | 2 | 100% |
| HIS University | 247 | 2 | 1 | 50% | 1 | 50% | 2 | 1 | 50% | 1 | 50% |
| Holy Names University, Oakland | 122 | 9 | 6 | 67% | 3 | 33% | 4 | 3 | 75% | 1 | 25% |
| Hope International University | 131 | 18 | 12 | 67% | 6 | 33% | 15 | 11 | 73% | 4 | 27% |
| Humboldt State University, Arcata | 014 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| International College, Los Angeles | 210 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| John F. Kennedy University, Orinda | 124 | 41 | 27 | 66% | 14 | 34% | 26 | 19 | 73% | 7 | 27% |
| Loma Linda University, Orinda | 125 | 5 | 5 | 100% | 0 | 0% | 5 | 5 | 100% | 0 | 0% |
| Loyola Marymount University, Los Angeles | 126 | 3 | 2 | 67% | 1 | 33% | 3 | 2 | 67% | 1 | 33% |
| Meridian University | 231 | 2 | 2 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Mount St. Mary's College, Los Angeles | 128 | 4 | 2 | 50% | 2 | 50% | 2 | 0 | 0% | 2 | 100% |
| National | 129 | 54 | 31 | 57% | 23 | 43% | 31 | 19 | 61% | 12 | 39% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| University | | | | | | | | | | | |
| New College of California, San Francisco | 130 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 | 100% |
| Northcentral University | 256 | 3 | 1 | 33% | 2 | 67% | 2 | 1 | 50% | 1 | 50% |
| Notre Dame de Namur University | 116 | 14 | 11 | 79% | 3 | 21% | 12 | 10 | 83% | 2 | 17% |
| OUT-OF-COUNTRY | 400 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 | 100% |
| Out-of-State | 300 | 33 | 21 | 64% | 12 | 36% | 25 | 16 | 64% | 9 | 36% |
| Pacific Oaks College, Pasadena | 133 | 21 | 14 | 67% | 7 | 33% | 7 | 5 | 71% | 2 | 29% |
| Pacifica Graduate Institute, Carpinteria | 154 | 8 | 6 | 75% | 2 | 25% | 7 | 5 | 71% | 2 | 29% |
| Palo Alto University | 258 | 14 | 13 | 93% | 1 | 7% | 13 | 13 | 100% | 0 | 0% |
| Pepperdine University, Malibu | 135 | 43 | 32 | 74% | 11 | 26% | 31 | 25 | 81% | 6 | 19% |
| Phillips Graduate Institute | 106 | 24 | 18 | 75% | 6 | 25% | 17 | 14 | 82% | 3 | 18% |
| Ryokan College, Los Angeles | 216 | 2 | 1 | 50% | 1 | 50% | 1 | 0 | 0% | 1 | 100% |
| San Diego State University | 015 | 3 | 3 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| San Diego University for Integrative Studies | 244 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| San Francisco State University | 016 | 5 | 4 | 80% | 1 | 20% | 3 | 3 | 100% | 0 | 0% |
| San Jose State University | 017 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| Santa Clara University | 144 | 15 | 12 | 80% | 3 | 20% | 11 | 10 | 91% | 1 | 9% |
| Simpson University | 254 | 4 | 4 | 100% | 0 | 0% | 0 | 0 | | 0 | |
| Sofia University, San Jose | 155 | 3 | 2 | 67% | 1 | 33% | 1 | 1 | 100% | 0 | 0% |
| Sonoma State University | 018 | 4 | 4 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| Southern | 237 | 2 | 0 | 0% | 2 | 100% | 0 | 0 | | 0 | |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| California Seminary (aka Southern CA Bible College and Seminary) | | | | | | | | | | | |
| St. Mary's College of CA, Moraga | 136 | 5 | 5 | 100% | 0 | 0% | 4 | 4 | 100% | 0 | 0% |
| The Chicago School of Professional Psychology at Los Angeles | 251 | 9 | 8 | 89% | 1 | 11% | 8 | 7 | 88% | 1 | 12% |
| TOURO UNIVERSITY | 262 | 4 | 2 | 50% | 2 | 50% | 4 | 2 | 50% | 2 | 50% |
| Trinity College of Graduate Studies, Orange | 201 | 3 | 2 | 67% | 1 | 33% | 2 | 1 | 50% | 1 | 50% |
| University of La Verne, La Verne | 140 | 9 | 6 | 67% | 3 | 33% | 5 | 4 | 80% | 1 | 20% |
| University of Phoenix, San Diego | 236 | 92 | 53 | 58% | 39 | 42% | 40 | 24 | 60% | 16 | 40% |
| University of San Diego, San Diego | 142 | 10 | 10 | 100% | 0 | 0% | 10 | 10 | 100% | 0 | 0% |
| University of San Francisco, San Francisco | 143 | 18 | 15 | 83% | 3 | 17% | 14 | 13 | 93% | 1 | 7% |
| University of Southern California, Los Angeles | 145 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| University of the West | 255 | 2 | 2 | 100% | 0 | 0% | 0 | 0 | | 0 | |
| Vanguard University of Southern California | 156 | 5 | 3 | 60% | 2 | 40% | 5 | 3 | 60% | 2 | 40% |
| Webster University | 248 | 2 | 0 | 0% | 2 | 100% | 0 | 0 | | 0 | |
| Western Institute for Social Research, Berkeley | 220 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Western Seminary (Western Conservative Baptist Seminary) | 232 | 9 | 9 | 100% | 0 | 0% | 8 | 8 | 100% | 0 | 0% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|----------------------------|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Wright Institute, Berkeley | 150 | 9 | 8 | 89% | 1 | 11% | 8 | 7 | 88% | 1 | 12% |

LMFT Law and Ethics TOTAL: 922 651 71% 271 29% 639 496 78% 143 22%

LICENSE TYPE: LPCC

EXAM: LPCC Law and Ethics

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Alliant International University (aka CSPP) | 112 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| Antioch University, Santa Barbara | 243 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Argosy University (aka American School of Prof. Psych.) | 204 | 4 | 2 | 50% | 2 | 50% | 0 | 0 | | 0 | |
| Azusa Pacific University, Azusa | 103 | 15 | 7 | 47% | 8 | 53% | 6 | 2 | 33% | 4 | 67% |
| Bethel Theological Seminary | 152 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 | 100% |
| Brandman University | 253 | 10 | 6 | 60% | 4 | 40% | 9 | 6 | 67% | 3 | 33% |
| California Baptist University, Riverside | 105 | 9 | 9 | 100% | 0 | 0% | 6 | 6 | 100% | 0 | 0% |
| California Institute of Integral Studies, S.F. | 107 | 4 | 4 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| California Lutheran University, Thousand Oaks | 108 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| California Southern University | 246 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| California State University, Chico | 003 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| California State University, | 006 | 5 | 5 | 100% | 0 | 0% | 5 | 5 | 100% | 0 | 0% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Fullerton | | | | | | | | | | | |
| California State University, Hayward | 007 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| California State University, Los Angeles | 009 | 4 | 4 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| California State University, Northridge | 010 | 1 | 1 | 100% | 0 | 0% | 0 | 0 | | 0 | |
| California State University, Sacramento | 011 | 7 | 6 | 86% | 1 | 14% | 5 | 4 | 80% | 1 | 20% |
| California State University, San Bernardino | 012 | 6 | 4 | 67% | 2 | 33% | 4 | 3 | 75% | 1 | 25% |
| California State University, Stanislaus | 013 | 3 | 2 | 67% | 1 | 33% | 2 | 1 | 50% | 1 | 50% |
| Capella University | 260 | 2 | 1 | 50% | 1 | 50% | 0 | 0 | | 0 | |
| Chapman University, Orange | 113 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| GRAND CANYON UNIVERSITY | 264 | 4 | 1 | 25% | 3 | 75% | 1 | 0 | 0% | 1 | 100% |
| John F. Kennedy University, Orinda | 124 | 3 | 3 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| Loma Linda University, Orinda | 125 | 4 | 4 | 100% | 0 | 0% | 3 | 3 | 100% | 0 | 0% |
| Loyola Marymount University, Los Angeles | 126 | 4 | 2 | 50% | 2 | 50% | 3 | 1 | 33% | 2 | 67% |
| National University | 129 | 6 | 3 | 50% | 3 | 50% | 3 | 1 | 33% | 2 | 67% |
| Notre Dame de Namur University | 116 | 5 | 4 | 80% | 1 | 20% | 4 | 3 | 75% | 1 | 25% |
| Out-of-State | 300 | 69 | 55 | 80% | 14 | 20% | 52 | 43 | 83% | 9 | 17% |
| Pacifica Graduate Institute, Carpinteria | 154 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Palo Alto University | 258 | 7 | 7 | 100% | 0 | 0% | 6 | 6 | 100% | 0 | 0% |

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|--|------|--------------|--------|----------------|--------|----------------|-------------|--------|----------------|--------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Pepperdine University, Malibu | 135 | 8 | 7 | 88% | 1 | 12% | 6 | 5 | 83% | 1 | 17% |
| San Diego State University | 015 | 6 | 4 | 67% | 2 | 33% | 2 | 2 | 100% | 0 | 0% |
| San Francisco State University | 016 | 5 | 4 | 80% | 1 | 20% | 3 | 3 | 100% | 0 | 0% |
| San Jose State University | 017 | 3 | 0 | 0% | 3 | 100% | 0 | 0 | | 0 | |
| Santa Clara University | 144 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Sonoma State University | 018 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| St. Mary's College of CA, Moraga | 136 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| The Chicago School of Professional Psychology at Los Angeles | 251 | 3 | 2 | 67% | 1 | 33% | 2 | 1 | 50% | 1 | 50% |
| UC, San Francisco | 055 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| University of La Verne, La Verne | 140 | 6 | 2 | 33% | 4 | 67% | 4 | 2 | 50% | 2 | 50% |
| University of Redlands | 259 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| University of San Diego, San Diego | 142 | 6 | 3 | 50% | 3 | 50% | 4 | 2 | 50% | 2 | 50% |
| University of San Francisco, San Francisco | 143 | 10 | 8 | 80% | 2 | 20% | 9 | 7 | 78% | 2 | 22% |
| WALDEN UNIVERSITY | 263 | 1 | 1 | 100% | 0 | 0% | 0 | 0 | | 0 | |
| Western Seminary (Western Conservative Baptist Seminary) | 232 | 2 | 1 | 50% | 1 | 50% | 2 | 1 | 50% | 1 | 50% |
| Wright Institute, Berkeley | 150 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |

LPCC Law and Ethics TOTAL: 241 178 74% 63 26% 167 132 79% 35 21%

EXAM: NCMHCE Exam

Board of Behavioral Sciences
EXAM RESULTS BY SCHOOL
EXAM DATES: Jan 1, 2019 THROUGH Mar 31, 2019

| SCHOOL | | EXAM RESULTS | | | | | FIRST TIMER | | | | |
|---|------|--------------|-----------|----------------|-----------|----------------|-------------|-----------|----------------|----------|----------------|
| SCHOOL NAME | CODE | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT | TAKING EXAM | PASSED | PASSED PERCENT | FAILED | FAILED PERCENT |
| Alliant International University (aka CSPP) | 112 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| California Baptist University, Riverside | 105 | 2 | 2 | 100% | 0 | 0% | 2 | 2 | 100% | 0 | 0% |
| California State University, Fresno | 005 | 2 | 0 | 0% | 2 | 100% | 1 | 0 | 0% | 1 | 100% |
| California State University, Fullerton | 006 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| Chapman University, Orange | 113 | 1 | 0 | 0% | 1 | 100% | 1 | 0 | 0% | 1 | 100% |
| John F. Kennedy University, Orinda | 124 | 1 | 0 | 0% | 1 | 100% | 0 | 0 | | 0 | |
| Loma Linda University, Orinda | 125 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Loyola Marymount University, Los Angeles | 126 | 4 | 1 | 25% | 3 | 75% | 2 | 1 | 50% | 1 | 50% |
| OUT-OF-COUNTRY | 400 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| Out-of-State | 300 | 15 | 10 | 67% | 5 | 33% | 11 | 7 | 64% | 4 | 36% |
| Pacific Oaks College, Pasadena | 133 | 1 | 1 | 100% | 0 | 0% | 0 | 0 | | 0 | |
| San Jose State University | 017 | 2 | 2 | 100% | 0 | 0% | 0 | 0 | | 0 | |
| Sonoma State University | 018 | 1 | 1 | 100% | 0 | 0% | 1 | 1 | 100% | 0 | 0% |
| University of Redlands | 259 | 2 | 1 | 50% | 1 | 50% | 2 | 1 | 50% | 1 | 50% |
| University of San Diego, San Diego | 142 | 3 | 2 | 67% | 1 | 33% | 3 | 2 | 67% | 1 | 33% |
| NCMHCE Exam TOTAL: | | 38 | 23 | 61% | 15 | 39% | 26 | 17 | 65% | 9 | 35% |

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QUARTERLY STATISTICAL REPORT FY 2018-2019

This report provides statistical information relating to various aspects of the Board's business processes. Statistics are grouped by unit.

CASHIERING

Renewals Processed In-House

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 170 | 246 | 232 | 160 | 184 | 147 | 160 | 123 | 148 | | | | 1570 |
| Closed | 163 | 186 | 271 | 229 | 185 | 178 | 226 | 136 | 113 | | | | 1687 |

Renewals Processed by DCA Central Cashiering

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 862 | 468 | 305 | 324 | 164 | 55 | 0 | N/A | N/A | N/A | N/A | N/A | 2178 |
| Closed | 1031 | 624 | 387 | 417 | 263 | 117 | 36 | N/A | N/A | N/A | N/A | N/A | 2875 |

Online Transactions

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|---------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| Online Renewals | 3716 | 4487 | 3875 | 4271 | 4325 | 3768 | 4895 | 4026 | 4012 | | | | 37375 |
| Online Cert Reorder | 173 | 312 | 202 | 228 | 162 | 143 | 202 | 164 | 195 | | | | 1781 |
| Address Changes | 946 | 1079 | 917 | 970 | 805 | 799 | 1006 | 796 | 860 | | | | 8178 |
| TOTAL | 4835 | 5878 | 4994 | 5469 | 5292 | 4710 | 6103 | 4986 | 5067 | | | | 47334 |

Application Payments Processed In-House (Does not include renewal applications)

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| Received | 3879 | 3292 | 3116 | 3820 | 2302 | 1914 | 2912 | 2422 | 2829 | | | | 26486 |
| Closed | 3683 | 3679 | 3260 | 2967 | 1995 | 1959 | 2369 | 2344 | 2910 | | | | 25166 |

LICENSING-REGISTRANTS APPLICATIONS

AMFT Registrations

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Initial Received | 467 | 336 | 411 | 213 | 145 | 107 | 239 | 212 | 193 | | | | 2323 |
| Sub. Received | 71 | 76 | 53 | 48 | 55 | 57 | 62 | 70 | 54 | | | | 546 |
| Approved | 373 | 589 | 469 | 453 | 203 | 202 | 181 | 261 | 287 | | | | 3018 |
| Process Time | 11 | 12 | 12 | 9 | 11 | 13 | 13 | 15 | 15 | | | | 12 |

ACSW Registrations

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Initial Received | 660 | 349 | 262 | 151 | 157 | 105 | 192 | 113 | 128 | | | | 2117 |
| Sub. Received | 64 | 44 | 53 | 55 | 44 | 22 | 26 | 27 | 23 | | | | 358 |
| Approved | 842 | 558 | 342 | 334 | 187 | 159 | 190 | 171 | 195 | | | | 2978 |
| Process Time | 8 | 8 | 12 | 9 | 9 | 9 | 12 | 11 | 13 | | | | 10 |

APCC Registrations

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Initial Received | 199 | 145 | 121 | 77 | 55 | 42 | 74 | 93 | 82 | | | | 888 |
| Sub. Received | 2 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 3 | | | | 8 |
| Approved | 138 | 182 | 128 | 137 | 58 | 39 | 65 | 64 | 58 | | | | 869 |
| Process Time | 17 | 17 | 14 | 11 | 8 | 13 | 14 | 16 | 16 | | | | 14 |

TOTAL Registrations Applications

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Initial Received | 1326 | 830 | 794 | 441 | 357 | 254 | 505 | 418 | 403 | | | | 5328 |
| Sub. Received | 137 | 120 | 107 | 103 | 100 | 79 | 89 | 97 | 80 | | | | 912 |
| Approved | 1353 | 1329 | 939 | 924 | 448 | 400 | 436 | 496 | 540 | | | | 6865 |
| Avg. Process Time | 12 | 12 | 13 | 10 | 9 | 12 | 13 | 14 | 15 | | | | 12 |

LICENSING-LAW & ETHICS APPLICATIONS

LMFT Law & Ethics

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 268 | 311 | 262 | 187 | 188 | 156 | 311 | 238 | 336 | | | | 2257 |
| Approved | 240 | 286 | 307 | 244 | 172 | 146 | 267 | 232 | 425 | | | | 2319 |

LCSW Law & Ethics

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 327 | 265 | 242 | 176 | 193 | 149 | 306 | 284 | 376 | | | | 2318 |
| Approved | 299 | 267 | 280 | 230 | 186 | 119 | 263 | 241 | 459 | | | | 2344 |

LPCC Law & Ethics

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Received | 71 | 79 | 58 | 52 | 49 | 55 | 67 | 79 | 103 | | | | 613 |
| Approved | 55 | 91 | 64 | 94 | 41 | 38 | 53 | 62 | 121 | | | | 619 |

TOTAL Law & Ethics Applications

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|----------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 666 | 655 | 562 | 415 | 430 | 360 | 684 | 601 | 815 | | | | 5188 |
| Approved | 594 | 644 | 651 | 568 | 399 | 303 | 583 | 535 | 1005 | | | | 5282 |

LICENSING-LICENSURE & EXAM APPLICATIONS

LMFT Licensure & Exam

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 306 | 274 | 220 | 221 | 230 | 222 | 237 | 235 | 281 | | | | 2226 |
| Approved | 274 | 249 | 225 | 248 | 216 | 222 | 224 | 208 | 189 | | | | 2055 |
| Process Time | 35 | 31 | 28 | 38 | 43 | 47 | 50 | 48 | 49 | | | | 41 |

LCSW Licensure & Exam

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 179 | 187 | 193 | 139 | 190 | 185 | 200 | 192 | 230 | | | | 1695 |
| Approved | 214 | 244 | 194 | 218 | 189 | 209 | 178 | 150 | 131 | | | | 1727 |
| Process Time | 27 | 32 | 33 | 26 | 25 | 23 | 26 | 29 | 37 | | | | 29 |

LPCC Licensure & Exam

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Received | 25 | 21 | 24 | 20 | 23 | 12 | 25 | 18 | 26 | | | | 194 |
| Approved | 15 | 29 | 21 | 21 | 18 | 17 | 16 | 14 | 21 | | | | 172 |
| Process Time | 10 | 16 | 14 | 9 | 8 | 13 | 21 | 16 | 24 | | | | 15 |

LEP Licensure & Exam

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Received | 15 | 17 | 16 | 8 | 13 | 11 | 9 | 8 | 15 | | | | 112 |
| Approved | 12 | 14 | 17 | 11 | 0 | 0 | 0 | 0 | 0 | | | | 54 |
| Process Time | 6 | 8 | 7 | 7 | 11 | 10 | 15 | 15 | 15 | | | | 10 |

TOTAL Licensure & Exam Applications

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------------|
| Received | 525 | 499 | 453 | 388 | 456 | 430 | 471 | 453 | 552 | | | | 4227 |
| Approved | 515 | 536 | 457 | 498 | 423 | 448 | 418 | 372 | 341 | | | | 4008 |
| Avg. Process Time | 20 | 22 | 21 | 20 | 22 | 23 | 28 | 27 | 31 | | | | 24 |

LICENSING-INITIAL LICENSE ISSUED

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------------|
| Initial Received | 1326 | 830 | 794 | 441 | 357 | 254 | 505 | 418 | 403 | | | | 5328 |
| Sub. Received | 137 | 120 | 107 | 103 | 100 | 79 | 89 | 97 | 80 | | | | 912 |
| Approved | 1353 | 1329 | 939 | 924 | 448 | 400 | 436 | 496 | 540 | | | | 6865 |
| Avg. Process Time | 12 | 12 | 13 | 10 | 9 | 12 | 13 | 14 | 15 | | | | 12 |

EXAMINATIONS

Examinations Administered

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|--------|--------|--------|--------------|
| LCSW L&E | 580 | 532 | 335 | 380 | 287 | 285 | 206 | 265 | 304 | | | | 3174 |
| LMFT L&E | 516 | 522 | 422 | 434 | 376 | 325 | 270 | 290 | 362 | | | | 3517 |
| LPCC L&E | 94 | 119 | 96 | 88 | 83 | 79 | 79 | 67 | 95 | | | | 800 |
| TOTAL L & E | 1190 | 1173 | 853 | 902 | 746 | 689 | 555 | 622 | 761 | | | | 7491 |
| ASWB Clinical | 321 | 289 | 249 | 333 | 274 | 272 | 153 | 262 | 355 | | | | 2508 |
| LMFT Clinical | 491 | 430 | 387 | 374 | 419 | 387 | 281 | 355 | 432 | | | | 3556 |
| LPCC NCMHCE | 29 | 20 | 25 | 26 | 27 | 26 | 17 | 1 | 38 | | | | 209 |
| LEP | 22 | 20 | 9 | 20 | 16 | 13 | 13 | 15 | 13 | | | | 141 |
| Total Exams Administered | 2053 | 1932 | 1523 | 1655 | 1482 | 1387 | 1019 | 1255 | 1599 | | | | 13905 |
| Examination Workshops | 4 | 3 | 5 | 3 | 3 | 2 | 5 | 2 | 3 | | | | 30 |

ENFORCEMENT INTAKE

Complaint Intake

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 147 | 146 | 139 | 166 | 131 | 108 | 161 | 111 | 119 | | | | 1228 |
| Closed without Assignment for Investigation | 55 | 71 | 21 | 80 | 74 | 41 | 98 | 37 | 35 | | | | 512 |
| Assigned for Investigation | 115 | 93 | 80 | 118 | 78 | 64 | 68 | 82 | 64 | | | | 762 |
| Average Days to Close or Assigned for Investigation | 12 | 8 | 7 | 10 | 11 | 7 | 8 | 10 | 12 | | | | 9 |
| Intake Pending | 34 | 20 | 66 | 43 | 23 | 24 | 23 | 24 | 49 | | | | 306 |

Conviction & Arrest Reports

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Received | 151 | 144 | 126 | 151 | 72 | 76 | 78 | 67 | 107 | | | | 972 |
| Closed / Assigned for Investigation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| Assigned for Investigation | 151 | 159 | 133 | 149 | 76 | 87 | 85 | 76 | 112 | | | | 1028 |
| Average Days to Close | 2 | 4 | 2 | 2 | 3 | 7 | 6 | 4 | 4 | | | | 4 |
| Intake Pending | 12 | 2 | 0 | 3 | 3 | 3 | 2 | 2 | 2 | | | | 29 |

ENFORCEMENT INVESTIGATION

The average days to close is measured by the date the complaint is closed or referred for an enforcement action. If a complaint is never referred for field investigation, it will be counted as closed under desk investigation. If a complaint is referred for field investigation, it will be counted as closed under non-sworn or sworn.

Desk Investigation

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| Assigned | 283 | 267 | 223 | 292 | 170 | 159 | 173 | 173 | 187 | | | | 1927 |
| Closed | 225 | 306 | 231 | 313 | 168 | 210 | 186 | 208 | 126 | | | | 1973 |
| Average Days to Close | 32 | 44 | 42 | 43 | 43 | 40 | 75 | 57 | 41 | | | | 46 |
| Pending | 343 | 314 | 311 | 276 | 276 | 232 | 218 | 185 | 249 | | | | |

Field Investigation (Non-Sworn)

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Assigned | 1 | 3 | 16 | 4 | 2 | 5 | 12 | 7 | 12 | | | | 62 |
| Closed | 2 | 13 | 0 | 6 | 4 | 3 | 17 | 10 | 3 | | | | 58 |
| Average Days to Close | 206 | 151 | 0 | 78 | 24 | 310 | 125 | 69 | 133 | | | | 122 |
| Pending | 22 | 12 | 28 | 26 | 24 | 27 | 21 | 20 | 29 | | | | |

Field Investigation (Sworn)

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Assigned | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 1 | 1 | | | | 5 |
| Closed | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | | | | 4 |
| Average Days to Close | 0 | 0 | 80 | 211 | 0 | 0 | 0 | 615 | 534 | | | | 160 |
| Pending | 5 | 5 | 6 | 5 | 6 | 6 | 6 | 6 | 6 | | | | |

TOTAL Investigations

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|-----------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|-------------|
| First Assignments | 284 | 270 | 239 | 296 | 172 | 164 | 185 | 180 | 199 | | | | 1989 |
| Closed | 227 | 319 | 231 | 319 | 172 | 213 | 203 | 218 | 129 | | | | 2031 |
| Average Days to Close | 119 | 98 | 61 | 110 | 34 | 175 | 100 | 247 | 236 | | | | 131 |
| Pending | 365 | 326 | 339 | 302 | 300 | 259 | 239 | 205 | 278 | | | | |

ENFORCEMENT ACTIONS

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| AG Cases Initiated | 19 | 16 | 13 | 20 | 10 | 7 | 11 | 14 | 3 | | | | 113 |
| AG Cases Pending | 204 | 207 | 209 | 188 | 192 | 167 | 157 | 153 | 132 | | | | |
| SOIs Filed | 3 | 11 | 2 | 6 | 9 | 4 | 2 | 5 | 5 | | | | 47 |
| Accusations Filed | 7 | 13 | 9 | 10 | 5 | 6 | 13 | 8 | 7 | | | | 78 |
| Proposed/Default Decisions Adopted | 10 | 4 | 5 | 0 | 13 | 3 | 6 | 8 | 5 | | | | 54 |
| Stipulations Adopted | 6 | 8 | 7 | 5 | 21 | 8 | 10 | 23 | 12 | | | | 100 |

Disciplinary Orders

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Final Orders (Proposed Decisions Adopted, Default Decisions, Stipulations) | 23 | 20 | 20 | 6 | 41 | 15 | 28 | 34 | 20 | | | | 207 |

AG Cycle Times

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Average |
|---------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---------|
| AG Transmittal | 617 | 472 | 497 | 465 | 525 | 459 | 531 | 604 | 450 | | | | 513 |
| Post AG Transmittal | 355 | 370 | 313 | 289 | 346 | 318 | 368 | 419 | 323 | | | | 345 |

Citations

| | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | YTD |
|--------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----|
| Final Citations | 3 | 32 | 6 | 28 | 7 | 5 | 5 | 27 | 0 | | | | 113 |
| Average Days to Complete | 95 | 21 | 63 | 36 | 53 | 127 | 223 | 35 | 0 | | | | 73 |



Board of Behavioral Sciences

Memo

1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830, (916) 574-8625 Fax
www.bbs.ca.gov

To: Board Members

Date: May 2, 2019

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7841

Subject: Personnel Update

New Employees

Career Executive Assignment (CEA) – Steve Sodergren promoted to a CEA and functions as the Board’s Assistant Executive Officer (AEO) effective April 11, 2019. The AEO is second in the organizational level that is solely responsible for assuring the efficient and effective daily operations of the organization, the delivery of program services, and compliance with state laws. The AEO responsibilities include development of policy initiatives based on the Board’s strategic planning goals and statutory mandates. The AEO provides expertise regarding complex legal, business processes, planning, and regulatory issues related to mental health professions regulated by the Board.

Departures

Tanya Bordei promoted to a Staff Services Analyst with the Department of Water Resources effective March 15, 2019. Ms. Bordei functioned as a Licensed Clinical Social Worker Evaluator in the Licensing Unit.

Paula Gershon will retire from state service effective July 19, 2019. Ms. Gershon acts as the Licensing Manager for the Board.

Vacancies

The Board currently has seven vacancies. The recruitment process for these vacancies will be conducted during the upcoming fiscal year (FY 2019-2020) due to current budget constraints.

Staff Services Manager II / Executive Office – This manager oversees, monitors, assigns, and maintains the daily oversight Enforcement Program.

Staff Services Manager I / Licensing Unit – This manager oversees, monitors, assigns, and maintains the daily oversight of the Licensing Unit.

Associate Governmental Program Analyst (Part-time 0.5) / Enforcement – This vacancy is assigned to the Discipline & Probation Unit in the Enforcement Program to function as a Probation Analyst.

Associate Governmental Program Analyst / Enforcement – This vacancy is assigned to the Consumer Complaint & Investigations Unit in the Enforcement Program to function as an Enforcement Analyst.

Management Services Technician (MST) / Licensing (Part-time 0.5) – This position will perform the duties related to the Licensed Clinical Social Worker (LCSW) as a Licensing Evaluator.

Staff Services Analyst / Enforcement Analyst – This position is assigned to the Criminal Conviction Unit and conducts subsequent arrest investigations.

Office Technician (OT) / Cashiering – This position functions as a cashier for the Board.



Board of Behavioral Sciences

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To: Board Members

Date: May 2, 2019

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7841

Subject: Strategic Plan Update

Attached for your review is the Strategic Plan update.

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CALIFORNIA BOARD OF BEHAVIORAL SCIENCES – STRATEGIC PLAN UPDATE
February 2019

| Licensing <i>Establish licensing standards to protect consumers and allow reasonable and timely access to the profession.</i> | DUE DATE | STATUS |
|---|---------------------|--|
| 1.1 Identify and implement enhanced communication during the application process to respond to stakeholder concerns regarding communication between applicants and the Board. | July 2021 | |
| 1.2 Improve and expand the Board's virtual online BreEZe functionality to provide applicants with the precise status of their applications and license. | July 2020 | |
| 1.3 Research and explore a comprehensive online application process to improve efficiency. | January 2021 | March 2018 – Request submitted to revise BreEZe to allow L/E exam and Initial Licensure Applications submitted online. March 2019 - Online submission for Law and Ethics exam and request for certification of licensure available. |
| 1.4 Evaluate and revise current laws and regulations relating to licensure portability to increase consumer access to mental health care. | January 2021 | August 2018 – License Portability Committee recommendations and draft regulations will be considered during the August 2018 Policy and Advocacy meeting. September 2018 -Board members approve recommendations January 2019 – Author for bill obtained March 2019 – In the Senate Appropriation committee |

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES – STRATEGIC PLAN UPDATE
February 2019

| Examinations <i>Administer fair, valid, comprehensive, and relevant licensing examinations.</i> | DUE DATE | STATUS |
|---|---------------------|--|
| 2.1 Improve the efficiency and reduce processing times to streamline the online exam application. | January 2021 | February 2019 – Submission of Law and Ethics application via online available March 2019 |
| 2.2 Explore methods to improve the candidate’s exam experience to address concerns relating to the quality and customer service. | July 2019 | August 2018 Board management initiates process to procure a vendor to administer Board developed examinations. February 2019 Contract submitted to DCA |
| 2.3 Improve the Board’s examination study materials to increase access to exam preparation. | July 2019 | October 2018 Board management met with OPES to discuss options to assist candidates in examination preparation. |
| 2.4 Evaluate the Association of Marriage and Family Therapy Regulatory Board’s (AMFTRB) national examination to determine if appropriate for use in California. | July 2020 | September 2018 Executive Officer attended presentation regarding national exam at the AMFTRB annual meeting. October 2018 OPES indicates evaluation will occur upon completion of Board’s OA for LMFTs. |

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES – STRATEGIC PLAN UPDATE
February 2019

| Enforcement <i>Protect the health and safety of consumers through the enforcement of laws.</i> | DUE DATE | STATUS |
|--|------------------|--|
| 3.1 Explore the feasibility of additional staff resources to address the increase in number of licensees placed on probation. | July 2020 | June 2018 – Restructured the Enforcement Program to establish a manager position to provide oversight of the Probation and Discipline Unit. July 2018 – Request for 1 full time and 1 half time position to monitor probationers was approved. Initiated recruitment for manager. Initiated recruitment for probation monitor positions. August 2018 – Manager hired. |
| 3.2 Educate registrant and licensees about general legal requirements and consequences to practitioners who fail to adhere to these legal requirements. | July 2019 | April 2018 - CALPCC Annual Meeting Unprofessional Conduct Presentation |
| 3.3 Educate the Deputy Attorney Generals and Administrative Law Judges regarding the disease of addiction and substance abuse to increase their awareness during the discipline process. | July 2021 | |
| 3.4 Establish uniform standards and templates for reports and evaluations submitted to the Board related to disciplinary matters. | July 2020 | April 2018, June 2018, October 2018 – Board staff attends Substance Abuse Coordination Committee to discussion possible revisions to Uniform Standard #4. |

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES – STRATEGIC PLAN UPDATE
February 2019

| Legislation and Regulation <i>Ensure that statutes, regulations, policies, and procedures strengthen and support the Board’s mandate and mission.</i> | DUE DATE | STATUS |
|---|---------------------|--|
| 4.1 Pursue legislation to implement the recommendations of the License Portability Committee to improve license portability. | January 2020 | August 2018 – Recommendations presented at August 24, 2018 Policy and Advocacy Committee meeting. September 2018 -Board approves language – directs staff to initiate legislation process. January 2019 - Author for bill obtained March 2019 – In the Senate Appropriation committee |
| 4.2 Reorganize the statutes and regulations specific to each Board license type to improve understanding of application statutes and regulations. | January 2021 | |
| 4.3 Continue to review statutory parameters for exempt settings and modify, if necessary, to ensure adequate public protection. | January 2021 | August 2018 - Final meeting of the Exempt Setting Committee scheduled for September 12, 2018. October 2018 P&A members recommend approving proposed setting definitions to full board. February 2019 P&A Committee refer definitions back to Exempt Committee for additional revisions. April 2019 Set meeting date for June 7, 2019 to discussion definitions. |
| 4.4 Explore the feasibility of improving the law and ethics renewal requirements to inform licensees about updates in relevant laws. | July 2021 | July 2018 – Board’s Continuing Education Analyst will attend all major outreach events to educate licensees regarding continuing education requirements. |

4.5

Review and update existing telehealth regulations to improve consumer protection and access to services.

January 2020 **May 2018**-Board established a Telehealth Committee to begin work after January 1, 2019.

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES – STRATEGIC PLAN UPDATE
February 2019

| Organizational Effectiveness <i>Build an excellent organization through proper Board governance, effective leadership, and responsible management.</i> | DUE DATE | STATUS |
|--|---------------------|---|
| 5.1 Implement a strategic succession plan of Board staff to ensure continued success of the Board's operations. | January 2020 | October 2018 – Probation unit updates procedure manuals. |
| 5.2 Support DCA efforts to contract with independent organizations to perform occupational analyses and salary surveys of management-level positions equivalent to the Executive Officer and Bureau Chief classifications to enhance the Board's ability to attract and retain competitive applicants. | July 2020 | Spring 2018 – Board management contacts DCA Executive Management offering assistance with the EO survey and process. July 2018 DCA reports requests for bid to conduct EO survey near completion. October 2018 DCA reports some EO's participated in phone interviews with contractor. Contractor will develop survey for all EO's to complete. ETA for report early 2019. March 2019 DCA reports study concluded and will share study information with EO's and Boards at a later date. |
| 5.3 Explore the feasibility of hiring in-house counsel to ensure consistency in the application of law. | July 2021 | Winter and Spring 2018 – Board management initiates review of existing laws that allow Board's to hire in-house counsel. Board management engaged in discussions to seek similar hiring authority. August 2018 - Proposed language to provide the Board with the hiring authority is removed from bill. |
| 5.4 Explore the feasibility of hiring a media and internet technology specialist to increase consistency in messaging to stakeholders. | July 2021 | |

5.5

Improve customer service with stakeholders to expand (or support) effective communication and accessibility to the Board.

July 2019

Spring 2018 – Implemented revised phone system.

January and March 2019 - Began working with department to develop and implement instructional videos and social media campaign that will increase engagement of registrants and licensees.

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES – STRATEGIC PLAN UPDATE
February 2019

| Outreach and Education <i>Engage stakeholders through continuous communication about the practice and regulation of the professions, and mental health.</i> | DUE DATE | STATUS |
|--|---------------------|---|
| 6.1 Explore modalities of communication to expand and increase outreach. | January 2020 | January and March 2019 Meeting with assigned PIO officer to discuss strategies to enhance social media presence. |
| 6.2 Advocate to increase Board presence at national professional association meetings to enhance awareness of national trends and best practices. | July 2021 | May 2018 – Received approval for Board EO to attend ASWB Spring Education Conference in Halifax, Nova Scotia to present draft license portability plan. July 2018- Received approval for Board EO to attend NBCC, AMFTRB, and ASWB national meetings in Fall 2018. |
| 6.3 Develop an outreach program to educate the public about the benefits of mental health to reduce barriers and destigmatize mental health care. | July 2020 | January and March 2019- Initiated a plan with assigned PIO to develop an instructional video to explain more about our licensees and what they do. |
| 6.4 Explore opportunities to coordinate with stakeholders to increase diversity of mental health practitioners to better serve California's diverse population. | July 2021 | October 2018- Board staff participates in meeting with various stakeholders to discuss implementation of AB 2105. |
| 6.5 Improve outreach activities to educational institutions, students, and applicants to educate incoming registrants of application requirements for licensure. | January 2021 | August 2018 – Board management initiates discussions with SOLID to discuss developing video tutorials for Board website. January and March 2019- Initiated a plan with PIO to develop an instructional video to guide associates through the registrant process. |



Board of Behavioral Sciences

Memo

1625 North Market Blvd., Suite S-200
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To: Board Members

Date: May 9, 2019

From: Kim Madsen
Executive Officer

Telephone: (916) 574-7841

Subject: Election of Officers

Business and Professions Code section 4990 requires the Board to elect a Chair and Vice-Chair prior to June 1 of each year. Currently, Betty Connolly serves as the Board Chair, and Massimiliano Disposti is the Vice-Chair. In order to comply with existing law, the Board members should elect both a chair and a vice-chair at this meeting for 2019-2020.

Below is a list of board members and the date on which their term will expire.

| Board Member | Type | Authority | Appointment Date | Term Expires | Grace Expires |
|----------------------------|--------|-----------|------------------|--------------|---------------|
| Massimiliano Disposti | Public | Assembly | 3/8/2016 | 6/1/2019 | 6/1/2020 |
| Dr. Christine Wietlisbach* | Public | Senate | 1/13/2010 | 6/1/2019 | 6/1/2020 |
| Dr. Leah Brew | LPCC | Governor | 8/8/2012 | 6/1/2020 | 8/1/2020 |
| Deborah Brown | Public | Governor | 8/20/2012 | 6/1/2021 | 8/1/2021 |
| Betty Connolly | LEP | Governor | 8/20/2012 | 6/1/2020 | 8/1/2020 |
| Dr. Peter Chiu | Public | Governor | 10/25/2013 | 6/1/2019 | 8/1/2019 |
| Alexander Kim* | Public | Governor | 7/27/2018 | 6/1/2022 | 8/1/2022 |
| Gabriel Lam* | LCSW | Governor | 7/27/2018 | 6/1/2022 | 8/1/2022 |
| Jonathan Maddox | MFT | Governor | 9/14/2017 | 6/1/2021 | 8/1/2021 |
| Vicka Stout * | MFT | Governor | 7/27/2018 | 6/1/2022 | 8/1/2022 |
| Christina Wong | LCSW | Governor | 5/10/2011 | 6/1/2021 | 8/1/2021 |
| VACANT | Public | Governor | | 6/1/2021 | 8/1/2021 |
| VACANT | Public | Governor | | 6/1/2021 | 8/1/2021 |

**These members are not eligible for consideration*

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Board of Behavioral Sciences

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| | | | |
|--------------------------------------|--|-------------------|----------------|
| To: | Board Members | Date: | May 2, 2019 |
| From: | Steve Sodergren Assistant Executive Officer | Telephone: | (916) 574-7847 |
| Subject: BBS Fee Audit Report | | | |

In August 2018, the Board contracted with CPS HR Consulting (CPS) to provide performance auditing and consulting services to review of the Board’s fee structure and staff workload to determine if fee levels are appropriate for the recovery of the actual cost of conducting its programs. In March 2019 CPS HR submitted the final report.

The report reviewed 25 main fees that represent approximately 90 percent of the Board’s fee revenue; applications for registrations, licenses, examination and renewals. It was noted that, during the last four years, while revenues for the 25 fees have increased by almost 39 percent the Board’s expenditures have increased by approximately 42 percent. This was due to a steady increase application volume and registrant/licensee population. Also, it was important to note the Board has not raised fees for the Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs) and Licensed Educational Psychologists (LEPs) in at least twenty years.

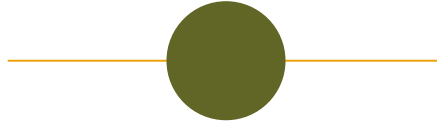
To determine appropriate fees CPS used three years (FY 16-17 to FY 18-19) of average expenditures and staff hours. Dividing the average expenditures by staff hours for the three years resulted in a \$120 per hour/\$2.00 per minute fully absorbed cost rate. The resulting proposed fee increases ranged from \$0 to \$315. These proposed fees were used to make projections for our fund condition for the next five years. Ultimately, the fees proposed would increase the Board’s revenue by \$6,016,000 per full fiscal year and would result in a five-month reserve by Fiscal Year 2023-24.

During the next months staff will develop a fee schedule based upon the recommendations made by CPS. In developing this fee schedule, the staff will take into consideration the impact a fee increase may have on the registrants and licensees. To begin the process the proposed fee schedule, along with corresponding draft bill language, will be presented to the next Policy and Advocacy Committee meeting for discussion. The hope is that the board will be able to establish the proposed fees on January 1, 2021.

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Board of Behavioral Sciences: Performance and Fee Review

Steve Sodergren



Scope

Review the Board's fee structure and staff workload to determine if fee levels are appropriate for the recovery of the actual costs of conducting its programs



Objectives

- ◆ Review 25 key fees which represent about 90% of fee revenue to determine whether they are adequate to recover the actual costs of BBS programs
- ◆ Determine an hourly or unit cost to support the Board's Licensing, Renewal and Enforcement programs
- ◆ Project fees/revenues and related costs for the next three to five fiscal years
- ◆ Determine additional revenue needed to maintain the Board's fund solvency over this period
- ◆ Determine a cost basis to assess other services provided by the Board when a separate fee is not provided,
- ◆ Propose fees using the hourly cost to meet those revenue requirements

Methodology

- ◆ Review pertinent materials, including: fee schedule, fund condition reports, fiscal data, business process flowcharts and current staff duty statements
- ◆ Develop workload time assumptions for processing licensing, renewal and examination applications
- ◆ Review licensing and disciplinary/enforcement work to confirm the completeness and accuracy of Board staff duty statements and workload processing time assumptions
- ◆ Analyze revenues and expenditures for four fiscal years FY 14-15 through FY 17-18 and projected through FY 23-24
- ◆ Determine revenue required to recover expenses and maintain fund stability
- ◆ Determine cost per hour and apply to workload assumptions to determine actual cost of various License applications



25 Selected Fees Examined

| Fee Type | Marriage and Family Therapists (LMFT) | | Licensed Clinical Social Worker (LCSW) | | Licensed Professional Clinical Counselor (LPCC) | | Licensed Educational Psychologist (LEP) | |
|--|---------------------------------------|-----------------|--|-----------------|---|-----------------|---|-----------------|
| | Current Fee | Statutory Limit | Current Fee | Statutory Limit | Current Fee | Statutory Limit | Current Fee | Statutory Limit |
| Associate Registration | \$75 | \$75 | \$75 | \$75 | \$100 | \$150 | | |
| Associate Renewal | \$75 | \$75 | \$75 | \$75 | \$100 | \$150 | | |
| Application for Licensure | \$100 | \$100 | \$100 | \$100 | \$180 | \$250 | \$100 | \$100 |
| Law and Ethics Exam/Re-exam | \$100 | \$100 | \$100 | \$100 | \$100 | \$100 | | |
| Clinical Exam/Rexam | \$100 | \$100 | * | \$100 | * | \$250 | | |
| Issuance of Initial License | \$130 | \$180 | \$100 | \$155 | \$200 | \$250 | \$80 | \$150 |
| License Renewal** | \$150 | \$180 | \$120 | \$155 | \$195 | \$250 | \$80 | \$150 |
| Written Exam/ Re-Exam | | | | | | | \$100 | \$100 |
| *These fees are paid by the applicants directly to the exam vendors and are not collected by BBS. | | | | | | | | |
| **This includes the renewal fee and \$20 charged for the Mental Health Provider Education Fund, except for LEP renewals. | | | | | | | | |



Fee vs. Non-fee Scheduled Revenue

| Description | FY 14-15 to FY 17-18 Avg | % of Total Revenue | % of Total Fee Schedule Revenue |
|-----------------------------------|--------------------------|--------------------|---------------------------------|
| Total Fee Schedule Revenue | \$ 8,954 | 95.5% | |
| 25 Selected Fee Revenue | \$ 8,096 | | 90.40% |
| Non-Fee Schedule Revenue | \$ 422 | 4.5% | |
| Total Revenue | \$ 9,376 | 100.0% | |

Dollars in thousands

- ◆ The selected fees under study constituted 90.4% of total fee scheduled revenue and 86.3% of total revenue
- ◆ Non-fee scheduled revenue includes income from surplus money investments and interest from interfund loans

Increasing Overall Fee Volumes

| | FY 14-15 | FY 15-16 | FY16-17 | FY 17-18 | 4 Yr Avg | 4 Yr Change |
|-----------------------------|----------|----------|---------|----------|----------|-------------|
| Associate Registration | 8,346 | 8,412 | 8,523 | 8,576 | 8,464 | 2.8% |
| Associate Renewal | 23,227 | 25,704 | 23,007 | 21,299 | 23,309 | -8.3% |
| Application for Licensure | 4,504 | 4,561 | 4,999 | 5,879 | 4,986 | 30.5% |
| Issuance of Initial License | 3,308 | 3,007 | 4,256 | 4,664 | 3,809 | 41.0% |
| License Renewal | 23,994 | 25,279 | 26,416 | 27,760 | 25,862 | 15.7% |

Notes:

- ◆ Figures represent total fee volumes across all license types (LMFT, LCSW, LPCC, LEP). LEPs do not have Associate Registrations or Associate Renewals
- ◆ The first LPCC students of California schools began graduating in the Spring of 2015 and intern applications and examination applications increased significantly.

Overall Expenses

| Category | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4-Yr Avg | % of Total | 4 year change |
|---|---------------------|---------------------|----------------------|----------------------|----------------------|------------|---------------|
| Personnel Services Subtotal | \$ 3,681,656 | \$ 3,986,241 | \$ 4,735,168 | \$ 4,981,115 | \$ 4,346,045 | 41.9% | 35.3% |
| Operating Expenses & Equipment Subtotal | \$ 4,549,595 | \$ 5,607,667 | \$ 6,497,077 | \$ 7,467,183 | \$ 6,030,381 | 58.1% | 64.1% |
| Total Expenses | \$ 8,231,251 | \$ 9,593,907 | \$ 11,232,245 | \$ 12,448,298 | \$ 10,376,425 | | 51.2% |

- ◆ Personnel Services increase related to:
 - » Increase in staff to meet workload demands across all units (FY 14/15 = 50 positions - July 1, 2018 = 60 positions)
 - » Increase costs associated with salary and benefits
- ◆ Increasing OE&E costs related to Breeze, Statewide pro-rata and increased enforcement actions



Current Projected Fund Balance

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|------------------------------------|----------|----------|-----------|-----------|------------|
| Fund Balance | | | | | |
| Reserve for economic uncertainties | \$ 4,814 | \$ 1,284 | \$ -2,461 | \$ -6,456 | \$ -10,707 |
| Months in Reserve | 4.5 | 1.2 | -2.2 | -5.7 | -9.3 |

Dollars in thousands

Projected Fund Balance with Selected Fee Increases

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|------------------------------------|---------|---------|---------|----------|----------|----------|
| Fund Balance | | | | | | |
| Reserve for economic uncertainties | \$4,814 | \$1,284 | \$ 526 | \$ 2,536 | \$ 4,301 | \$ 5,812 |
| Months in Reserve | 4.5 | 1.2 | 0.5 | 2.3 | 3.8 | 5.0 |

Dollars in thousands

- ◆ An increase of \$3,008,000 in revenue (from FY 2019-20 to FY 2020-21) during the second half of FY 2020-21 would result in .5 months in reserve in FY 2020-21.
- ◆ Beginning in FY 2021-22 and continuing forward, the proposed fee increases could lead to about \$6,016,000 additional revenue each full fiscal year. This increase would ultimately result in 5 months in reserve by FY 2023-24.

Develop Fully Absorbed Cost Per Hour/Minute

- ◆ Used 3 year (FY 16-17 to FY 18-19) Average Expenditures and Staff hours. The 12 percent salary increase spread over those three years made previous years' expenditures inconsistent with current costs
- ◆ Divided average expenditures by average staff hours for those three years to determine the fully absorbed cost per hour
- ◆ Resulted in \$120 per hour and \$2.00 per minute, (see table 17, page 44)

Created Workload Assumptions and Estimated Costs for each target fee, (Appendix A)

- ◆ Used processing times for Cashiering and Licensing Staff where available
- ◆ Distributed costs for Enforcement, Exams and other Licensing functions to specific fees using time allocations from Duty Statements and Exam Volumes Report
- ◆ Spread Administration, Management and other Board activities that apply to all fees, using four year average fee volumes
- ◆ Applied \$2.00 cost per minute to time estimates developed in the workload assumptions



Projected Additional Revenue Generated (Table 18)

- ◆ Proposed fees determined by multiplying the time spent by BBS employees according to the workload assumptions (Appendix A) by the fully absorbed cost of \$2.00 per minute
- ◆ Compared the financial impact of the of the study fees at their current levels and proposed levels using the fully absorbed cost of \$120 an hour/ \$2.00 per minute (Table 18)
- ◆ The resulting proposed fee increases range from \$0 to \$315
- ◆ Assuming implementation beginning January, 2020, the proposed fee structure is projected to generate the estimated revenue needed to ensure fund solvency through FY 23-24

Summary of Findings

- ◆ The Board has grown steadily since FY 2014/15, experiencing a 20 percent growth in staff over those four years
- ◆ The Board implemented the BreEZe online licensing and enforcement system in October 2013, incurring significant initial and ongoing costs
- ◆ Revenues for the 25 fees studied, with a 39.3% increase have not kept up with expenditures, which have increased by 42.8% over the same four years
- ◆ Fees for the LMFT, LCSW and LEP programs have not increased in at least 20 years. The LPCC program was established in FY 2011-12 and the fees have not increased since
- ◆ Beginning in FY 16-17 and continuing, revenue has not covered expenditures. Financial projections indicate that if this continues, the fund will become insolvent in FY 20-21

Recommendations

- ◆ The Board should charge for select scheduled and unscheduled services based on a fully absorbed cost rate of \$120 per hour
- ◆ Services should be charged, and fees set, to the extent possible, based on the actual time used to provide the service
- ◆ BBS management should develop, approve and implement regulations or introduce legislation, as needed, to revise the fee schedule as soon as possible, and inform current and prospective licensees of the changes
- ◆ The Board in obtaining legislative approval for fee increases should set the statutory maximum higher than currently needed for fund solvency and a satisfactory reserve. By enabling this administrative strategy now, the Board will have the flexibility to set fees in the future as expenditures increase or revenues decline without needing frequent legislation

End

April 24, 2019

FINAL REPORT

Board of Behavioral Sciences: Performance and Fee Review

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About CPS HR Consulting

CPS HR is an innovative, client-centered human resources and management consulting firm specializing in solving the unique problems and challenges faced by government and non-profit agencies. As a self-supporting public agency, we understand the needs of public sector clients and have served as a trusted advisor to our clients for more than 25 years. The distinctive mission of CPS HR is to transform human resource management in the public sector.

CPS HR offers clients a comprehensive range of competitively priced services, all of which can be customized to meet your organization’s specific needs. We are committed to supporting and developing strategic organizational leadership and human resource management in the public sector. We offer expertise in the areas of classification and compensation, organizational strategy, recruitment and selection, and training and development.

CPS HR occupies a unique position among its competitors in the field of government consulting; as a Joint Powers Authority (JPA), whose charter mandates that we serve only public sector clients, we actively serve all government sectors including Federal, State, Local, Special Districts and Non-Profit Organizations. This singular position provides CPS HR with a systemic and extensive understanding of how each government sector is inter-connected to each other and to their communities. That understanding, combined with our knowledge of public and private sector best practices, translates into meaningful and practical solutions for our clients’ operational and business needs.

With more than 80 full-time employees as well as 200+ project consultants and technical experts nationwide, CPS HR delivers breakthrough solutions that transform public sector organizations to positively impact the communities they serve.

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Executive Summary

The Board of Behavioral Sciences is one of 40 regulatory agencies within the Department of Consumer Affairs. The mission of the Board of Behavioral Sciences is to protect and serve Californians by setting, communicating, and enforcing standards for safe and competent mental health practice. The Board's vision is to ensure that Californians are able to access the highest-quality mental health services. To achieve this, the Board is responsible for licensing, examination, and enforcement of professional standards for: licensed Marriage and Family Therapists (LMFT) and Associates (AMFT); Licensed Clinical Social Workers (LCSW) and Associates (ACSW); Licensed Professional Clinical Counselors (LPCC) and Associates (APCC) and Licensed Educational Psychologists (LEP).

A specific function of the Board is to review/set fees levied on applicants for initial and renewal licensure, registrations and exam fees. The fees are intended to be sufficient to cover the cost of the Board's regulatory services. In August 2018, the Board engaged CPS HR Consulting (CPS) to provide performance auditing and consulting services to review Board performance and the structure for 25 of the fees collected by the Board.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Based on the review, CPS HR found the following. The information is covered in detail in the body of the report.

- The Board has grown steadily since FY 2014/15. In FY 2014/15, the Board was authorized 48.2 permanent positions and 1.8 blanket positions for a total of 50 positions. As of July 1, 2018, the Board has 58.2 authorized positions and 1.8 blanket positions for a total of 60 positions, a 20% increase. The DCA Budget Office uses an average of 1,776 available hours per PY each fiscal year for workload budget projections. Employees are paid for 2,080 hours per fiscal year.
- In October 2013, the Board implemented DCA's BreEZe online licensing and enforcement system which offers one-stop shopping for BBS licensees, applicants and consumers. The Board incurred significant costs to implement BreEZe.
- Revenue associated with the 25 fees under examination has increased 39.3% from FY 14-15 through FY 2017-2018.
- On average, BBS Operating Expenses & Equipment costs constitute 58.1% of total expenses and Personnel Services constitute 41.9%.
- Overall revenue has not kept up with expenditures since FY 16-17.
- Beginning in FY 2020-21 and moving forward, revenue and expense projections indicate that BBS will have insufficient revenue to cover operational costs and maintain an acceptable 3 to 6-month fund reserve.
- Fees associated with the LMFT, LCSW and LEP licenses have not increased in at least 20 years. The LPCC program was established in FY 2011-12 and the fees have not increased since.

As a result of the above findings, CPS recommends the following:

- After consultation with the DCA Budget Office and its registrant and licensee client populations, the Board should charge for select scheduled and unscheduled services based on a fully absorbed cost rate of \$120 per hour. Services should be charged, and fees set, to the extent possible, based on the actual time the Board uses to provide the service.
- BBS management should develop, approve and implement or introduce legislation to revise the fee schedule as soon as possible, and inform current and prospective licensees of the changes.
- In lieu of a lengthy legislative process to change future license fees, CPS HR recommends that the Board, in obtaining legislative approval for fee increases also set a statutory maximum higher than the fees currently needed to restore the fund to a satisfactory reserve. By enabling this administrative strategy now, the Board would have flexibility in setting fees in the future to ensure adequate fund reserves as revenues decline or expenses increase.

Introduction

The Board of Behavioral Sciences is one of 40 regulatory agencies within the Department of Consumer Affairs. The mission of the Board of Behavioral Sciences is to protect and serve Californians by setting, communicating, and enforcing standards for safe and competent mental health practice. The Board's vision is to ensure that Californians are able to access the highest-quality mental health services. To achieve this, the Board is responsible for licensing, examination, and enforcement of professional standards for: licensed Marriage and Family Therapists (LMFT) and Associates (AMFT); Licensed Clinical Social Workers (LCSW) and Associates (ACSW); Licensed Professional Clinical Counselors (LPCC) and Associates (APCC) and Licensed Educational Psychologists (LEP). The Board's statutes and regulations set forth the requirements for registration and licensure and provide the Board authority to discipline a registration or license. The Board's operations are funded by fees charged to its applicants and licensees. The purpose of this study is to review the Board's fee structure to determine whether current fees are adequate to support the Board's licensing activities through the next three to five years. If CPS HR determines that the fees are not adequate for this purpose, CPS HR is to recommend a methodology and basis to determine appropriate fees.

BACKGROUND

Board History, Composition and Governance Structure

In 1945, the legislature created the Board of Social Work Examiners, making California the first state to register social workers. The legislation created a seven-member board to represent both consumers and the profession. At least two of the members were required to be "lay persons". All Board members were appointed by the Governor. During the first sixteen months of its existence, the Board registered 4,098 social workers. The intent of the registration was to identify competent professionals who were working for higher standards and services to the public.

In 1963, the Marriage, Family and Child Counselor Act gave the Board of Social Work Examiners responsibility for licensing and regulating Marriage, Family and Child Counselors. Now known as Licensed Marriage and Family Therapists (LMFT). Shortly afterward the Board was renamed the Social Worker and Marriage Counselor Qualifications Board.

In 1969, the legislature added Clinical Social workers (LCSW) to the list of required licensees and in 1970, they added Licensed Educational Psychologists (LEP). As a result, the Board's name was changed to the Board of Behavioral Sciences Examiners. In 1997, the Board's name was changed to the current title, Board of Behavioral Sciences (BBS). In 2010, the legislature added a fourth mental health profession, Licensed Professional Clinical Counselor (LPCC) to the Board's responsibilities.

The current Board is made up of thirteen board members, six licensees and seven public members. Eleven members are appointed by the Governor and require Senate Confirmation. One public member is appointed by the Speaker of the Assembly and the other public member is appointed by the Senate Rules Committee. The six licensee members are distributed as follows: two (2) LMFT, two (2) LCSW, one (1) LPCC and one (1) LEP.

Applicable Practice Acts

Licensed Marriage and Family Therapist Practice Act

Licensed Marriage and Family Therapists are regulated by Chapter 13 of the California Business and Professions Code. Per Section 4980. The Act indicates that many California families and many individual Californians are experiencing difficulty and distress, and are in need of wise, competent, caring, compassionate, and effective counseling in order to enable them to improve and maintain healthy family relationships. Healthy individuals and healthy families and healthy relationships are inherently beneficial and crucial to a healthy society and are our most precious and valuable natural resource. Licensed marriage and family therapists provide a crucial support for the well-being of the people and the State of California. Per Section 4980.02, the practice of marriage and family therapy is a service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and pre-marriage counseling. The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Sections 4980.36, 4980.37, and 4980.41.

Licensed Educational Psychologist Practice Act

Chapter 13.5 of the Business and Professions Code constitutes the Educational Psychologist Practice Act and regulates the licensing of Educational Psychologists. Section 4989.14 defines the scope of practice as performance of any of the following professional functions pertaining to academic learning processes or the educational system or both: Educational Evaluation; Diagnosis of psychological disorders related to academic learning processes; Administration and interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors; Consultation with other educators and parents on issues of social development and behavioral and academic difficulties; Conducting psychoeducational assessments for the purposes of identifying special needs; Developing treatment programs and strategies to address problems of adjustment; and Coordinating intervention strategies for management of individual crises.

Clinical Social Worker Practice Act

Chapter 14 of the Business and Professions Code defines Clinical Social Work as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services;

doing research related to social work; and the use, application, and integration of the coursework and experience required by Sections 4996.2 and 4996.23.

Licensed Professional Clinical Counselor Practice Act

Chapter 16 of the Business and Professions Code defines the scope of Professional Clinical Counselors. It defines professional clinical counseling as the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems, and the use, application, and integration of the coursework and training required by Sections 4999.32 and 4999.33. Professional clinical counseling includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well informed, rational decisions. This new program was initiated in FY 2011-12.

License/Renewal Fees and Fee Change History

The Board's current licensing/ renewal fee schedule collects 59 separate fees, ranging from \$20 to \$200. This study will audit 25 of these fees. A review of the fee history of the study's target fees indicates that there have been no fee increases in the LMFT, LCSW and LEP fees in at least 20 years. The LPCC program was established in FY 2011-12 and the fees have not increased since.

Beginning July 1, 2018, SB 1188 (Chapter 557, Statutes of 2017) requires that a \$20 surcharge be added to all biennial renewal fees for the LMFTs, LCSWs, and LPCCs. This \$20 surcharge is collected by the Board for the Mental Health Provider Education Fund. Prior to this a \$10 fee was collected for this fund. The 2017 statute raised the fee to \$20 and added the LPCC renewal.

Board Functions and Staffing

The Board has grown steadily since FY 2014/15. In FY 2014/15, the Board was authorized 48.2 permanent positions and 1.8 blanket positions for a total of 50 positions. As of July 1, 2018, the Board has 58.2 authorized positions and 1.8 blanket positions for a total of 60 positions, a 20% increase. In FY 14-15, the Board added 4.5 positions to support increased Enforcement workload, and 3 positions (2 ongoing) to address licensing workload increases. Effective July 1, 2016 the Board added 3 positions to address the requirements of SB 704 (Chapter 387) Statutes of 2011 and SB 788, (Chapter 619) Statutes of 2009. This legislation restructured the examination requirements and revised continuing education requirements, increasing workload for the program. The Board also increased a half time fingerprint processing position to address backlogs caused by increasing applications volumes.

In FY 16-17, the Board received 8.5 positions to address increased Licensing and Examination workload. A large part of the increase was attributable to the workload from the LPCC Licensure program which was initiated in FY 2011/2012. The first LPCC students of California schools began graduating in the Spring of 2015 and intern applications and examination applications increased significantly. The Examination Restructure initiated January 1, 2016 also contributed to the need for additional staff. Under the new examination process, all Board registrants and licensees were required to take a Law and Ethics examination within the first year of the program. Ongoing, registrants who are not successful in

the Law and Ethics examination may retake the Law and Ethics Exam every 90 days and must take it at least once a year to renew their registration until they pass the exam. Once they pass the exam, they do not need to take it again.

In FY 18-19, the Board received authority for 1.5 two-year limited term positions to support the Probation program which has experienced increasing numbers of probationers. Frequently, the formal discipline process results in placing the individual on probation with specific terms and conditions for a specified period of time. These positions will monitor the Board's probationers to ensure that the conditions of their probation are met, protecting consumers.

The Board's Executive Officer is an exempt position and serves at the pleasure of and reports to the 13-member Board. The 13 Board members are appointed by the governor (11), who are subject to Senate confirmation, the Senate (1) and the Assembly (1). The Board consists of seven public members; two LMFT members; two LCSW members; one LPCC member; and one LEP member.

The Executive Officer (EO) functions as operations officer for the Board and manages the Board's resources and staff. The EO oversees the 60 Board positions, directly supervising an Assistant Executive Officer (SSM II) and six-unit managers (SSMIs). The staff are divided among the Criminal Conviction, Consumer Complaint and Investigations, and Discipline and Probation Units in the Enforcement Program and the Licensing, Examination/Cashiering, and Administration Units.

The Board's primary civil service classes include:

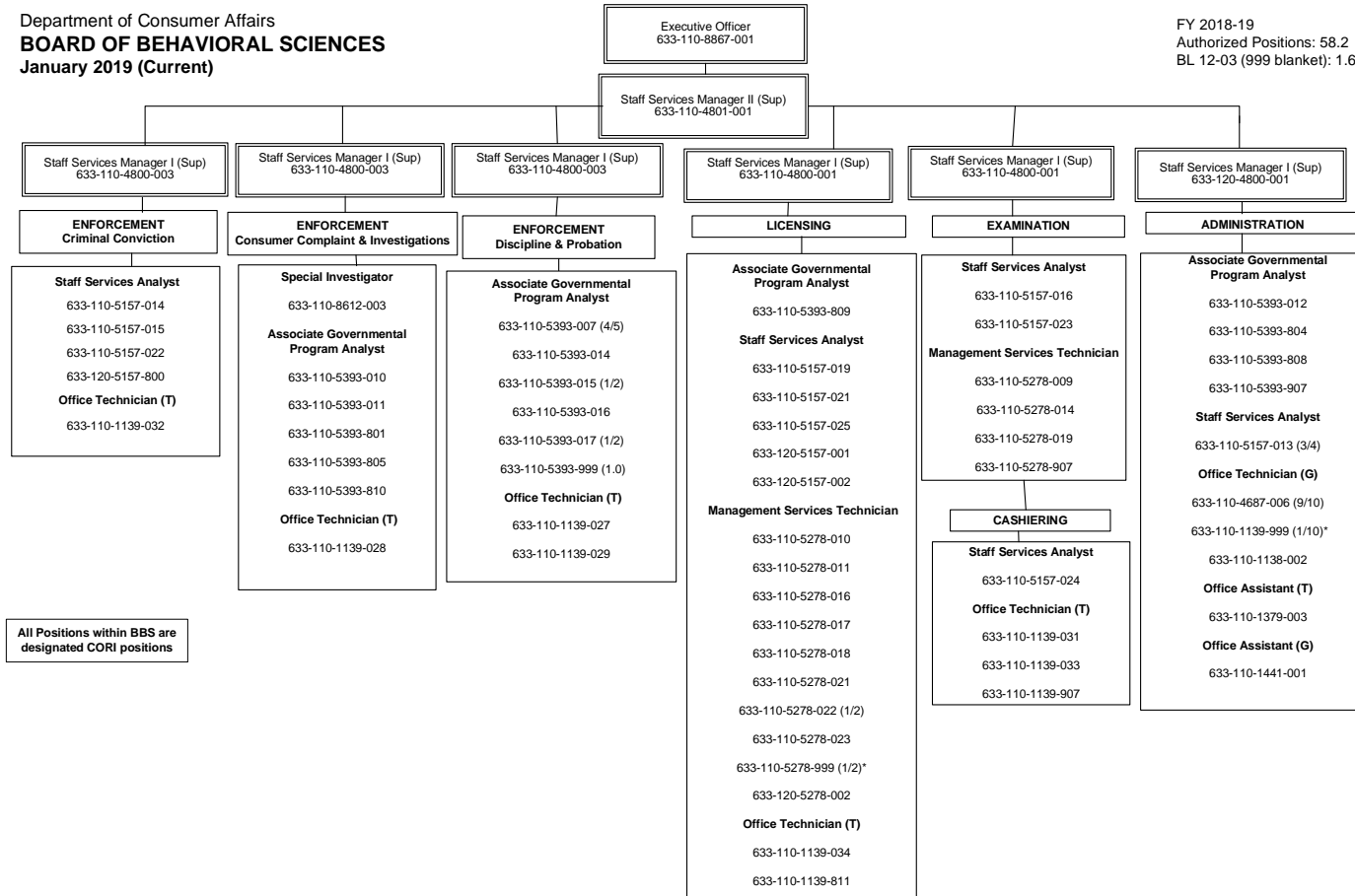
- Staff Services Manager (SSM) I and II
- Associate Governmental Program Analyst (AGPA)
- Staff Services Analyst (SSA)
- Special investigator (SI)
- Management Services Technician (MST)
- Office Technician (Typing)(OT) (T)
- Office Technician (General) (OT) (G)
- Office Assistant (Typing) (OA) (T)
- Office Assistant (General) (OA) (G)

The Boards organization chart was effective January 2019

Figure 1
Board of Behavioral Services
Organizational Chart, Effective January 2019

Department of Consumer Affairs
BOARD OF BEHAVIORAL SCIENCES
 January 2019 (Current)

FY 2018-19
 Authorized Positions: 58.2
 BL 12-03 (999 blanket): 1.6*



All Positions within BBS are designated CORI positions

SCOPE, OBJECTIVES, AND METHODOLOGY

The scope of this engagement focused on a review of the Board's fee structure and staff workload to determine if fee levels are appropriate for the recovery of the actual cost of conducting its programs for the Marriage and Family Therapists (LMFT) and Associates (AMFT), Licensed Clinical Social Workers (LCSW) and Associates (ACSW), Licensed Professional Clinical Counselors (LPCC) and Associates (APCC), and Licensed Educational Psychologists (LEP). This includes the 25 fees listed in Table 1 below and the following objectives:

- Assess and correlate the workload for approximately 60 Board employees to determine an hourly or unit cost to support licensing, renewal, and enforcement activities.
- Analyze all fees and other revenues collected by the Board to determine if fee levels are sufficient for the recovery of the actual cost of conducting its programs.
- Based on the financial analysis, project fees/revenues and related costs for the next three to five fiscal years.
- Determine a cost basis to assess other services provided by the Board when a separate fee is not provided, if any.

The CPS HR methodology included:

- An onsite kickoff meeting
- Offsite document review of pertinent practice acts, the 2015 Sunset Review, fee schedule, online forms, multi-year financial information covering revenues and expenditures for four fiscal years, FY 14-15 through FY 17-18, the Board's organization chart, and current staff duty statements.
- Reviewed current business process flowcharts.
- Reviewed and applied staff workload time assumptions, regarding the processing of initial and renewal paper and online licensing and examination applications.
- Observed and sampled licensing and disciplinary/enforcement work performed to confirm the completeness and accuracy of Board staff duty statements and workload processing time assumptions.
- Analyzed revenues and expenditures for four fiscal years FY 14-15 through FY 17-18 for fees required to recover expenses.
- Prepared draft and final reports with recommendations for fund condition stabilization.

**Table 1
Study Fee Types**

| Fee Type | Marriage and Family Therapists (LMFT) | | Licensed Clinical Social Worker (LCSW) | | Licensed Professional Clinical Counselor (LPCC) | | Licensed Educational Psychologist (LEP) | | |
|--|---------------------------------------|-----------------|--|-----------------|---|-----------------|---|-----------------|--|
| | Current Fee | Statutory Limit | Current Fee | Statutory Limit | Current Fee | Statutory Limit | Current Fee | Statutory Limit | |
| Associate Registration | \$75 | \$75 | \$75 | \$75 | \$100 | \$150 | | | |
| Associate Renewal | \$75 | \$75 | \$75 | \$75 | \$100 | \$150 | | | |
| Application for Licensure | \$100 | \$100 | \$100 | \$100 | \$180 | \$250 | \$100 | \$100 | |
| Law and Ethics Exam/Re-exam | \$100 | \$100 | \$100 | \$100 | \$100 | \$100 | | | |
| Clinical Exam/Rexam | \$100 | \$100 | * | \$100 | * | \$250 | | | |
| Issuance of Initial License | \$130 | \$180 | \$100 | \$155 | \$200 | \$250 | \$80 | \$150 | |
| License Renewal** | \$150 | \$180 | \$120 | \$155 | \$195 | \$250 | \$80 | \$150 | |
| Written Exam/ Re-Exam | | | | | | | \$100 | \$100 | |
| *These fees are paid by the applicants directly to the exam vendors and are not collected by BBS. | | | | | | | | | |
| **This includes the renewal fee and \$20 charged for the Mental Health Provider Education Fund, except for LEP renewals. | | | | | | | | | |

Study Results

The following presents information about the Board’s license types, staff tasks, work process flows, fees and revenue, fund condition and findings and recommendations. Finally, this section presents a fully absorbed hourly rate and license fee revenue projections based on fully absorbed cost to cover future estimated expenses.

LICENSE TYPES

Table 2 displays for Fiscal Years 14-15 through FY 17-18 the number of Licensees/Registrants for each license type. The table shows that the LMFT licensees represent the largest part of Licensee population regulated by the Board of Behavioral Sciences, followed by the LCSW, LPCCs and LEP licensees. Overall, the total number of licensees and registrants regulated by the BBS has grown by 11.2% between FY 14-15 and FY 17-18. This increase is not only due to a growing population, but also to the increase in Health Care coverage from implementation of the Affordable Care Act. However, this overall number disguises some internal trends. Historically and in FY 17-18, Marriage and Family Therapists/Associates represent the largest Licensee population, 44,277 (39.5%) of all licensees and registrants licensed by the Board. These licensees increased by 15.5% over the period reviewed by this study (FY 14-15 through FY17-18). However, the Marriage and Family Therapist Intern population has decreased in each of the last two Fiscal Years, bringing its total population to 17, 176 (15.3%) of the total number of licensees/registrants. This is down from 18.7% in FY 15-16. At 27,773, Licensed Clinical Social Workers (LCSW) are the second largest group regulated by the Board, representing 24.8% of the total licensee/registrant population, and up from 22.7 % at the beginning of the study period. Although small in numbers, the Licensed Professional Clinical Counselor population has grown rapidly as this program instituted in FY 11-12, began seeing the first students graduating in 2015. LPCC Licensees grew by 34.7% from FY 14-15 to FY17-18. The number of LPCC Associates has greatly expanded, increasing by 186.5% over the four-year period and presaging continued significant growth in the number of LPCCs in the near future.

**Table 2
Licensees/Registrants by License Types**

| Licensees/Registrants by License Type | FY 2014-15 | FY 2015-16 | FY 2016-17 | FY 2017-18 | % Increase |
|---|-------------------|-------------------|-------------------|-------------------|-------------------|
| Marriage and Family Therapist | 38,343 | 40,360 | 41,901 | 44,277 | 15.50% |
| Marriage and Family Therapist Intern | 19,272 | 19,783 | 18,829 | 17,176 | -10.90% |
| Licensed Clinical Social Worker | 22,842 | 24,197 | 25,734 | 27,773 | 12.10% |
| Associate Social Worker | 14,499 | 15,784 | 15,865 | 15,619 | 7.70% |
| Licensed Educational Psychologist | 2,141 | 2,195 | 2,073 | 2,038 | -4.80% |
| Continuing Education Provider | 2,850 | - | - | - | |
| Licensed Professional Clinical Counselor | 1,282 | 1,390 | 1,536 | 1,727 | 34.70% |
| Licensed Professional Clinical Counselor Intern | 1,214 | 1,940 | 2,724 | 3,478 | 186.50% |
| Total | 102,443 | 105,649 | 108,662 | 112,088 | 11.20% |

HISTORICAL FEE VOLUME ANALYSIS

Table 3 shows the volumes for the 25 fee types under review for Fiscal Years (FYs) 2014-15 through 2017-18. The Associate Registrations and Associate Renewals for LMFTs appear to be declining by -6.2% and -18.6% respectively (see 4 Yr Change column). The Associate Registrations and Associate Renewals for LCSWs appear to be relatively stable at a 1.2% increase and a -4.8% decrease, respectively. However, for both LMFTs and LCSWs, Application for Licensure and the Issuance of Initial License is up significantly (LMFT – Application for Licensure up 11.7%, LCSW – Application for Licensure up 52.7%, LMFT – Issuance of Initial License up 34.9%, LCSW – Issuance of Initial License up 73.1%). In essence, it appears for the LMFTs and LCSWs that there may have been an influx of new Associates who are now receiving their license. In addition, License Renewals for LMFTs and LCSWs have been increasing as well, at 13.5% and 16% respectively, which is indicative of the growing licensee population.

The LPCCs and especially the LEPs have significantly less volume than the LMFTs and LCSWs and are therefore better addressed separately. Their lower volumes therefore also have less implications on the overall revenue picture for BBS. For the LPCCs, while their Issuance of Initial License has declined from 248 in FY 14-15 to 155 in FY 17-18 (a 30.6% drop), their Associate Registration (67.8%), Associate Renewal (196.7%) and Application for Licensure (134.1%) have all increased significantly. The first LPCC students of California schools began graduating in the Spring of 2015 and intern applications and examination applications increased significantly. From a raw volume standpoint, the Application for Licensure, Issuance of Initial License and License Renewals for LEPs appear relatively stable. However, the Written Exam/Re-exam has increased from 133 in FY 14-15 to 171 in FY 17-18, a 48.9% increase.

The table also shows the impact of the examination restructure that went into effect January 1, 2016. This restructure requires registrants to take the Law and Ethics Exam in their first year. They must take it at least once a year until they pass the exam in order to renew their registration or obtain their license. If they are not successful in passing the examination, they can now retake the exam every 90 days, whereas before they could only retake it once every 180 days. For LMFTs, LCSWs and LPCCs the Law and Ethics Exam/Re-exam volumes were the highest in FY 16-17. This disproportionately increased volumes in FY 16-17 above ongoing levels, because it required new applicants to take the exam as well as existing registrants who were not previously required to take an examination prior to the completion of their supervised work experience hours. Note that only the FY 17-18 volumes for the Law and Ethics

Exams were used to make projections about future volumes which are incorporated in the workload assumptions discussed later in the report.

Individuals applying for LMFT, LCSW, and LPCC licenses are all required to take and pass a clinical exam as well. Part of the way through FY 14-15 the clinical exam for LCSWs was outsourced to an external vendor, which is why the table displays volume data for only FY 14-15. The clinical exam for LPCCs has always been outsourced to an external vendor which is why volume data are absent for that fee as well. LMFTs, LCSWs and LPCC used to take a written exam, but since they no longer do, that data has been excluded from the analysis. The Law and Ethics exam essentially replaced the written exam for the LMFTs, LCSWs and LPCCs.

Table 3
BBS Fee Type Volumes Summary
FY 2014-15 through 2017-18

| Fee Type | | | | | | |
|---------------------------------|-----------------|-----------------|----------------|-----------------|-----------------|--------------------|
| LMFT | FY 14-15 | FY 15-16 | FY16-17 | FY 17-18 | 4 Yr Avg | 4 Yr Change |
| Associate Registration | 4138 | 3992 | 3899 | 3880 | 3977 | -6.2% |
| Associate Renewal | 13450 | 13904 | 12184 | 10948 | 12622 | -18.6% |
| Application for Licensure | 2708 | 2619 | 2695 | 3024 | 2762 | 11.7% |
| Law and Ethics Exam/Re-exam | 0 | 5520 | 10543 | 5958 | | |
| Clinical Exam/Re-exam | 3263 | 4663 | 5526 | 4549 | 4500 | 39.4% |
| Issuance of Initial License | 1871 | 1734 | 2259 | 2524 | 2097 | 34.9% |
| License Renewal | 14368 | 14879 | 15841 | 16304 | 15348 | 13.5% |
| | | | | | | |
| LCSW | | | | | | |
| Associate Registration | 3553 | 3428 | 3567 | 3597 | 3536 | 1.2% |
| Associate Renewal | 9260 | 10840 | 9558 | 8817 | 9619 | -4.8% |
| Application for Licensure | 1658 | 1731 | 2067 | 2532 | 1997 | 52.7% |
| Law and Ethics Exam/Re-exam | 0 | 4583 | 8785 | 5092 | | |
| Clinical Exam/Re-exam | 1660 * | | * | * | | |
| Issuance of Initial License | 1107 | 1132 | 1828 | 1916 | 1496 | 73.1% |
| License Renewal | 8682 | 9072 | 9479 | 10072 | 9326 | 16.0% |
| | | | | | | |
| LPCC | | | | | | |
| Associate (Intern) Registration | 655 | 992 | 1057 | 1099 | 951 | 67.8% |
| Associate Renewal | 517 | 960 | 1265 | 1534 | 1069 | 196.7% |
| Application for Licensure | 138 | 211 | 237 | 323 | 227 | 134.1% |
| Law and Ethics Exam/Re-exam | 139 | 601 | 1332 | 996 | | |
| Clinical Exam/Re-exam | * | * | * | * | | |
| Issuance of Initial License | 248 | 88 | 111 | 172 | 155 | -30.6% |
| License Renewal | 338 | 688 | 486 | 757 | 567 | 124.0% |
| | | | | | | |
| LEP | | | | | | |
| Associate Registration | | | | | | |
| Associate Renewal | | | | | | |
| Application for Licensure | 101 | 123 | 118 | 125 | 117 | 23.8% |
| Issuance of Initial License | 82 | 53 | 58 | 52 | 61 | -36.6% |
| License Renewal | 606 | 640 | 610 | 627 | 621 | 3.5% |
| Written Exam/Re-exam | 133 | 178 | 173 | 151 | 159 | 13.5% |

Source: BBS Workload and Revenue Reports were used for all volumes except for the Law and Ethics Exam/Re-exam and Clinical Exam/Re-exam for LMFTs, LCSWs and LPCCs, and the LEP Written Exam/Re-exam where BBS Exam Results by School reports were used.

*These fees are paid by the applicants directly to the exam vendors and are not collected by BBS.

LICENSE FEES AND REVENUE

The Board collects approximately 59 fees. The fees range from \$20 to \$200. The renewal period for licenses is every two years and for registrations its annually, but as noted above since 2016, all of the LMFT, LCSW and LPCC Associates are required to take the Law and Ethics exam at least annually until they pass it. A new practice act for the Licensed Professional Clinical Counselors was added in 2010 and implemented in FY 11-12. Its impact on the Board's licensing workload began in 2015 when the first students began graduating from colleges. Table 4 shows the historical trends for 25 out of the 59 fees that BBS collects. For the majority of fees, the 4-year percent changes are nearly the exact same as in the fee volume table (table 3). Over the four fiscal years studied, these 25 fees constitute on average 90.4% of the total fee scheduled revenue. Of the total fee scheduled revenue collected by BBS, license and associate renewals constitute 54.2%, exams constitute 17.9% and issuance of initial license, application for license, associate registration cumulatively constitute 18.4%. Given the introduction of the Law and Ethics exam in January 2016 described in the historical fee volume analysis section above, only the FY 17-18 revenue could really be considered a typical year moving forward for the reasons mentioned in that section.

**Table 4
BBS Fee Type Volumes Summary
FY 2014-15 through 2017-18**

| License Type | | | | | | | |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|--------------|----------------------------------|
| LMFT | FY 14-15 | FY 15-16 | FY16-17 | FY 17-18 | 4 Year Avg | 4 Yr Change | % of Total Fee Scheduled Revenue |
| Associate Registration | \$ 310,350 | \$ 299,370 | \$ 292,420 | \$ 287,975 | \$ 297,529 | -7.2% | 3.3% |
| Associate Renewal | \$ 1,008,755 | \$ 1,042,830 | \$ 913,805 | \$ 821,094 | \$ 946,621 | -18.6% | 10.6% |
| Application for Licensure | \$ 270,805 | \$ 261,860 | \$ 269,530 | \$ 302,430 | \$ 276,156 | 11.7% | 3.1% |
| Law and Ethics Exam/Re-Exam | \$ - | \$ 552,000 | \$ 878,529 | \$ 1,054,250 | \$ 621,195 | | 6.9% |
| Clinical Exam/Re-Exam | \$ 326,300 | \$ 277,700 | \$ 552,625 | \$ 520,400 | \$ 419,256 | 59.5% | 4.7% |
| Issuance of Initial License | \$ 243,294 | \$ 225,439 | \$ 293,627 | \$ 328,108 | \$ 272,617 | 34.9% | 3.0% |
| License Renewal | \$ 1,867,829 | \$ 1,934,205 | \$ 2,059,355 | \$ 2,119,520 | \$ 1,995,227 | 13.5% | 22.3% |
| LCSW | | | | | | | |
| Associate Registration | \$ 266,475 | \$ 257,100 | \$ 267,495 | \$ 269,775 | \$ 265,211 | 1.2% | 3.0% |
| Associate Renewal | \$ 694,525 | \$ 813,035 | \$ 716,875 | \$ 661,275 | \$ 721,428 | -4.8% | 8.1% |
| Application for Licensure | \$ 165,849 | \$ 173,100 | \$ 206,700 | \$ 253,200 | \$ 199,712 | 52.7% | 2.2% |
| Law and Ethics Exam/Re-exam | \$ - | \$ 458,300 | \$ 878,520 | \$ 509,525 | \$ 461,586 | | 5.2% |
| Clinical Exam/Re-Exam | * | * | * | * | * | * | |
| Issuance of Initial License | \$ 110,716 | \$ 113,215 | \$ 182,760 | \$ 191,629 | \$ 149,580 | 73.1% | 1.7% |
| License Renewal | \$ 868,240 | \$ 907,160 | \$ 947,900 | \$ 1,007,208 | \$ 932,627 | 16.0% | 10.4% |
| LPCC | | | | | | | |
| Associate Registration | \$ 65,500 | \$ 99,150 | \$ 105,700 | \$ 109,875 | \$ 95,056 | 67.7% | 1.1% |
| Associate Renewal | \$ 51,675 | \$ 95,975 | \$ 126,500 | \$ 153,400 | \$ 106,888 | 196.9% | 1.2% |
| Application for Licensure | \$ 24,780 | \$ 38,060 | \$ 42,580 | \$ 58,140 | \$ 40,890 | 134.6% | 0.5% |
| Law and Ethics Exam/Re-Exam | \$ 13,900 | \$ 60,100 | \$ 133,200 | \$ 118,100 | \$ 81,325 | | 0.9% |
| Clinical Exam/Re-Exam | * | * | * | * | * | * | |
| Issuance of Initial License | \$ 49,574 | \$ 17,501 | \$ 22,269 | \$ 34,496 | \$ 30,960 | -30.4% | 0.3% |
| License Renewal | \$ 59,145 | \$ 120,400 | \$ 85,050 | \$ 132,470 | \$ 99,266 | 124.0% | 1.1% |
| LEP | | | | | | | |
| Associate (Intern) Registration | | | | | | | 0.0% |
| Associate Renewal | | | | | | | 0.0% |
| Application for Licensure | \$ 10,100 | \$ 12,300 | \$ 11,800 | \$ 12,500 | \$ 11,675 | 23.8% | 0.1% |
| Issuance of Initial License | \$ 6,523 | \$ 4,256 | \$ 4,600 | \$ 4,158 | \$ 4,884 | -36.3% | 0.1% |
| License Renewal | \$ 48,475 | \$ 51,160 | \$ 48,760 | \$ 50,160 | \$ 49,639 | 3.5% | 0.6% |
| Written Exam/Re-Exam | \$ 13,300 | \$ 17,800 | \$ 17,300 | \$ 19,800 | \$ 17,050 | 48.9% | 0.2% |
| Selected Fee Totals | \$ 6,476,109 | \$ 7,832,016 | \$ 9,057,900 | \$ 9,019,488 | \$ 8,096,378 | 39.3% | 90.4% |
| Total Fee Scheduled Revenue | \$ 7,863,000 | \$ 8,907,000 | \$ 9,786,000 | \$ 9,259,000 | \$ 8,954,000 | 17.8% | 100.0% |
| Selected Fee Totals/Total Fee Scheduled Revenue | 82.4% | 87.9% | 92.6% | 97.4% | 90.4% | | |

Source: Individual fee revenue obtained from FM 13 reports; total fee scheduled revenue obtained from BBS Fund Condition

STAFF TASKS AND WORKLOAD BREAKDOWN –

As shown in the organization chart (figure 1), the Board’s staffing and workload are broken into leadership and six functional program units: Licensing, Examination and Cashiering, the three subprograms that make up Enforcement: Criminal Convictions, Consumer Complaints and Investigations, and Discipline and Probation, and Administration. The following task/workload discussion is based on the incumbents’ current duty statements. CPS HR validated workload tasks and

processing assumptions through observation and interviews. In some cases, multiple staff in the same or similar classifications perform the same duties.

CPS HR found that in each unit BBS staff have current written standard operating procedures.

In addition, applicants and licensees have access to a variety of guides, reference documents, forms and instructions on the Board's Website (www.bbs.ca.gov).

The Executive Officer (EO), and exempt position, under the general direction of the 13-member Board, interprets and implements the Board's policies and actions and develops and manages the Board's \$11.5 million annual budget to ensure appropriate allocation of resources and maintain fund solvency. The EO oversees all licensing and enforcement activities, including investigations and administrative actions. The EO advises the Attorney General's Office and Hearing Officers on Board discipline guidelines. The EO is responsible for administering Board meetings, and is the Board spokesperson to the legislature, professional organizations and the public. The EO develops proposed legislation and, develops, implements and administers Board regulations.

The Assistant Executive Officer (AEO), a Staff Services Manager II, works under the direction of the EO and is responsible for planning, organizing, directing and administering the day to day activities of the Board of Behavioral Sciences. The Assistant EO directly supervises 6 subordinate managers and their respective programs: licensing, examination, administration, and the three subprograms within enforcement: Criminal Convictions, Consumer Complaints and Investigations, and Discipline and Probation. The AEO provides consulting and high level expertise to the EO and the 13 Member Board on complex policy and program issues. The AEO manages sensitive communications, including with the media, Governor's office, legislature and control agencies. In the absence of the EO, functions as chief executive.

Licensing Unit

The Licensing Unit is responsible for licensing and registering the Board's four (4) license types; Licensed Marriage and Family Therapists (LMFT), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC) and Licensed Educational Psychologist (LEPs) and their associated registrants. The unit consists of 18 positions: Staff Services Manager I (SSMI) (1); Associate Governmental Program Analyst (AGPA) (1); Staff Services Analysts (SSAs) (5); Management Services Technicians (MSTs) (9); and Office Technicians (Typing)(OT) (T) (2).

Staff Services Manager I (SSMI)

The Staff Services Manager I is responsible for the day-to-day operations of the Licensing Unit. The SSM I is the recognized authority for the Licensing Program and as such formulates, recommends, analyzes and implements legislation, regulations, policies and procedures for the licensing program. The SSMI provides guidance and insight to Board staff and the public concerning the Board's four (4) license types; LMFT, LCSW, LPCC and LEP and their specific practice acts. The SSMI makes recommendations on complex and sensitive issues in the Licensing Unit, monitors workload, identifies backlogs and develops solutions. The SSMI investigates the more complex and sensitive complaints and responds to inquiries on statutory and regulatory provisions, licensure requirements and departmental policies and procedures.

Associate Governmental Program Analyst (AGPA)

The Associate Governmental Program Analyst is the personnel liaison between the Board and the department's Office of Human Resources (OHR) concerning personnel matters and advises executive and management staff on personnel issues. The AGPA prepares personnel documents for submission to and approval by OHR, develops duty statements for all Board positions, and creates and maintains organizational charts. The AGPA also maintains attendance and personnel files for Board staff and monitors vacancies. The AGPA researches and analyzes personnel issues, working with the OHR to effect appropriate resolution. The AGPA is the statistical analyst for the Board, producing productivity reports that provide program data for the Board Members and Executive staff on the Board's Licensing, Examination and Cashiering and Enforcement Units. The AGPA also performs various program analyses and creates statistical reports to support program management. The AGPA is responsible for analyzing new laws and consulting with DCAs Senior Staff Counsel, the Board's Executive Staff, unit managers and professional associations to design forms to meet statutory requirements. The AGPA also evaluates and makes recommendations for revision of existing licensing forms to meet the Board's ongoing requirements and to ensure that forms posted on the Board's website are accessible and in compliance with the Americans with Disabilities Act.

Staff Services Analysts (SSAs)

Two Staff Services Analysts act as resource lead analysts, performing the final review and analyzing applications to ensure the applicant has met the statutory and regulatory requirements, education, intern hours and clinical experience requirements and that there are no pending enforcement issues to qualify for licensure. They assist first level reviewers and clerical staff with licensing issues. They maintain a working knowledge of various laws, rules and regulations specific to licensing and provide interpretation to staff and act as an expert resource for Board Management. These two SSAs also conduct educational outreach with faculty and staff at accredited universities and colleges. They work with professional associations to ensure Board participation at professional events. They develop and present information on the BBS licensing process to graduate students, pre-licensed registrants and licensees. They are responsible for developing an Evaluator Training Program for each licensure type, including writing procedures, developing training materials and maintaining the Licensing Unit procedure training manuals. They review licensing procedures to identify areas that could benefit from improved or streamlined processes and develop alternative to improve these processes.

The third Staff Services Analyst is responsible for preparing statistical reports of Licensing Processing Times and Licensing Performance Measures and presenting results to the Licensing Manager and Executive staff. This position represents Licensing at the BreEze Reports Users Group and the Licensing Users Group meetings. Also, this SSA works with the BreEze team on Licensing Performance Measures. This SSA also conducts audits to determine if a licensee is in compliance with the Board's Continuing Education (CE) requirements. The SSA prepares audit letters and maintains an audit tracking system to ensure deficiencies have been corrected. The SSA refers non-complaint CE audits and licensees who fail the CE audit to the Board's Consumer Complaint and Investigations Unit for issuance of a citation and fine.

The remaining two Staff Services Analysts are responsible for the analysis of material involved in the Licensure of Licensed Clinical Counselors who graduate from clinical counseling programs. The SSAs review and evaluate all applications for professional clinical counselor intern registrations. This includes

applications from individuals whose education and experience in other states and countries do not qualify under standard criteria used for applicants from within California. The SSAs review the submitted course descriptions and syllabi from these academic clinical counseling programs and determine whether the course work meets the requirements for registration. They validate the documentation submitted. Where there are deficiencies in the material submitted, they determine whether to issue an intern registration based on fulfillment of the education requirements and prepare a deficiency letter to the applicant identifying the deficient areas of the application and review the additional documents submitted in response to the deficiency letter. They ascertain if the applicant has prior convictions that may be a basis for application denial and referral to the Board's Enforcement Unit for further investigation. The two SSAs also develop detailed procedures for all licensure programs to evaluate education gained in degree programs not previously evaluated by the Board to determine whether they meet the statutory curriculum requirements. They gather documentation such as applicant transcripts and course catalogs from clinical counseling advanced degree programs and make recommendations to colleges and universities on changes necessary to ensure compliance with core curriculum to meet the Board's statutory and regulatory requirements. They also work with faculty and staff at accredited universities and colleges to facilitate outreach events and presentations and with professional associations to ensure Board participation at their events. They develop and present information on the BBS licensing process to graduate-level students, pre-licensed registrants and licensees.

Management Services Technician (MST)

One Management Services Technician is responsible for evaluating Marriage and Family Therapist Intern applications and supporting documentation to determine the applicant's eligibility for IMF registration. The MST reviews and evaluates course descriptions and syllabi from Marriage and Family Therapist graduate school programs to determine if the coursework is equivalent and meets statutory and regulatory requirements for licensure. The MST evaluates transcripts and other documents, including for out-of-state and out-of-country degrees to determine if the required educational requirements have been met. The MST enters applicant data into BreEZe and determines whether the applications are complete and comply with all educational requirements and notifies applicants of any deficiencies. The MST follows up on the deficient applications to determine whether they have been "abandoned". If so, the MST withdraws the application and updates BreEZe. The MST identifies prior convictions that may be a basis for registration denial and referral to the Board's Enforcement Unit. The MST is the Board's school liaison and reviews new schools and degree programs for compliance with statutes and regulations. The MST proposes curriculum changes to school programs, if appropriate. The MST reviews existing school programs to ensure they continue in compliance and maintain their accreditation or approval and verifies the regional accreditation credentials of the graduate schools. The MST responds to applicant inquiries regarding the MFT licensure process, requirements and how to complete the various required forms.

There are eight Management Services Technician positions that review and evaluate licensure applications, assess the applicant's pre-degree practicum and post degree clinical experience and verify the total supervised hours per licensee. They analyze the validity of the supporting documentation to determine whether the education and experience requirements have been met. They identify deficiencies and prepare a letter to the applicant identifying specific issues with the application or other supporting documents. They evaluate the licensee applicant experience verification forms and confirm

that the applicant meets the required supervisions hours in all therapeutic categories. They make the final determination of the application and whether the applicant is eligible to enter the exam process. They ascertain if the applicant has prior convictions that may be a basis for application denial and referral to the Board's Enforcement Unit for further investigation. They follow up by reviewing the documents submitted in response to the deficiency letter and determine whether to clear the deficiency, determine that the applicant has "abandoned" the application, or generate an additional letter requesting information on the continued deficiencies. The MSTs respond to applicant inquiries regarding application status, the licensure process, licensing requirements, and completion of the various forms.

Office Technicians (Typing) (OT) (T)

There are two Office Technicians (Typing) who provide support to the licensing MSTs by keying and updating licensing information in BreZE and preparing and mailing out approval letters. The OTs (T) verify supervisors to ensure that the applicant's hours of experience are acquired under a licensed supervisor. The OTs (T) prepare correspondence responding to inquiries from supervisors, professional organizations, other governmental agencies or licensure applicants. They are also responsible for creating new files and preparing and coordinating the transfer of the archived files to the State Record Center for storage.

Examinations and Cashiering Unit

The Examinations and Cashiering Unit is responsible for developing, administering, evaluating accommodations requests and investigating complaints for the examinations administered through the Board of Behavioral Sciences and for the cashiering of fees paid for licensing and renewal applications as well as payments for citations and fines and enforcement cost recovery fees paid by licensees and registrants. The Unit consists of 10 positions: one Staff Services Manager I (SSMI); the examination team which consists of six staff, two Staff Services Analysts (SSAs) and four Management Services Technicians (MST); and the cashiering team which consists of three staff, one Staff Services Analyst (SSA) and three Office Technicians (Typing) (OT) (T).

Staff Services Manager I (SSMI)

Under the direction of the Executive Officer (EO) and the Assistant Executive Officer (AEO) the Staff Services Manager I over the Examination and Cashiering Unit oversees, monitors and maintains the examination and cashiering units. The SSMI directs the day-to-day activities of the Examination and Cashiering Units and acts as the recognized authority for the Examination Program. As such, the SSMI formulates, recommends, analyzes and implements legislation, regulations, policies and procedures, and reviews and approves all versions of Board developed examinations. The SSMI represents the Board with professional examination entities, including the Office of Professional Examination Services (OPES), the Association of Social Work Boards (ASWB), and the National Board for Certified Counselors. The SSMI makes recommendations on complex and sensitive issues in the Examination and Cashiering Unit, monitors workload, identifies backlogs and develops solutions. The SSMI also investigates client complaints, responds to inquiries about licensure requirements, departmental policies and procedures, and statutory and regulatory provisions. The SSMI is also responsible for ensuring that all cashiering functions are accurate and adhere to the State Administrative Manual (SAM) and Department of Consumer Affairs (DCA) cashiering policies and procedures.

Examination Team

Staff Services Analysts (SSAs)

Two Staff Services Analysts perform examination development, administration, complaint and contract analysis duties for the Examination Unit. The two SSAs are liaisons to the Office of Professional Examination Services (OPES) regarding examination development workshops and the selection of Subject Matter Experts (SME). They proofread new versions of exams and oversee the implementation of the exams. They assist OPES in conducting occupational analyses for all Board license types. They recruit new and existing SMEs from all license types to participate in examination development workshops. They develop and maintain SME information in BreZE. They evaluate applications submitted by potential SMEs and determine whether the applicant should be approved by the Board. The SSAs prepare materials for exam workshops and assist OPES research analysts and participants. The SSAs also verify applicant clinical exam eligibility. They are the Board liaison for the National Exams given by the AWSB and NBCC and gather exam statistics for management. They research complaints regarding examination administration, testing sites, candidate concerns and accommodations. The SSAs recommend an appropriate response to the complaint and prepare the written response to the candidate and document it in the Board's database.

Management Services Technicians (MSTs)

There are two Management Services Technicians responsible for evaluating testing accommodation requests for compliance with the guidelines for Title II of the Americans with Disabilities Act (ADA). They determine whether the accommodation requested is appropriate for the candidate's needs. They review the supporting medical documentation and verify the medical professional's license. They communicate with the candidates regarding their accommodation request, the accommodation process, examination requirements and completion of the appropriate forms. They may request additional documentation or information regarding the testing accommodation requested. They correspond with the candidates notifying them of the accommodation approval and the specific accommodation granted. The SSAs review special accommodation candidate applications to retake the exam and identify whether any changes to the existing accommodation are needed. They update the candidates' BreZE file with the testing accommodation outcome. They also investigate and resolve special accommodation candidate's complaints/concerns regarding the testing facility's failure to provide the approved testing accommodation. The MSTs generate a monthly testing accommodation report and statistics. They review and approve the examination testing vendor's invoices for payment. They identify, investigate and resolve discrepancies regarding the fees charged candidates, including accommodation fees. The MSTs also assist in hand scoring the examination, when the examination candidate requests hand scoring.

Cashiering Team

Staff Services Analyst (SSA)

The Cashiering Team SSA acts as a Business Process Analyst. The SSA reviews and documents cashiering business processes and makes recommendations to support and improve those processes. The SSA develops cashiering and functional technical specifications and provides assistance in designing, developing and implementing cashiering business process changes in BreZE. The SSA develops new or

revises existing cashiering policies to streamline processes and improve efficiency. The position reviews and reports potential cashiering defects, prepares complete documentation of the cashiering defects and participates in meetings with the DCA Central Cashiering Unit and BreEze team staff to resolve issues. The SSA develops and updates the Board's BreEze training and procedure manual. The SSA also assists staff with cashiering issues and provides direction to resolve them and personally handles the most complex issues. The SSA also reviews cashiering data error reports and corrects records in BreEze and writes and tests cashiering scripts to test business requirements and cashiering designs. The SSA is also responsible for developing a Cashiering BreEze Training Program and writes procedures and develops material for training new users.

Office Technicians (Typing) (OT) (T)

The three Cashiering Team OTs (T) are responsible for cashiering the Board's licensing and renewal applications by entering the cashiering data into BreEze. They process requests for replacement licenses, license certificates, citations and fines, cost recovery payments and name and address changes and update the information in BreEze. They also process reimbursement of dishonored checks, refunds and revenue transfers. The OTs (T) respond to cashiering inquiries regarding the renewal process, submission of insufficient fees and dishonored checks.

Criminal Conviction Unit

The unit is responsible for investigating all criminal convictions for existing licensees and registrants and works with the Attorney General's Office to ensure timely resolution to criminal conviction cases. The unit consists of seven employees; an SSM I (1), SSAs (4) and Office Technicians (Typing) (OT) (T)(2).

Staff Services Manager I

Under the direction of the Executive Officer and Assistant Executive Officer, the Staff Services Manager I is responsible for supervising the Criminal Conviction Unit. The SSMI reviews and approves investigation reports and recommends approval or denial of applicants with criminal conviction history for licensure/registration. The SSMI initiates action to immediately suspend licensee or registrant from practice upon notification of an arrest involving significant public harm under the provisions of PC 23 (Penal Code). Works with the Division of Investigation(DOI) within DCA, local District Attorney Offices and with the Office of the Attorney General. The SSMI is the recognized authority for the Criminal Conviction Unit, and formulates, recommends, analyzes and implements legislation, regulations, policies and procedures. The SSMI also represents the Board at statewide hearings, enforcement meetings and task forces, as required.

Staff Services Analysts

The Criminal Conviction Unit has four Staff Services Analysts. Three of the SSAs are responsible for conducting Applicant Background Investigations. They analyze Criminal Offender Record Information (CORI) (rapsheets) received from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) to determine if the applicant can be approved for licensure, registration or renewal in compliance with the Board's Statutes and regulations. The SSAs review and evaluate the applicant's prior conviction history and/or prior disciplinary history relating to a professional license held in California or other states. They request additional information from the applicant, and contact local law

enforcement agencies and courts to obtain a certified copy of arrest and/or other court documents. They maintain and update the case record in the BreEZe system.

Two of these Staff Services Analysts also prepare disciplinary cases and settlement terms for review and approval by the Assistant Executive Officer and Executive Officer for referral to the Office of the Attorney General and provide testimony at administrative hearings.

The other two Staff Services Analysts are responsible for reviewing Subsequent Arrest Notifications (subraps) to determine possible violation of the Board's statutes and regulations. They request additional documents, review and analyze the arrest reports/court documents and information from the registrants/licensees to determine if the case should be referred to the Office of the Attorney General (AG) for possible disciplinary action. They present recommendations to the SSMI, EO and AEO regarding case disposition and settlement terms. They respond to inquiries from the Deputy Attorney Generals and testify at administrative hearings. They review cases referred by the Licensing Unit to determine whether the convictions disclosed on the Licensure Exam Eligibility Applications have been previously reviewed by the Enforcement Unit and determine if a new enforcement case should be opened. They prepare citations for failure to disclose conviction(s) and for minor violations convictions cases.

One of these Staff Services Analysts is also the Public Disclosure Coordinator. This SSA is responsible for preparing accusations, PC 23 orders, Petitions to Revoke Probation, citations, Final Decisions and other court documents for public disclosure on the Board's website. This SSA also updates BreEZe to ensure all appropriate information has been entered and updated and conducts a final review of the Board's disciplinary file before closure to ensure that all required steps are completed.

Office Technician (Typing) (OT)(T)

The two Office Technicians (Typing) provide clerical support to the unit and are the Board's liaison to the DOJ to assist in processing fingerprint submissions to obtain CORI information. The OTs (T) enter CORI information into the BreEZe system. They process hard copy fingerprint cards by mailing them to applicants, reviewing the returned cards for accuracy and completeness, and they batch the fingerprint cards for transmission to DOJ. They research unmatched fingerprint submissions. They respond to inquiries from applicants, Live Scan operators and Board staff regarding Live Scan/Fingerprint processes, status and other related questions.

The OTs (T) also conduct the initial review of subsequent arrest notifications, subsequent dispositions, CORI and applicant reported convictions to determine if a case needs to be opened. If so, they create new case records in BreEZe, set up a case file and assign to an Enforcement Analysts.

Consumer Complaint and Investigations Unit

The Consumer Complaint and Investigations Unit is responsible for reviewing, investigating and determining whether complaints against licensees/registrants/applicants should be pursued for prosecution, disciplinary action, citation, and fine. The unit recommends case disposition and as needed settlement terms. The unit consists of 8 employees: Staff Services Manager I (SSMI)(1), Special Investigator(1), Associate Governmental Program Analyst s (AGPA) (5) and Office Technician (OT) (1).

Staff Services Manager I (SSMI)

Under the direction of the Executive Officer and the Assistant Executive Officer, the Staff Services Manager I is responsible for directing the Consumer Complaint & Investigations Unit of the BBS Enforcement Program. The SSM I reviews and approves investigation reports, citations, petitions, accusations, statements of issues, proposed decisions and stipulated settlement agreements. The SSMI works with the Division of Investigations, and Office of the Attorney General in interpreting the BBS's laws, regulations and disciplinary guidelines and the direction or handling of each disciplinary case. The position monitors case status and assists the Deputy Attorney General s (DAGs) with preparation of technical language and makes recommendations for case disposition. The SSMI testifies at administrative hearings. The position formulates, recommends, analyzes and implements legislation, regulations, policies and procedures.

Special Investigator (SI)

The Special Investigator conducts diverse administrative investigations of professional licensees and registrants for alleged violations and pursues cases for prosecution or hearing. The SI plans and conducts investigations into allegations of unprofessional conduct against licensees, registrants and applicants. The SI conducts face-to-face field interviews with complainants, licensees/registrants and witnesses. The SI identifies, gathers assembles and preserves statements, affidavits and other evidence, and prepares and serves subpoenas and other legal papers. The SI also interacts with federal, state and local law enforcement agencies on investigations and advises and makes recommendations to the EO, AEO and SSM I regarding case disposition. The SI prepares detailed investigation reports, including documented evidence, witness statements and other information to ensure that the findings are fully supported by the facts and evidence. The SI also assists with probation case monitoring by conducting interviews with probationers and examining a variety of records to obtain or verify compliance with the probationary order. The SI also confers with and assists the DAGs in preparing cases for administrative hearings.

Associate Governmental Program Analysts (AGPAs)

The five Associate Governmental Program Analysts are responsible for evaluating and investigation incoming consumer complaints. They request, review, evaluate, and analyze a variety of documents, notifications and evidence from consumers, law enforcement agencies, other Boards and licensees to determine whether the evidence supports formal field investigation and whether the case warrants review by the Office of the Attorney General. The AGPAs prepare investigation reports detailing the findings and evidence collected during the investigation and document violations of the law. The AGPAs apply policies, procedures and regulatory requirements to make determinations regarding violations of the law. They use disciplinary guidelines and consider mitigating and aggravating factors to develop recommendations regarding case disposition and the appropriate level of discipline. They also determine merit for issuance of an administrative citation and fine and prepare and issue citation orders. They schedule and participate in informal hearings and coordinate citation appeal cases with the AG's Office. They respond to verbal and written inquiries regarding enforcement matters and represent the Board at administrative appeal hearings.

Office Technician (Typing) (OT)(T)

The Office Technician (Typing) provides clerical support to the Consumer Complaint and Investigations Unit. The OT (T) performs the initial review of customer complaints to determine if a case should be

opened. If so, the OT (T) creates the case record on the BreEZe system and assigns the case to an analyst. The OT (T) answers, screens and refers complaint telephone calls to appropriate Board staff and provides general information regarding the Board's complaint process. The OT (T) maintains hard copy documents and files and updates enforcement records in BreEZe. The OT (T) reviews, logs and distributes mail for the unit and processes investigative reports. The OT (T) also copies and forwards confidential and sensitive documents to analysts, DOI, the AGs Office, Board Members, licensees and other concerned parties.

Discipline and Probation Unit

The Discipline and Probation Unit is responsible for ensuring that the licensees and registrants who have been disciplined and or placed on probation are in full compliance with their probationary terms and conditions. For licensees and/or registrants that are not in full compliance, the unit ensures that all measures are taken to bring them into compliance, including referral to the AGs Office for an Accusation and/or Petition to Revoke Probation. The unit consists of 7.8 positions, one Staff Services Manager I, 4.8 Associate Governmental Program Analysts (AGPA) and two Office Technicians (OT).

Staff Services Manager I

Under the direction of the Executive Officer and the Assistant Executive Officer, the Staff Services Manager I supervises the day-to-day operations of the Board's Discipline and Probation Unit. The SSMI reviews and approves citations, accusations, statements of issues, proposed decisions and petitions to revoke probation. The SSMI acts as a liaison with the Division of Investigations (DOI), and the Office of the Attorney General (AG) to assist with interpretation of the BBS's laws, regulations and disciplinary guidelines and approach to handling specific discipline cases. The SSMI makes recommendations for case disposition. The SSMI acts as an authority for the Discipline & Probation Unit including formulating, analyzing and implementing legislation, regulations, procedures and policies.

Associate Governmental Program Analysts (AGPA)

Two point eight (2.8) Associate Governmental Program Analysts spend fifty percent of their time on probation related cases. The AGPAs review and approve plans submitted by probationers to ensure compliance with the specific terms of their probation. They schedule and conduct comprehensive interviews with probationers to monitor adherence to their probation terms and conditions. The AGPAs authenticate and certify all terms and conditions documents and corroborate employment and duties performed. They address non-compliance when a probationer is not appropriately employed. They serve notice to the probationer of any failure to comply with the terms and conditions of probation, which may include suspension of their registration/license. The AGPAs oversee and track cost recovery and probation monitoring payments from the probationers. They maintain and update the probationer's information in BreEZe. They ensure that probationers whose terms and conditions require random drug testing are compliant. When there is a positive test result or discrepancies, they prepare and send out cease and desist notices to the probationer and to the probationer's current employer. The AGPAs analyze probation violations and make recommendations for petitions to revoke the probationer's registration/license. They compile documents from the case files and refer cases to the Attorney General's Office for further disciplinary action. They review legal pleadings for content and compliance with the Board's statutes, regulations and disciplinary guidelines and make recommendations regarding case disposition and settlement terms. The AGPAs review requests from

probationers to determine whether they are eligible to file a petition to modify the terms of their probation or for reinstatement of their license. If so, they send out a petition package and coordinate the petition hearing and answer questions as needed by the Board.

Two AGPAs are responsible for the discipline process. The AGPAs review accusations, statement of issues, default decisions, stipulations and other related documents for accuracy and content and determine whether they are in compliance with the Board's statutes, regulations and disciplinary guidelines. The AGPAs coordinate with the AG's Office in preparing various discipline cases. Also, the AGPAs are liaisons to the DCA legal counsel, the Division of Investigations and the Office of the Attorney General on discipline cases. The AGPAs provide settlement terms to the DAGs. The AGPAs also review proposed decisions for accuracy and content.

One of the AGPAs oversees the Expert Reviewer Program including recruitment, policy development and training and develops Expert Reviewer criteria and maintains the expert reviewer list and data. This AGPA updates enforcement procedures and manuals as needed and trains staff to ensure consistent application of procedures. This AGPA also formulates and recommends new policies, procedures and program improvements.

The other AGPA monitors and tracks all disciplinary cases for timeliness and compliance with the Board's goals and maintains disciplinary case records in BreZE. The AGPA monitors and tracks all billing from the AGs office. The AGPA conducts quality control reviews of disciplinary cases, citations, and court documents to ensure that the information is accurately reported on the Board's website. The AGPA reports disciplinary action information to the National Practitioner Data Bank (NPDB) and reports to the California State Department of Health Care Services specific licensure information for any person whose license has been revoked, suspended, surrendered or made inactive by the licensee to prevent state reimbursement for services provided after the license is cancelled.

Office Technicians (Typing) (OT) (2)

One of the Office Technicians provides Enforcement Unit support by reviewing subsequent arrest notifications, subsequent dispositions, CORI information and applicant reported convictions to determine whether a case should be opened. The OT creates new case records in BreZE and creates a hard copy case file and assigns cases to the appropriate enforcement analysts. The OT answers inquiries regarding enforcement issues, maintains case files and provides clerical support to the analysts. The OT processes accusations, statements of issues, and other disciplinary documents and prepares declarations and official certifications of license history for disciplinary cases. The OT prepares citations, accusations, final disciplinary documents and court documents for public disclosure, updates disciplinary information in BreZE and responds to Public Records Act requests.

The other OT acts as the Cite and Fine Coordinator by preparing and mailing out citations to licensees, registrants and unlicensed individuals. The OT reviews requests for appeals and schedules informal conferences and updates citation case files in BreZE. The OT processes and tracks all enforcement related cost reimbursements from licensees and unlicensed individuals and sends demand for payment letters. The OT refers non-compliant licensees and unlicensed individuals to the Franchise Tax Board for collection. This OT also assists the Expert Reviewer Program Coordinator by preparing cases to be transmitted for expert review and updating BreZE records. The OT also reviews and processes expert reviewer invoices and maintains payment records and contracts.

Administration Unit

The Administration Unit is composed of 9 and 3/4 positions that are responsible for legislative and regulations review and analysis, budget review and tracking, internal accounting, procurement, maintaining and supporting the Board's website, coordinating communication with the Board members, DCA, the media and the legislative office. The unit supports Board and Committee meetings and provides front office support. The unit staff consists of nine and three quarters positions: one Staff Services Manager I, three and three quarters (3.75) Associate Governmental Program Analysts (AGPA), one (1) Staff Services Analyst, three (3) Office Technician (General) (OT) (G), one (1) Office Assistant (Typing) (OA) (T) and one Office Assistant(General) (OA)(G).

Staff Services Manager I

Under the direction of the Executive Officer and the Assistant Executive Officer, the Staff Services Manager I is responsible for the day-to-day operations of the Board's Administration Unit. The SSMI is responsible for the formulating, recommending, analyzing and implementing legislation, regulations, budgets, procedures and policies. The SSMI prepares correspondence on the legislative or regulatory functions of the Board and recommends policy, procedure or regulatory changes to the EO for consideration by relevant committees and the Board. The SSMI investigates sensitive customer complaints, responds to inquiries on statutory and regulatory procedures, licensure requirements and department policies and procedures.

Associate Governmental Program Analysts

One AGPA is responsible for legislative bill analysis, including recommending the Board's position. For Board sponsored legislation, the AGPA drafts amendments, works with stakeholders, agency and department analysts, and legislative staff to ensure passage of legislation. The AGPA provides administrative support by preparing issue papers, memoranda and reports for management staff and Board member review. The AGPA develops rulemaking proposals, including initial statement of reasons, public notice and regulation text, and ensures Board compliance with Administrative Procedures Act requirements for rulemaking.

One AGPA is responsible for budget analysis, is the liaison with DCA's budget office, developing budget change proposals, and reporting to assist the fiscal administration of the Board's programs. The AGPA is also the Business Services Coordinator and is responsible for working with the DCA Telecom Unit on communications issues and updating the BBS automated telephone system. This AGPA is also responsible for developing and implementing the Board's Continuity of Operations/Continuity of Government plan.

One AGPA (3/4 position) is responsible for rulemaking. The position develops rulemaking proposals, attends regulatory hearings and revises Board forms related to the rulemaking project. The AGPA also provides administrative support for implementing new legislation and approved rulemaking proposals.

One AGPA conducts the Board Customer Service Survey, interprets results and presents findings to management. The AGPA evaluates volume and licensee and registrant population trends. The position prepares annual performance data for the Department of Consumer Affairs Annual Report. This position is also responsible for reviewing all Board procurement requests to determine the most appropriate and cost-effective method for procurement and for preparing all procurement requests for

management approval. The AGPA also maintains and updates the Board's website, ensures that the Board's website meets accessibility requirements, and identifies and troubleshoots website operational problems. The AGPA also supports the Board's IT Staff Information Systems Analyst in problem solving and resolving user issues and coordinates maintenance and repair of the Board's computers for the Board's end users through the DCA Help Desk.

Staff Services Analyst (SSA)

The Staff Services Analyst develops documents, special reports, statistical reports and recommends actions. The SSA responds to inquiries from the legislature, stakeholders and DCA on sensitive or confidential issues for the EO and AEO. The SSA is the Board's liaison to oversee the administrative operations and activities of all Board and Committee Meetings. The SSA interprets and incorporates information from management and Board Meeting recordings to prepare accurate Board Meeting Minutes and Agendas. The SSA creates Board Meeting packets, prepares meeting materials for posting on the Board's website, and schedules meeting sites for Board meetings. The SSA also acts as the Public Records Act custodian, receiving records requests, researching what information can be released and ensures that responses are in compliance with the Department's Public Records Request Policy and consults with the Board's legal counsel in responding to subpoenas.

Office Technician (OT) General

There are two Office Technicians (General). One OT (G) is the receptionist and answers and directs incoming calls to the appropriate staff or unit, and answers inquiries regarding legal and procedural requirements for licensure, renewal procedures, exam scheduling and status of applications and other general licensing questions. The OT(G) processes address changes and initial licenses for successful exam candidates received from the DCA Central Cashiering Unit.

The other OT (G) prepares registrant and licensing documents for filing, files documents, and ensures that files are maintained in order. The OT (G) prepares archive transfer documents and organizes files for archiving at the State Records Center. The position prepares and updates the Board's Record Retention Schedule. The OT (G) also backs up the receptionist and provides front office support by answering, screening and directing incoming telephone calls and responding to inquiries concerning licensure requirements, renewal procedures and the examination process.

Office Assistant (Typing) OA (T)

The Office Assistant (Typing) responds to correspondence regarding general licensing requirements and regulations. The OA (T) enters fingerprint clearance and rejection data into BreEZe. The position opens, sorts and distributes incoming mail and backs up the receptionist by answering phone inquiries regarding legal and procedural requirements for registration for licensure, status of applications and other general licensing questions. The OA (T) prepares licensing documents for filing, files documents in the file room and prepares and coordinates requests for reproduction of Board forms, pamphlets and publications.

Office Assistant (General) OA (G)

The Office Assistant (General) opens, sorts and distributes all mail received by the Board. The position also sorts and distributes fax inquiries and prepares and sends overnight or certified mailings. The

position provides back up reception and front office support by answering, screening and directing incoming telephone calls and answering and responding to inquiries regarding licensure requirements, renewal procedures and the examination process. The OA (G) verifies the status of licenses and registrations. The OA (G) accepts license, registration and exam applications and provides clerical support to the unit as needed.

HISTORICAL REVENUE ANALYSIS

Table 5 shows the Board’s revenue sources include fee schedule and non-fee schedule revenue for the last four fiscal years. Fee schedule income represents approximately 95.5% of all income and Non-fee schedule revenues accounted for 4.5% of income over this period.

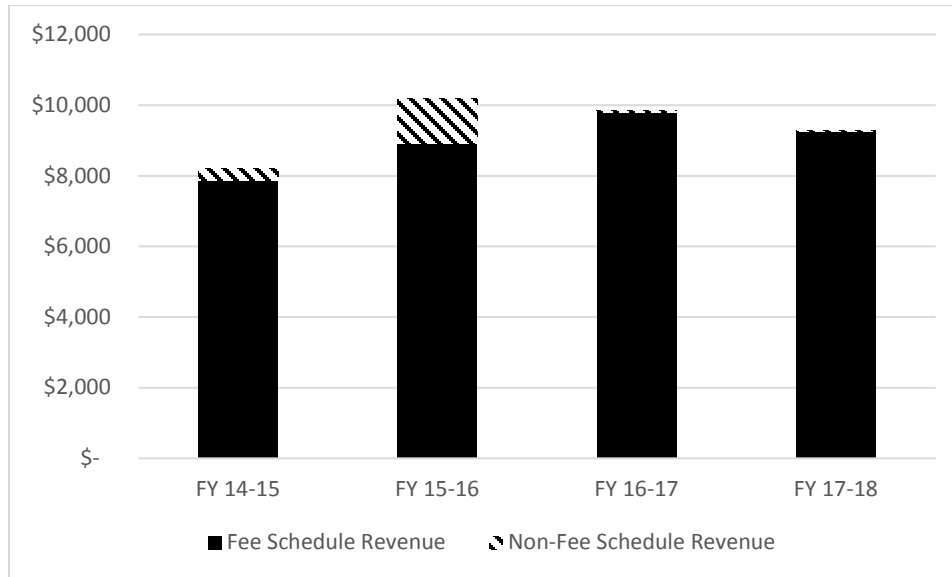
Table 5
BBS Fee and Non-Fee Scheduled Revenue
FY 2014-15 through 2017-18

| Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4 Yr Avg | % Total |
|--------------------------|-----------------|------------------|-----------------|-----------------|-----------------|----------------|
| Fee Schedule Revenue | \$ 7,863 | \$ 8,907 | \$ 9,786 | \$ 9,259 | \$ 8,954 | 95.5% |
| Non-Fee Schedule Revenue | \$ 338 | \$ 1,274 | \$ 62 | \$ 13 | \$ 422 | 4.5% |
| Totals | \$ 8,201 | \$ 10,181 | \$ 9,848 | \$ 9,272 | \$ 9,376 | 100.0% |

Dollars in thousands
Source: BBS Fund Condition

Figure 2 below graphically displays the Board’s Fund revenue sources and trends from FY 2014-15 through FY 2017-18. It shows that fee revenue has increased from FY 14-15 while non-fee revenue was much higher in FY 14-15 and FY 15-16 than it was in FY 16-17 and FY 17-18.

Figure 2
BBS Fund Revenue Sources
FY 2014-15 through 2017-2018



NON-FEE SCHEDULE REVENUE

Table 6 details and summarizes the Board’s Non-Fee Schedule revenue for FY 2014-15 through FY 2017-18. Interest from Interfund Loans constituted 93% of the non-fee scheduled revenue from across the four years. Interfund loan interest is the interest BBS derives from loans given to the State General Fund in years prior. There was no revenue from interfund loan interest for FY 16-17 and FY 17-18 and the fund condition projections from FY 18-19 through FY 23-24 also don’t show any revenue for interfund loan interest. The second highest source of non-fee scheduled revenue was from the Income from Surplus Money Investments category at 5.3%, which has been steadily increasing. The remaining non-fee revenue sources have been relatively stable over the four years and constitute 1.7%.

Table 6

BBS Non-Fee Schedule Revenue Summary

FY 2014-15 through 2017-2018

| Source | Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4 Yr Avg | % Total |
|---------|--|---------------|-----------------|--------------|--------------|---------------|---------------|
| 4163000 | Income from Surplus Money Investments | \$ 9 | \$ 18 | \$ 53 | \$ 9 | \$ 22 | 5.3% |
| 150500 | Interest from Interfund Loans | \$ 321 | \$ 1,248 | \$ - | \$ - | \$ 392 | 93.0% |
| 160100 | Attorney General Proceeds of Anti-Trust | \$ 1 | \$ - | \$ - | \$ - | \$ 0 | 0.1% |
| 4171500 | Escheat of Unclaimed Property | \$ - | \$ - | \$ 1 | \$ - | \$ 0 | 0.1% |
| 4171400 | Escheat of Unclaimed Checks and Warrants | \$ 3 | \$ 4 | \$ 3 | \$ - | \$ 3 | 0.6% |
| 4172500 | Miscellaneous Revenues | \$ 4 | \$ 4 | \$ 5 | \$ 4 | \$ 4 | 1.0% |
| | Totals | \$ 338 | \$ 1,274 | \$ 62 | \$ 13 | \$ 422 | 100.0% |

Dollars in thousands
Source: BBS Fund Condition

FEE SCHEDULE REVENUE

Table 7 details and summarizes the Board’s Fund Fee Schedule revenue for FY 2014-15 through FY 2017-18. At 57.6% and 39.8%, respectively, the table shows Renewal Fees and Other Regulatory Licenses and Permits have consistently been the Board’s primary revenue drivers. The Renewal Fee category includes standard renewal fees, inactive to active fees, retired license fees and inactive renewal fees. The Other Regulatory Licenses and Permits category includes initial licenses fees, application fees, and fees associated with the Board’s various exams including the law and ethics exam, clinical exams, and the LEP written exam. The Other Regulatory Fees and Delinquent Fees categories only constituted 1.5% and 1.0% percent, respectively. The Other Regulatory Fees category included citations and fines, duplicate document and certification fees. The Delinquent Fees category included delinquent renewal and inactive delinquent fees.

Table 7

BBS Fee Schedule Revenue Summary

FY 2014-15 through 2017-18

| Source | Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4 Yr Avg | % Total |
|---------|---------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|---------------|
| 4127400 | Renewal Fees | \$ 5,019 | \$ 5,242 | \$ 5,161 | \$ 5,213 | \$ 5,159 | 57.6% |
| 4129400 | Other Regulatory Licenses and Permits | \$ 2,680 | \$ 3,462 | \$ 4,345 | \$ 3,770 | \$ 3,564 | 39.8% |
| 4129200 | Other Regulatory Fees | \$ 74 | \$ 117 | \$ 181 | \$ 176 | \$ 137 | 1.5% |
| 4121200 | Delinquent Fees | \$ 90 | \$ 86 | \$ 99 | \$ 100 | \$ 94 | 1.0% |
| | Totals | \$ 7,863 | \$ 8,907 | \$ 9,786 | \$ 9,259 | \$ 8,954 | 100.0% |

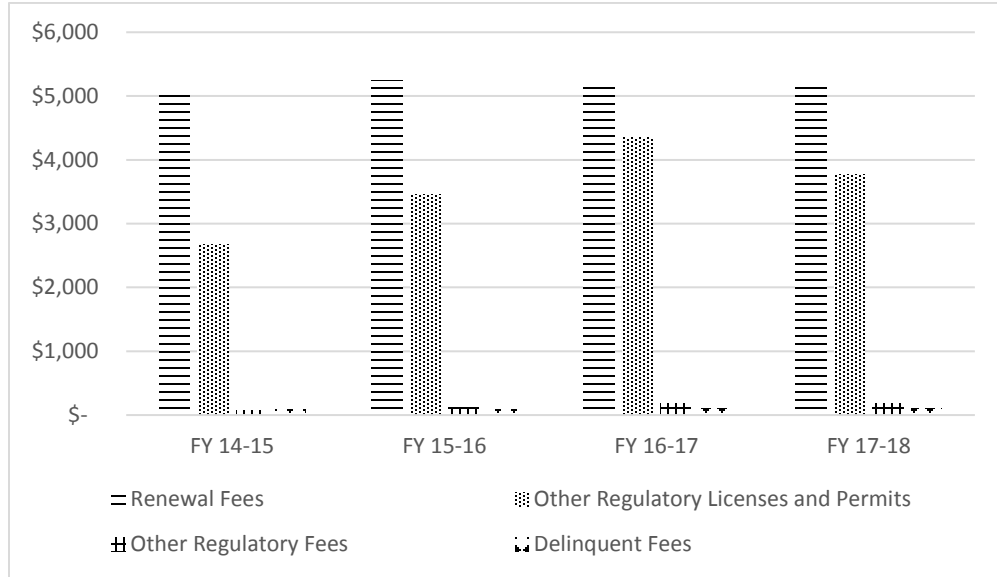
Dollars in thousands
Source: BBS Fund Condition

Figure 3 shows that while Renewal Fees, Other Regulatory Fees and Delinquent Fees have been relatively stable, Other Regulatory Licenses and Permits increased steadily from FY 14-15 through FY 16-17 and then declined slightly again in FY 17-18.

Figure 3

BBS Fee Schedule Revenue Sources, Trends & Analysis

FY 2014-15 through FY 2017-18



HISTORICAL TRANSFERS ANALYSIS

From FY 2001-2002 to FY 2010 to 2011 BBS made loans to the State General Fund that BBS has been receiving repayment for show below in table 8. These repayments are considered transfers in the BBS fund condition and are treated as income. Since FY 14-15 BBS has been receiving repayment for three separate loans as shown below. BBS has received an average of \$1,900,000 per year from FY 2014-15 through 2017-18. There are no loan repayments for GF loan repayment per item 1110-011-0773 BA of 2011 between FY 2014-15 through 2017-18, however, in FY 2018-19 \$3,300,000 is projected to be repaid from that loan.

Table 8

BBS Transfers Summary

FY 2014-15 through 2017-18

| Source | Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4 Yr Avg | % Total |
|--------|---|-----------------|-----------------|-------------|-----------------|-----------------|---------------|
| F00001 | GF loan repayment per item 1170-011-0773 BA of 2002 | \$ 1,000 | \$ 3,600 | \$ - | \$ - | \$ 1,150 | 60.5% |
| F00001 | GF loan repayment per item 1110-011-0773 BA of 2008 | \$ - | \$ - | \$ - | \$ 3,000 | \$ 750 | 39.5% |
| F00001 | GF loan repayment per item 1110-011-0773 BA of 2011 | \$ - | \$ - | \$ - | \$ - | \$ - | 0.0% |
| | Totals | \$ 1,000 | \$ 3,600 | \$ - | \$ 3,000 | \$ 1,900 | 100.0% |

Dollars in thousands
Source: BBS Fund Condition

HISTORICAL EXPENSE ANALYSIS

The following expense analysis covers the Board’s major budget categories: Personnel Services and Operating Expenses and Equipment (OE&E) for FY 14-15 through FY 17-18. Table 9 summarizes and displays that OE&E expenses constitutes 58.1% of expenses whereas Personnel Services constitute 41.9% of expenses.

Table 9
BBS Overall Expense Categories
FYs 2014-15 through 2017-18

| Category | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4-Yr Avg | % of Total | 4 year change |
|--|---------------------|---------------------|----------------------|----------------------|----------------------|--------------|---------------|
| Personnel Services-Salaries and Wages | \$ 2,412,998 | \$ 2,596,204 | \$ 3,056,383 | \$ 3,131,253 | \$ 2,799,210 | 27.0% | 29.8% |
| Personnel Services-Staff Benefits | \$ 1,268,657 | \$ 1,390,036 | \$ 1,678,785 | \$ 1,849,862 | \$ 1,546,835 | 14.9% | 45.8% |
| Personnel Services Subtotal | \$ 3,681,656 | \$ 3,986,241 | \$ 4,735,168 | \$ 4,981,115 | \$ 4,346,045 | 41.9% | 35.3% |
| OE&E-Departmental Services | \$ 1,660,217 | \$ 2,496,948 | \$ 2,526,220 | \$ 2,945,000 | \$ 2,407,096 | 23.2% | 77.4% |
| OE&E-Central Administrative Services | \$ 388,161 | \$ 409,927 | \$ 488,000 | \$ 692,000 | \$ 494,522 | 4.8% | 78.3% |
| OE&E-Examinations | \$ 560,468 | \$ 686,082 | \$ 908,408 | \$ 798,353 | \$ 738,328 | 7.1% | 42.4% |
| OE&E-Enforcement | \$ 1,293,041 | \$ 1,337,089 | \$ 1,901,394 | \$ 2,072,093 | \$ 1,650,904 | 15.9% | 60.2% |
| OE&E-Other OE&E Expenses | \$ 647,708 | \$ 677,621 | \$ 673,055 | \$ 959,737 | \$ 739,530 | 7.1% | 48.2% |
| Operating Expenses & Equipment Subtotal | \$ 4,549,595 | \$ 5,607,667 | \$ 6,497,077 | \$ 7,467,183 | \$ 6,030,381 | 58.1% | 64.1% |
| Total Expenses | \$ 8,231,251 | \$ 9,593,907 | \$ 11,232,245 | \$ 12,448,298 | \$ 10,376,425 | | 51.2% |

Source: FM 13 CalSTARS reports for FY 14-15 through FY 16-17 and FM 11 projected expenses for FY 17-18, with the exception of Central Administrative Services. Central Administrative Services utilizes FM 13 CalSTARS reports for FY 14-15 and FY 15-16 and BBS Fund Condition for FY 16-17 and FY 17-18 which is also factored into the Operating Expenses & Equipment Subtotal and Total Expenses for FY 16-17 and FY 17-18.

Overall expenses have increased significantly at 42.8% in the 4 years studied. The largest increases were in Departmental Services (77.4%) and Enforcement (60.2%).

PERSONNEL SERVICES EXPENSES

Within Personnel Services, Salaries and Wages constituted 64.4% percent and Staff Benefits constituted 35.6% percent over the last four fiscal years. In addition to regular employee salaries, the salary and wages category also includes expenses related to temporary help and overtime. The staff benefits category covers medical, dental and vision insurance. It also covers Medicare taxes, OASDI and retirement contributions. Salary and Wages have increased 29.8% over the last 4 fiscal years while Staff Benefits have increased 45.8% over the same time period. A primary driver of the increased costs associated with Salaries and Wages and Staff Benefits is been the increase in the number of employees. In FY 2014/15, the Board was authorized 48.2 permanent positions and 1.8 blanket positions for a total of 50 positions. As of July 1, 2018, the Board has 58.2 authorized positions and 1.8 blanket positions for a total of 60 positions. The reason for these additional positions are discussed in more detail in the Staff Tasks and Workload Breakdown section of the report, but in essence, workload has increased across all the Licensing, Examination and Enforcement units. Another driver of the increased costs related to Salaries and Wages is a 4% salary increase on July 1, 2016, a 4% increase on July 1, 2017 and an additional 3.8% scheduled for July 1, 2018.

OPERATING AND EQUIPMENT EXPENSES

As table 9 above on page displays, the Board's (OE&E) expenses include Departmental Services (23.2%), Central Administrative Services (4.8%), Examinations (7.1%), Enforcement (15.9%), and Other OE&E Expenses (7.1%) (percentages listed are related to total expenses). Examined below are the Departmental Services, Central Administrative Services, Examinations and Enforcement categories in detail. The Other OE&E Expenses category in table 9 includes expenses the following remaining OE&E categories: Fingerprints, General Expense, Printing, Communications, Postage, Insurance, Travel in State, Travel out of State, Training, Facilities Operations, Utilities, C/P SVS Interdepartmental, C/P SVS External, Data Processing, Major Equipment, Vehicle Operations, Minor Equipment.

DEPARTMENTAL SERVICES

Below, table 10 summarizes and figure 4 displays the Board's Departmental Services expenses for FYs 2014-15 through FY 2017-18. At a four-year fiscal average of 23.2% of total expenses, these activities are the Board's second largest recurring expense category next to Salaries and Wages (27%) and include all DCA services charged to the Board. Depending on the service or DCA department or division charging the service, DCA allocates or charges these expenses to BBS annually on the basis of authorized positions or workload units consumed (e.g., license transactions).

Costs that have routinely represented 96.5% of BBS's Departmental Services costs are for the Office of Information Services (OIS) (57.7%), Administration Pro-Rata (28.1%), and Interagency Agreement with OPES (10.6%). OIS costs relate to the DCA's support of all the Board's information technology activities relating to computers, software, network servers, telephones and online licensing systems (previous Online Professional Licensing System and currently BreEZe). Over the period reviewed, OIS expenses increased significantly due to the costs associated with the Board's implementation of the BreEZe system beginning in October 2013.

The Administration Pro Rata cost is primarily associated with the cost of salary and benefits of the centralized DCA staff that supports the Board, such as Human Resources, Finance, Procurement, the Budget Office, Accounting, Travel, Executive Office. This cost has risen significantly in the past four years due to increases in employee salaries and health and retirement benefits.

The Interagency Agreement with OPES category represents charges going to the DCA Office of Examination Services. The charges pay for the work performed by State staff at the Office of Examination Services coordinating the development of new test items for the various tests the Board administers (e.g. the Law and Ethics exams, the LMFT Clinical exam and the LEP written exam). The tests constantly need new test items to help avoid the possibility of the tests being compromised. In addition, new legal and practice requirements may necessitate new test item creation. This cost category has remained relatively stable.

The Other Departmental Services category contains the DCA Communications Division, the DCA Internal Investigations Unit and the DCA Program Policy and Regulations Division. The DCA Communications Division employees support staff who are responsible for internal and external support of the Breeze system. The DCA Internal Investigation unit investigates internal issues at DCA related to security (e.g. investigating employees that are involved in work with the potential for crime, such as employees who handle cash, or employees who are involved in sensitive legal work). The DCA Program Policy and

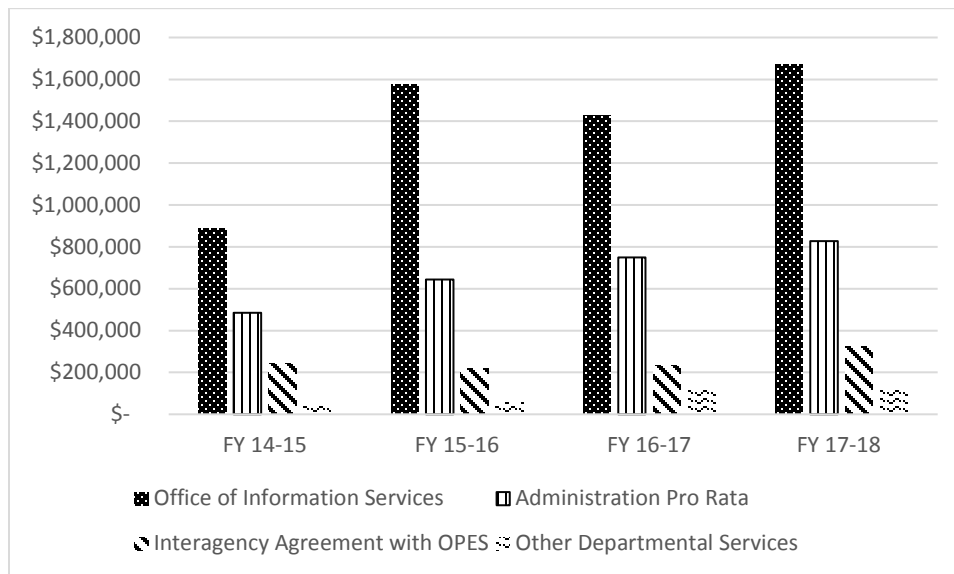
Regulations Division that is responsible for analyzing new policies and regulations in order to make recommendations about how the Board should address the changes.

Table 10
DCA Departmental Services
FYs 2014-15 through 2017-18

| Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4-Yr Avg | % of Total |
|---------------------------------|--------------|--------------|--------------|--------------|--------------|------------|
| Office of Information Services | \$ 885,579 | \$ 1,575,028 | \$ 1,428,381 | \$ 1,670,000 | \$ 1,389,747 | 57.7% |
| Administration Pro Rata | \$ 485,370 | \$ 644,320 | \$ 750,084 | \$ 828,000 | \$ 676,944 | 28.1% |
| Interagency Agreement with OPES | \$ 245,297 | \$ 219,870 | \$ 231,140 | \$ 325,000 | \$ 255,327 | 10.6% |
| Other Departmental Services | \$ 43,971 | \$ 57,730 | \$ 116,615 | \$ 122,000 | \$ 85,079 | 3.5% |
| Totals | \$ 1,660,217 | \$ 2,496,948 | \$ 2,526,220 | \$ 2,945,000 | \$ 2,407,096 | 100.0% |

Source: FM 13 CalSTARS reports for FY 14-15 through FY 16-17 and FM 11 projected expenses for FY 17-18

Figure 4
BBS DCA Departmental Services Trend & Analysis
FY's 2012-13 through 2017-18



CENTRAL ADMINISTRATIVE SERVICES (STATEWIDE PRO RATA)

Table 11 summarizes expenses for Pro Rata, the only sub-category within the Centralized Services category, for FYs 2014-15 through 2017-18, which has constituted 4.8% of all the Board’s total expenses over the last four fiscal years. Statewide pro rata represents the Board’s share of indirect costs incurred by central services agencies such as the Department of Finance, State Controller’s Office, and the State

Personnel Board. The Department of Finance allocates the costs of providing central administrative services to all state departments that benefit from the services. This apportioned amount is further allocated to each state department's funding sources based on the percentage of total expenditures in each special fund. Expenses in this category increased significantly at 78.3% from FY 14-15 to FY 17-18. Much of this increase is related to the increasing personnel costs (e.g. salaries, and benefits) across the state.

Table 11
Central Administrative Services
FYs 2014-15 through 2017-18

| Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4-Yr Avg | % of Total | 4 year change |
|---------------|------------|------------|------------|------------|------------|------------|---------------|
| Pro Rata | \$ 388,161 | \$ 409,927 | \$ 488,000 | \$ 692,000 | \$ 494,522 | 100.0% | 78.3% |
| Totals | \$ 388,161 | \$ 409,927 | \$ 488,000 | \$ 692,000 | \$ 494,522 | | 78.3% |

Source: FM 13 CalSTARS reports for FY 14-15 and FY 15-16 and BBS Fund Condition for FY 16-17 and FY 17-18

ENFORCEMENT

Table 12 summarizes and figure 5 graphically displays expenses for Enforcement activities for FYs 2014-15 through 2017-18, which has constituted 15.9% of all the Board’s expenses over the last four fiscal years. Collectively at 96.5% of total enforcement expenses, services from the DOJ’s Office of the Attorney General, the Department of General Service’s (DGS) Office of Administrative Hearings, and the DCA’s DOI (Divisions of Investigation) Investigations Enforcement Unit account for most spending. The Other Enforcement Expenses contains court reporter services and evidence and witness fees. The Board’s cost for the Division of Investigation (DOI), DCA’s law enforcement branch, is related to investigations of the Board’s licensees and are part of the Department’s pro rata costs. This expense is calculated based on a two-year roll forward methodology. DOI costs are budgeted each fiscal year based on the number of investigative hours work on enforcement cases in the prior year. This annual expense more appropriately reflects the Board’s current and projected ongoing usage of DOI as the Board expects to refer more cases because of the growing need for law enforcement to perform investigations. The Office of Administrative Hearings costs are associated with work performed by State employees when a licensee appeals a violation they have been charged with. The Attorney General costs are for work performed by State employees at the Attorney General’s office when the Board escalates an enforcement case to that office. The increases in all Enforcement expenses are associated with the increasing licensee population, the increased need to take enforcement related actions against licensees and the increasing salary and benefits costs associated with employees at DGS and the DOJ.

Table 12

BBS Enforcement Expense Summary

FY's 2014-15 through 2017-18

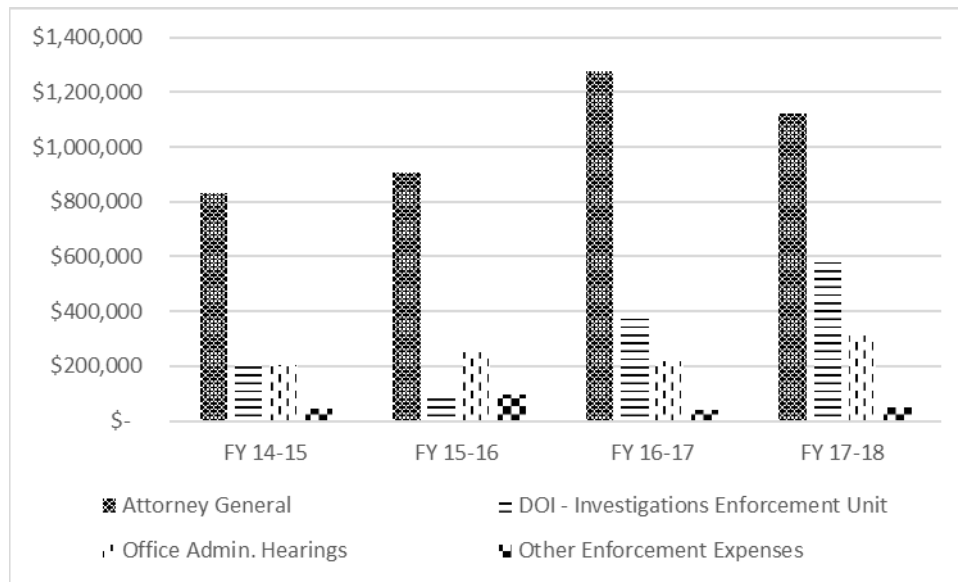
| Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 4-Yr Avg | % of Total |
|---------------------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|------------|
| Attorney General | \$ 829,362 | \$ 907,836 | \$ 1,274,123 | \$ 1,123,302 | \$ 1,033,656 | 62.6% |
| DOI - Investigations Enforcement Unit | \$ 217,959 | \$ 82,608 | \$ 371,795 | \$ 589,000 | \$ 315,341 | 19.1% |
| Office Admin. Hearings | \$ 202,461 | \$ 249,975 | \$ 216,656 | \$ 310,425 | \$ 244,879 | 14.8% |
| Other Enforcement | \$ 43,260 | \$ 96,669 | \$ 38,820 | \$ 49,366 | \$ 57,029 | 3.5% |
| Totals | \$ 1,293,041 | \$ 1,337,089 | \$ 1,901,394 | \$ 2,072,093 | \$ 1,650,904 | |

Source: FM 13 CalSTARS reports for FY 14-15 through FY 16-17 and FM 11 projected expenses for FY 17-18

Figure 5

BBS Enforcement Expense Trends & Analysis

FY's 2014-15 through 2017-18



EXAMINATIONS

Table 13 summarizes and figure 6 displays expenses for Examinations, which accounts for 7.3% of the Board's overall expenses. Within Examinations, the exam contract with an outside vendor, PSI, accounts for 75.1% of expenses. The Board contracts with PSI to provide computer-based testing administration. The Board is currently in the process of securing a new vendor to administer its computer-based examinations beginning July 1, 2019. While there will no longer be an expense for PSI, there will be an expense, just to another vendor. The Board currently collects the fees to take the exam from the candidates and then pays PSI. The increase in money spent on PSI is related to an increasing number of individuals applying for licensees and the introduction of the Law and Ethics exam.

The C/P Svcs – External Subject Matter category is the money paid to the Subject Matter Experts to write new test items. In FY 17-18 this expense was moved to a different line item called “Consulting Services”. The Exam Site Rental category is a contract with the Fairfield Inn & Suites hotel that is used to host the Subject Matter Expert test item writers during the exam development workshops. The values for FY 16-17 and FY 17-18 are blank because the Board did not have a contract in place as a result of exam unit staff transition. The Board did in fact conduct exam development workshops during that time, however; SMEs were reimbursed through the Travel Expense Claim process.

Table 13

BBS Examination Expense Summary

FY’s 2014-15 through 2017-18

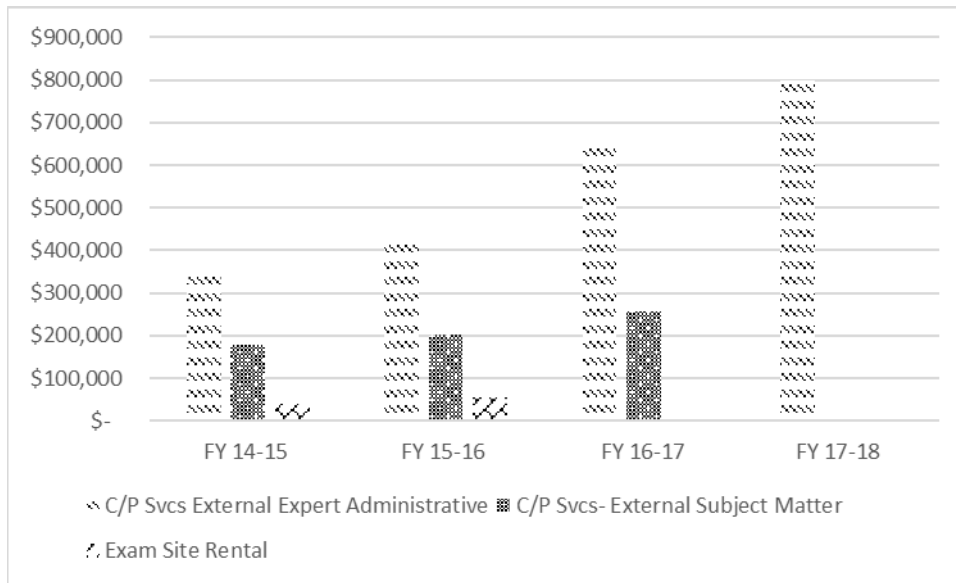
| Description | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | 2-Yr Avg | 4-Yr Avg | % of Total |
|---|-------------------|-------------------|-------------------|-------------------|-----------|-------------------|------------|
| Exam Site Rental | \$ 41,656 | \$ 55,233 | \$ - | \$ - | \$ 48,445 | \$ 24,222 | 3.3% |
| C/P Svcs External Expert Administrative | \$ 338,722 | \$ 429,296 | \$ 651,208 | \$ 798,353 | | \$ 554,395 | 75.1% |
| C/P Svcs- External Subject Matter | \$ 180,090 | \$ 201,553 | \$ 257,200 | \$ - | | \$ 159,711 | 21.6% |
| Totals | \$ 560,468 | \$ 686,082 | \$ 908,408 | \$ 798,353 | | \$ 738,328 | |

Source: FM 13 CalSTARS reports for FY 14-15 through FY 16-17 and FM 11 projected expenses for FY 17-18

Figure 6

BBS Examination Expense Trends & Analysis

FY’s 2014-15 through 2017-18



REVENUE, EXPENSE AND FUND BALANCE PROJECTIONS

The following presents assumptions used by the DCA Budget Office to project estimated revenue and expenses for FYs 2018-19 through 2022-23, and the results. Table 14 displays the DCA Budget revenue and expense projections for 2018-19 through 2022-23 based on DCA Budget Office guidelines. All revenue is expected to remain flat with the exception of the Income from Surplus Money Investments which is expected to vary somewhat. Generally speaking, this number grows as the Board has surplus money to actually invest and varies based on the securities market performance. In FY 2018-19 the last of the loans that the Board made to the State General Fund is expected to be repaid. The Total Revenues and Transfers amount is the total projected income estimated to be received by the Board.

Expenses include paying for development, implementation and use of the Financial Information System for California (FI\$Cal). FI\$Cal combines accounting, budgeting, cash management and procurement operations into a single financial management system. Also included are statewide general administrative pro-rata expenses which the Board pays as its apportioned share for central service agencies such as the Department of Finance, State Treasurer, State Controller and the Legislature. Central services are budgeting, banking, accounting, auditing, payroll and other services used by all state departments. The Supplemental Pension Payment is additional money allocated to the CalPERS retirement system. Finally, the DCA Budget Office allocates a large program expenditure amount (expenditure #1111) to the Board to cover all operations, including projected staffing increases and other Operating & Equipment expenses analyzed in this report. This expense is expected to increase 2% each year.

The total disbursement amount represents the annual appropriation which the DCA Budget Office assumes the Board will fully spend. Table 14 (the one right below) shows a growing net loss starting in FY 2018-19 and continuing over the projected remaining fiscal years with a cumulative net loss of \$16.3 million in FY 2022-23.

Table 14

BBS Projected Revenues and Expenses by the DCA Budget Office

FY's 2018-19 through 2022-23

| | FY 2018-19 | FY 2019-20 | FY 2020-21 | FY 2021-22 | FY 2022-23 |
|--|------------|------------|------------|-------------|-------------|
| Revenues and Transfers | | | | | |
| Revenues: | | | | | |
| 4129200 Other regulatory fees | \$ 221 | \$ 228 | \$ 228 | \$ 228 | \$ 228 |
| 4129400 Other regulatory licenses and permits | \$ 3,637 | \$ 3,637 | \$ 3,637 | \$ 3,637 | \$ 3,637 |
| 4127400 Renewal fees | \$ 5,268 | \$ 5,268 | \$ 5,268 | \$ 5,268 | \$ 5,268 |
| 4121200 Delinquent fees | \$ 93 | \$ 93 | \$ 93 | \$ 93 | \$ 93 |
| 4163000 Income from surplus money investments | \$ 14 | \$ 19 | \$ 40 | \$ 31 | \$ 19 |
| 4172500 Miscellaneous revenues | \$ 11 | \$ 11 | \$ 11 | \$ 11 | \$ 11 |
| Total Revenues | \$ 9,244 | \$ 9,256 | \$ 9,277 | \$ 9,268 | \$ 9,256 |
| Transfers from Other Funds | | | | | |
| F00001 GF loan repayment per item 1110-011-0773 BA of 2011 | \$ 3,300 | \$ - | \$ - | \$ - | \$ - |
| Totals, Revenues and Transfers | \$ 12,544 | \$ 9,256 | \$ 9,277 | \$ 9,268 | \$ 9,256 |
| Expenditures | | | | | |
| 1111 Department of Consumer Affairs Regulatory Boards, Bureaus, Divisions (State Operations) | \$ 11,837 | \$ 11,823 | \$ 12,059 | \$ 12,300 | \$ 12,546 |
| 8880 Financial Information System for California (State Operations) | \$ 1 | \$ -3 | \$ -3 | \$ -3 | \$ -3 |
| 9892 Supplemental Pension Payment (State Operations) | \$ 100 | \$ 212 | \$ 212 | \$ 212 | \$ 212 |
| 9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations) | \$ 957 | \$ 754 | \$ 754 | \$ 754 | \$ 754 |
| Total Disbursements | \$ 12,895 | \$ 12,786 | \$ 13,022 | \$ 13,263 | \$ 13,509 |
| Net Gain/Loss | \$ (351) | \$ (3,530) | \$ (3,745) | \$ (3,995) | \$ (4,253) |
| Cummulative Net Gain/Loss | \$ (833) | \$ (4,363) | \$ (8,108) | \$ (12,103) | \$ (16,356) |

Dollars in thousands
Source: DCA Budget Office

Fund Balance Projections

Table 14 and table 15 below show there is a significant fund solvency problem. Table 15 displays months in reserve declining rapidly from 4.5 to -9.3 months by the end of the projection period, well below the desired safety range. According to the DCA budget office projections, the BBS fund will become insolvent during FY 2021 unless revenue is increased. If, at the end of any fiscal year, the amount in the fund equals or is greater than two years of reserves, licenses or other fees shall be reduced during the following fiscal year. There is no mandated minimum reserve amount, but DCA and Board management agree that a three to six-month reserve is the desired range.

Table 15

BBS Projected Fund Balance Projection

FY's 2018-19 through 2022-23

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---------------------------------------|------------------|------------------|------------------|------------------|------------------|
| Beginning Balance | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ -2,461 | \$ -6,456 |
| Prior Year Adjustment | \$ - | \$ - | \$ - | \$ - | \$ 2 |
| Adjusted Beginning Balance | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ (2,461) | \$ (6,454) |
| Revenues and Transfers | | | | | |
| Totals, Revenues and Transfers | \$ 12,544 | \$ 9,256 | \$ 9,277 | \$ 9,268 | \$ 9,256 |
| Totals, Resources | | | | | |
| Totals, Resources | \$ 17,709 | \$ 14,070 | \$ 10,561 | \$ 6,807 | \$ 2,802 |
| Expenditures | | | | | |
| Total Disbursements | \$ 12,895 | \$ 12,786 | \$ 13,022 | \$ 13,263 | \$ 13,509 |
| Fund Balance | | | | | |
| Reserve for economic uncertainties | \$ 4,814 | \$ 1,284 | \$ -2,461 | \$ -6,456 | \$ -10,707 |
| Months in Reserve | 4.5 | 1.2 | -2.2 | -5.7 | -9.3 |

Dollars in thousands
Source: DCA Budget Office

Based on this analysis, CPS has determined the current Board fee structure is insufficient to cover expenses and will ultimately eliminate the Board’s reserve unless action is taken now. Board licensing revenue is expected to cover all expenses, including enforcement, test development, and Board overhead. Given that staffing levels, workload and operating costs are expected to grow substantially, the Board must either decrease expenses, increase revenue or achieve a combination of both to ensure the fund is solvent with a sufficient reserve.

Closing the Gap

Table 15 above demonstrates that the fund will be insolvent starting in FY 2020-21. An overall increase in revenue is required to close the revenue gap and build a satisfactory reserve by meeting or exceeding total expenditures. This assumes that, except for the selected fee increases, the Board retains the current initial and renewal license fee structure, maintains costs within its control, and does not incur significant increases in costs beyond its control, such as Departmental, inter-service agency and pro rata costs.

In raising fees, the Board must also consider the impact on licensees and the fund balance. The Board needs to set fees at a level that ensures an adequate reserve, but avoids triggering the provision that requires lowering fees when the fund has 24 months in reserve. How much the Board actually increases selected fees should be based on consultation with the DCA Budget Office and the Board’s licensee base.

Assuming non-urgency legislation was enacted, the soonest revised fees would go into effect would be January 2021. Given the urgency of the fund condition, CPS HR recommends that the Board implement

increased fees as soon as possible. An increase of \$3,008,000 in revenue (from FY 2019-20 to FY 2021-21) during the second half of FY 2020-21 would result in .5 months in reserve in FY 2020-21, thereby maintaining the fund’s solvency. Beginning in FY 21-22 and continuing forward, the proposed fee increases could lead to about \$6,016,000 additional revenue each full fiscal year. This increase would ultimately result in 5 months in reserve by FY 2023-24. Therefore, we recommend that BBS raise fees which would result in an at least an additional \$6,016,000 annually. Another aspect to note is that since 2002, fee related revenue has risen in most years even without fee increases. However, the current fund condition projections from FY 2019-20 to FY 2023-24 show at most only a \$21,000 revenue fluctuation from year to year (table 15) which is driven by income from surplus money invested (table 14). Therefore, it is probable that there may be more revenue generated than what the fund condition forecasts. In addition, a 2% increase in expenditures is projected year over year.

Table 16
Financial Impact of Selected License Fee Increase on Fund Condition

FY's 2018-19 through 2022-23

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 |
|---------------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|
| Beginning Balance | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ 526 | \$ 2,536 | \$ 4,301 |
| Prior Year Adjustment | \$ - | \$ - | \$ - | \$ - | \$ 2 | \$ 2 |
| Adjusted Beginning Balance | \$ 5,165 | \$ 4,814 | \$ 1,284 | \$ 526 | \$ 2,538 | \$ 4,303 |
| Revenues and Transfers | | | | | | |
| Totals, Revenues and Transfers | \$ 12,544 | \$ 9,256 | \$ 12,264 | \$ 15,272 | \$ 15,272 | \$ 15,272 |
| Totals, Resources | \$ 17,709 | \$ 14,070 | \$ 13,548 | \$ 15,799 | \$ 17,810 | \$ 19,575 |
| Expenditures | | | | | | |
| Total Disbursements | \$ 12,895 | \$ 12,786 | \$ 13,022 | \$ 13,263 | \$ 13,509 | \$ 13,763 |
| Fund Balance | | | | | | |
| Reserve for economic uncertainties | \$4,814 | \$1,284 | \$ 526 | \$ 2,536 | \$ 4,301 | \$ 5,812 |
| Months in Reserve | 4.5 | 1.2 | 0.5 | 2.3 | 3.8 | 5.0 |

Dollars in Thousands

HOURLY RATE AND RECOMMENDED FEE PROJECTIONS

One study objective is to establish a cost basis to fairly assess services the Board provides for a scheduled fee and for services that lack statutory scheduled fees. Without an accurate cost accounting system, the most convenient and fairest way to charge for services is to determine an hourly charge based on full absorption costing that accounts for all Board staff, operating and overhead costs. By dividing the Board’s costs by total staff paid hours, a fully absorbed hourly and minute cost rate can be derived to identify the cost for current scheduled fees and non-scheduled tasks or services.

Table 17 shows that both expenditures and staffing have increased over the last five years, reflecting increased workload. Several factors have contributed to this increase including: the introduction of the Licensed Professional Clinical Counselor program in 2011; the implementation of the Affordable Care Act in 2014 which increased mental health care coverage and thus the demand for mental health

counseling; the revised examination program beginning in January 2016; and a Collective Bargaining agreement for a three-year salary increase package totaling 12% that began in July 2016 with the third increase in July 2018.

Table 17
Fully Absorbed Cost
FY 14-15 Through FY 18-19

| | FY 14-15 | FY 15-16 | FY 16-17 | FY 17-18 | FY 18-19 | Total last 3 years | AVG Last 3 years |
|-----------------------------------|-------------|--------------|--------------|--------------|--------------|--------------------|------------------|
| Total Annual Expenditures | \$8,671,000 | \$10,134,000 | \$11,953,000 | \$12,754,000 | \$12,895,000 | \$37,602,000 | \$12,534,000 |
| Filled PYs | 51 | 52 | 56 | 61 | 60 | 177 | 59 |
| Annual Paid Hours per PY | 1776 | 1776 | 1776 | 1776 | 1776 | 5328 | 1776 |
| Annual PY Hours per Fiscal Year | 90576 | 92352 | 99456 | 108336 | 106560 | 314352 | 104784 |
| Fully Absorbed Hourly Cost Per PY | \$96 | \$110 | \$120 | \$118 | \$121 | | \$120 |
| Fully Absorbed Cost Per Minute | \$1.60 | \$1.83 | \$2.00 | \$1.96 | \$2.02 | | \$2.00 |

Source: Total Annual Expenditures from BBS Fund Condition

The hourly costs increased by 26.4% percent over this four-year period, with a slight dip in FY 17-18. The fully absorbed hourly cost results from dividing the total net expenditures by the total annual paid PY hours per fiscal year. The DCA Budget Office uses 1776 paid hours per year for budgetary forecasting and CPS HR used that for these calculations. The cost per minute is derived by dividing the hourly cost by 60. In other areas of the report, CPS HR looked at a four-year average for data forecasts. However, the cost per hour jumped over 9% in FY 16-17 and has remained relatively stable for the three-year period of FY 16-17 through FY 18-19, with a three-year average of \$120 per hour or \$2.00 a minute. CPS HR recommends using the three-year average (FY 16-17 to FY 18-19) to determine the costs per hour and minute for setting the fees at this time, since including the costs from the two earlier years would significantly understate current and future costs for the Board and would result in setting fees at levels that are too low to generate the needed revenue to support the Behavioral Science Examiners Fund and maintain a prudent reserve of 3-6 months.

Recommended Fee Rates

As previously noted, the Board of Behavioral Services has not increased fees for the LMSTs, LCSWs and LEPs for over 20 years. The LPCC program was established in FY 11-12 and fees have not been increased since then. As a result, the fee structure does not accurately reflect the time it takes staff to provide the services. In Table 15, above, the fund condition analysis shows that without fee increases, the months in reserve will drop and the fund will become insolvent in FY 20-21. Further analysis shows in Table 16 above that the Board needs to increase total revenue from all sources by approximately 65% or \$6,016,000 to develop and maintain an acceptable reserve of between three to six months over the next five fiscal years.

CPS HR developed workload time estimates for each of the 25 study fees by using licensing process times, developed by BBS and confirmed by CPS HR through interviews with the unit managers. However, this only covered Licensing Unit staff time. CPS HR spread the time spent by staff in other Units that related directly to specific fees using the percent of time identified in duty statements for the

Unit employees. Lastly, general overhead time such as management, administration and other activities that apply to all fees were spread across the fees using the four-year average volumes, except for the Examination fees. As described earlier in this report, the Board instituted an examination restructure January 1, 2016. It required all current registrants and new applicants to take the Law and Ethics exam for their specific license type in the first year of the new program. This affected exam and exam retake volumes in FY 15-16 and FY 16-17. It was not until FY 17-18 that there was a full fiscal year of data that was not skewed by: the initial volume of existing registrants having to take the new examinations; and that there was only a half year of exam data in FY 15-16 because the new examination was implemented in the middle of FY 15-16. CPS HR, in consultation with Board staff, determined that only FY 17-18 examination data reflected ongoing examination volumes. As a result, CPS HR was only able to use one year of examination data in the workload assumptions.

The proposed fees were determined by multiplying the time spent by BBS employees according to the workload assumptions by the fully absorbed cost of \$2.00 per minute. The fee specific workload assumptions are presented in Appendix A.

Table 18 compares the financial impact of the of the study fees at their current levels and the proposed fees at the four-year average volumes with the fees using the fully absorbed cost of \$120 an hour/ \$2.00 per minute. The \$120 hourly rate increases fees from the 25 study fees as a total by approximately 72%. In preparing this forecast, CPS HR left any existing fees that are higher than the newly calculated fees unchanged since they were already in place and had been charged. Also, CPS HR found that the difference in cost between initial and retake exams was relatively minor. Therefore, CPS HR proposes that the Law and Ethics Exam and Exam Retake fees be set at the same rate, based on a weighted average of the two fee costs and that the LMFT Clinical and LEP Written tests be set in the same manner.

The resulting proposed fee increases range from \$0 to \$315. After calculating the estimated additional revenue generated by the projected fees, there is an excess of approximately \$280,000

Table 18

**Projected Fees and Additional Revenue Generated using
the \$120 an hour Fully Absorbed Cost Rate**

| Fee Type | 4 YR AVG Volume | Current Fee | Estimated Current Revenue* | Cost based Fee | Projected Revenue | Additional Revenue Generated |
|--|--------------------|-------------|----------------------------------|-------------------|----------------------|------------------------------------|
| Associate Registration | 8464 | | | | | |
| LMFT & LCSW | 7513 | \$75 | \$563,475 | \$280 | \$2,103,640 | \$1,540,165 |
| LPCC | 951 | \$100 | \$95,100 | \$280 | \$266,280 | \$171,180 |
| Associate Renewal | 23310 | | | | | |
| LMFT & LCSW | 22241 | \$75 | \$1,668,075 | \$160 | \$3,558,560 | \$1,890,485 |
| LPCC | 1069 | \$100 | \$106,900 | \$160 | \$171,040 | \$64,140 |
| Application for Licensure | 5103 | | | | | |
| LMFT & LCSW | 4759 | \$100 | \$475,900 | \$275 | \$1,308,725 | \$832,825 |
| LPCC | 227 | \$180 | \$40,860 | \$275 | \$62,425 | \$21,565 |
| LEP | 117 | \$100 | \$11,700 | \$275 | \$32,175 | \$20,475 |
| Law and Ethics Exam/Re-exam | 12046 | \$100 | \$1,204,600 | \$170 | \$2,047,820 | \$843,220 |
| Clinical Exam/Rexam* | 7756 | | | | | |
| LMFT | 4549 | \$100 | \$454,900 | \$215 | \$978,035 | \$523,135 |
| LCSW | 2988 | * | \$0 | \$0 | \$0 | \$0 |
| LPCC | 219 | * | \$0 | \$0 | \$0 | \$0 |
| Issuance of Initial License | 3809 | | | | | |
| LMFT | 2097 | \$130 | \$272,610 | \$130 | \$272,610 | \$0 |
| LCSW | 1496 | \$100 | \$149,600 | \$120 | \$179,520 | \$29,920 |
| LPCC | 155 | \$200 | \$31,000 | \$200 | \$31,000 | \$0 |
| LEP | 61 | \$80 | \$4,880 | \$120 | \$7,320 | \$2,440 |
| License Renewal | 25862 | | | | | |
| LMFT** | 15348 | \$130 | \$1,995,240 | \$130 | \$1,995,240 | \$0 |
| LCSW** | 9326 | \$100 | \$932,600 | \$130 | \$1,212,380 | \$279,780 |
| LPCC** | 567 | \$175 | \$99,225 | \$175 | \$99,225 | \$0 |
| LEP | 621 | \$80 | \$49,680 | \$130 | \$80,730 | \$31,050 |
| LEP Written Exam/ Re-Exam | 151 | \$100 | \$15,100 | \$415 | \$62,665 | \$47,565 |
| | | | | | | |
| | | | | | | |
| Total Estimated Revenues based on Fee times four year volumes | | | \$8,171,445 | | \$14,469,390 | \$6,297,945 |
| | | | | | | |
| Additional Revenue Needed | | | | | | \$6,016,000 |
| Difference | | | | | | -\$281,945 |
| * The Estimated Current Revenue was determined by multiplying the current fee by the Four year average volume | | | | | | |
| **This fee represents the renewal fee only and does not contain the additional \$20 that is collected by the Board for | | | | | | |

As mentioned above, in considering fee increases, the Board must also be sensitive to and consider the impact of the proposed fee increases on: applicants, registrants and licensees, while maintaining an adequate fund reserve. How much the Board actually increases specific fees is a judgment call that

should be based on consultation with the DCA budget office and its applicant, registrant, licensee customer base.

One factor for the Board to consider in setting fees is that over time some fees have been set at different levels between the various practices, when the cost to the Board is the same. For example, the License Renewal fee is currently different for each of the 4 practices. CPS HR recommends that the Board consider increasing the License Renewal fee to \$120 for the LCSW and LEP licenses and lowering the LMFT and LPCC renewal fees to \$120. This will acknowledge the recent move to an almost fully automated renewal process, eliminate the disparity for the LMFT and LPCC Licensees who are currently paying \$130 and \$175 for their renewals and reduce the excess revenue generated. This approach would also allow the Board to consider setting the Issuance of the Initial License fee to \$130 for all the licensees and reduce the LPCC License fee from the current \$200, making it the same as that proposed for the LMFT, LCSW and LEP licensees.

Another consideration for the Board is that because of the very small volumes for the LEP written exam/retake, the exam development costs per exam/retake are disproportionately high and the resultant proposed fee of \$415 may represent a hardship to LEP applicants. It is high, in comparison to other exam/re-exam fees. The Board may wish to consider setting the fee for the LEP written exam/re-exam fee more in line with the proposed LMFT Clinical Exam fee of \$215, since the processes are similar.

RECOMMENDATIONS

- After consultation with the DCA Budget Office and its registrant and licensee client populations, the Board should charge for select scheduled and unscheduled services based on a fully absorbed cost rate of \$120 per hour. Services should be charged and fees set, to the extent possible, based on the actual time the Board uses to provide the service.
- BBS management should develop, approve and implement or introduce legislation to revise the fee schedule as soon as possible, and inform current and prospective licensees of the changes.
- In lieu of a lengthy legislative process to change future license fees, CPS HR recommends that the Board, in obtaining legislative approval for fee increases also set a statutory maximum higher than the fees currently needed to restore the fund to a satisfactory reserve. By enabling this administrative strategy now, the Board would have flexibility in setting fees in the future to ensure adequate fund reserves as revenues decline or expenses increase.

Appendix A: Workload Assumptions

INITIAL LICENSE APPLICATION

| 1021 Initial License Application | | | | | | |
|---|--|---|--|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 14-15 to FY 17-18 average annual application volume | Total Processing Minutes | Total Estimated Cost | License Cost |
| | | | 8464 | | | |
| Clean | | 90% | 7618 | | | |
| App opened, sorted, cashiered, deficiency determination | 18 | | | | | |
| App Processed | 35 | | | | | |
| Total Clean App | 53 | | | 403733 | | |
| Deficient | | 10% | 846 | | | |
| App opened, sorted | 3 | | | | | |
| Clear App | 30 | | | | | |
| Total Returned Deficiency Time | 33 | | | | | |
| Total Deficient App | 86 | | | 72790 | | |
| Fingerprint Review (Licensing Unit) and referral to Enforcement | 5 | 10% | 846 | 4230 | | |
| Total Clean and Deficient App and Fingerprint Review | | | | 480753 | | |
| Other Direct costs | | | | | | |
| Criminal Conviction Unit | | | | | | |
| Fingerprint Review/ investigation | | | | 292507 | | |
| IMFT Inquiries | | | | 14386 | | |
| School Liaison | | | | 12947 | | |
| Total Other Direct Costs | | | | 319840 | | |
| Overhead | | | | | | |
| Enforcement Costs | | | | 72743 | | |
| Admin and Mgt | | | | 159920 | | |
| licensing | | | | 143595 | | |
| T&D/Stats | | | | 13701 | | |
| Total overhead | | | | 389959 | | |
| Total Costs | | | | 1190552 | \$2,381,104 | \$281 |

LAW & ETHICS EXAM APPLICATION

| 1010 Law and Ethics Exam Application | | | | | | |
|--|--|---|-------------------------------|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Cleared vs. Deficient Application | FY 17-18 annual Exam volume * | Total Processing Minutes | Total Estimated Cost | License Cost |
| Total Application Volume** | | | 8177 | | | |
| Clean | | 70% | | 5724 | | |
| App opened, sorted, cashiered, deficient determination | 18 | | | | | |
| Total | 18 | | | 103030 | | |
| Deficient | | 30% | | 2453 | | |
| App Returned and opened, sorted, and cleared | 8 | | | | | |
| Total | 26 | | | 63781 | | |
| Total Application Time | | | | 180512 | | |
| Direct Costs | | | | | | |
| Exam Unit | | | | | | |
| Exam Development L & E Exam (3) | | | | 31698 | | |
| Exam Complaints | | | | 13111 | | |
| Accommodation Evaluations | | | | 61183 | | |
| Exam Administration | | | | 26221 | | |
| Exam Evaluator | | | | 52442 | | |
| Exam Inquiries | | | | 34962 | | |
| Total Exam Unit | | | | 219617 | | |
| Overhead | | | | | | |
| licensing Cost | | | | 13701 | | |
| Admin Mgt | | | | 155014 | | |
| Total Overhead | | | | 168715 | | |
| Total Minutes Exams | | | | 568844 | \$1,137,688 | \$139 |
| Cost for PSI | | | | | | \$26 |
| Total Cost | | | | | | \$165 |

*FY 17-18 only full year under new Exam process

**Used L & E First Time Taker from the Exam Results Report for FY 17-18

LAW & ETHICS EXAM RE/EXAM APPLICATION

| 1015 L & E Exam Retake | | | | | | |
|--|--|---|------------------------------|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 17-18 annual Exam volume* | Total Processing Minutes | Total Estimated Cost | License Cost |
| Total Application Volume** | | | 3869 | | | |
| Clean Application Processing | | | | | | |
| App opened, sorted, cashiered, deficiency determination | 18 | | | | | |
| Verify appropriate coursework taken before retake | 5 | | | | | |
| Total Clean Application Processing Subtotal | 23 | 90% | 3482 | 80088 | | |
| Deficient Application | | | | | | |
| When returned App opened, sorted, cleared | 8 | | | | | |
| verify appropriate coursework taken before retake. | 5 | | | | | |
| Total Deficient Application Processing Subtotal | 36 | 10% | 387 | 13928 | | |
| Direct Costs | | | | | | |
| Exam Development L & E Exam | | | | 31698 | | |
| Exam complaints | | | | 6198 | | |
| Accommodations Eval | | | | 28924 | | |
| Exam Admin | | | | 12396 | | |
| Exam Evaluator | | | | 24792 | | |
| Exam Inquiries | | | | 16528 | | |
| Total Exam Unit Direct Costs | | | | 120536 | | |
| Overhead | | | | | | |
| Admin/Mgt | | | | 73284 | | |
| Total Overhead | | | | 73284 | | |
| Total Application Processing, Exam Unit Direct Costs and Overhead | | | | 287837 | \$575,673 | \$149 |
| Cost for PSI per exam | | | | | | \$26 |
| Total | | | | | | \$175 |
| *FY 17-18 only full year under new Exam process | | | | | | |
| **Used L & E Total Taking Exam less First Time Taker from Exam Results Report for FY 17-18 | | | | | | |

AVERAGE: LAW AND ETHICS EXAM AND RE/EXAM

| Law & Ethics Exam/Retake Avg | | | | | | |
|---|--|--|---------------|------------------|--|--|
| Weighted Average Initial and Retake Costs | | | Volumes | Cost | | |
| Total Exams Taken | | | 12,046 | | | |
| Initial Exam | | | | \$1,137,688 | | |
| Retake Exam | | | | \$575,673 | | |
| Total Cost all Exams | | | | 1,713,361 | | |
| Average Cost Initial and Retake | | | | \$147 | | |
| Cost to PSI per Exam | | | | \$26 | | |
| Total Average Cost per Exam | | | | \$168 | | |

LICENSURE APPLICATION

| 1011 Licensure Application | | | | | | |
|--|---|--|--|---------------------------------|-----------------------------|---------------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | to FY 17-18 average annual applicatio | Total Processing Minutes | Total Estimated Cost | License Cost |
| Total License Apps | | | 5103 | | | |
| Clean Application | | 50% | 2552 | | | |
| App opened, sorted, cashiered, deficiency | 18 | | | | | |
| App processed | 50 | | | | | |
| Total Clean Application | 68 | | | 173502 | | |
| Deficient Application | | 50% | 2552 | | | |
| App opened, sorted, cashiered | 18 | | | | | |
| App processed Deficient | 75 | | | | | |
| Total initial review Deficient | 93 | | | 237290 | | |
| Deficient Application Returned | | | | | | |
| App opened, sorted | 8 | | | | | |
| Processed App/Clear Deficiency | 30 | | | | | |
| Total Deficiency Returned | 38 | | | 96957 | | |
| Total Deficient Application | 131 | | | 334247 | | |
| Overhead | | | | | | |
| T & D /Stats | | | | 13071 | | |
| Outreach and Licensing Inquiries | | | | 86574 | | |
| Admin & Mgt | | | | 96417 | | |
| Overhead Cost Subtotal | | | | 196062 | | |
| Total Application and Overhead Cost | | | | 703811 | \$1,407,621 | \$276 |

CLINICAL EXAM APPLICATION

| Clinical Exam Application | | | | | | |
|--|-------------------------------------|---|--------------------------------------|---------------------------------|-----------------------------|---------------------|
| Cost Category | Total Processing Minutes per | Percent Clean vs. Deficient Applicatio | FY 17-18 annual Exam volume * | Total Processing Minutes | Total Estimated Cost | License Cost |
| Clinical Exam Volume** | | | 3360 | | | |
| Direct Costs | | | | | | |
| Exam Development | | | | 10656 | | |
| Exam Administration Clinical | | | | 63936 | | |
| Exam Complaints | | | | 9899 | | |
| Accommodation Eval | | | | 46194 | | |
| Exam Administration | | | | 19797 | | |
| Exam Evaluator | | | | 39615 | | |
| Exam Inquires | | | | 26397 | | |
| Total Direct Costs | | | | 216494 | | |
| Overhead | | | | | | |
| Licensing | | | | 13701 | | |
| Admin and Magt | | | | 70145 | | |
| Tota Overhead | | | | 83846 | | |
| Total Overhead and Direct Costs | | | | 300340 | \$600,680 | \$179 |
| PSI Cost per Exam | | | | | | \$46 |
| Total Exam Costs | | | | | | \$224 |
| *FY 17-18 only full year under new Exam process | | | | | | |
| **Used Clinical First Time Taker from the Exam Results Report for FY 17-18 | | | | | | |

CLINICAL EXAM-RE/EXAM APPLICATION

| 1015 Clinical ReExam | | | | | | |
|--|---|--|--------------------------------------|---------------------------------|-----------------------------|----------------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 17-18 annual Exam volume * | Total Processing Minutes | Total Estimated Cost | Cost per Exam |
| ReExam Application Volume** | | | 1189 | | | |
| App opened, sorted,cashiered | 18 | 100% | | 21402 | | |
| Total Application Processing | | | | 21402 | | |
| Direct Costs | | | | | | |
| Exam Development Clinical | | | | 10656 | | |
| Exam Complaint | | | | 2537 | | |
| Accommodation Evaluation | | | | 11839 | | |
| Exam Administration | | | | 5074 | | |
| Exam Evaluation | | | | 10147 | | |
| Exam Inquiries | | | | 6765 | | |
| Direct Cost Subtotal | | | | 47018 | | |
| Overhead | | | | | | |
| Admin/Mgt | | | | 17997 | | |
| Overhead Subtotal | | | | 17997 | | |
| Total Application, and Direct Costs Minutes | | | | 86417 | \$172,834 | \$145 |
| PSI Cost per Exam | | | | | | \$46 |
| Total Cost for Exam | | | | | | \$191 |
| *FY 17-18 only full year under new Exam process | | | | | | |
| **Used Total Taking Exam less First Time Taker from Exam Results Report for FY 17-18 | | | | | | |

AVERAGE: CLINICAL EXAM AND RE/EXAM

| Clinical Exam/ReExam Avg | Volumes | Cost |
|--|----------------|------------------|
| Total Volumes | 4549 | |
| Initial Exams | | \$600,680 |
| Retake Exam | | \$172,834 |
| Total Cost all Exams | | \$773,514 |
| Average Cost Initial and Retake | | \$170 |
| Cost to PSI per Exam | | \$46 |
| Total Average Cost per Exam | | \$216 |

LEP WRITTEN EXAM APPLICATION

| LEP Written - Exam App | | | | | | |
|---|--|---|-------------------------------|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 17-18 annual Exam volume * | Total Processing Minutes | Total Estimated Cost | License Cost |
| LEP Written Exam** | | | 101 | | | |
| Direct Costs | | | | | | |
| Exam Dev | | | | 10656 | | |
| Exam Complaints | | | | 171 | | |
| Accommodation Eval | | | | 864 | | |
| Exam Admin | | | | 370 | | |
| Exam Evaluator | | | | 741 | | |
| Exam Inquiries | | | | 494 | | |
| Total Direct Costs | | | | 13296 | | |
| Overhead | | | | | | |
| Admin and Mgt | | | | 2419 | | |
| Overhead and Direct Cost Subtotal | | | | 15715 | \$31,430 | \$311 |
| PSI Cost per Exam | | | | | | \$34 |
| Total Costs | | | | | | \$345 |
| *FY 17-18 only full year under new Exam process | | | | | | |
| *FY 17-18 only full year under new Exam process | | | | | | |

LEP WRITTEN EXAM RE/EXAM APPLICATION

| LEP Written ReExam | | | | | | |
|---|--|---|-------------------------------|--------------------------|----------------------|---------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 17-18 annual Exam volume * | Total Processing Minutes | Total Estimated Cost | Cost per Exam |
| LEP Written Exam ReExam** | | | 50 | | | |
| Direct Costs | | | | | | |
| Exam Dev | | | | 10656 | | |
| Exam Complaint | | | | 85 | | |
| Accommodation Eval | | | | 395 | | |
| Exam Admin | | | | 169 | | |
| Exam Eval | | | | 339 | | |
| Exam Inquiries | | | | 226 | | |
| Total Direct Costs | | | | 11870 | | |
| Overhead | | | | | | |
| Admin and Mgt | | | | 1197 | | |
| Total Overhead | | | | 1197 | | |
| Total Direct and Overhead Costs | | | | 13067 | \$26,134 | \$523 |
| PSI Cost | | | | | | \$34 |
| Total Rexam Costs with PSI | | | | | | \$557 |
| *FY 17-18 only full year under new Exam process | | | | | | |
| **Used LEP Standard Written Exam First Time Taker from the Exam Results Report for FY 17-18 | | | | | | |

AVERAGE: LEP STANDARD WRITTEN EXAM AND RE/EXAM

| LEP Written Exam Avg | Volumes | Cost | Avg Cost per Exam |
|----------------------------------|---------|-----------------|-------------------|
| LEP Written Initial | 151 | \$31,430 | |
| ReExam | | \$26,134 | |
| Total | | \$57,564 | \$381 |
| PSI Cost | | | \$34 |
| Total Costs Including PSI | | | \$415 |

ISSUANCE OF INITIAL LICENSE APPLICATION

| 1020.3020 Initial License Application | | | | | | |
|---------------------------------------|--|---|--|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 14-15 to FY 17-18 Average Annual Application Volume | Total Processing Minutes | Total Estimated Cost | License Cost |
| Total Applications | | | 3809 | | | |
| App opened, sorted,cashiered, | 18 | | | | | |
| App processed | 15 | | | | | |
| Total Clean app | 33 | 100% | 3809 | 125697 | | |
| Final review before licensure | 5 | 100% | | 19045 | | |
| Total Application Processing | | | | 144742 | | |
| Overhead | | | | | | |
| T & D/Stats | | | | 13701 | | |
| Admin/Mgt | | | | 71968 | | |
| Total Overhead | | | | 85669 | | |
| Total Costs | | | | 230411 | \$460,822 | \$121 |

ASSOCIATE RENEWAL APPLICATION

| 2021 Associate Renewal | | | | | | |
|--|--|---|---|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 14-15 to FY 17-18 Average Annual Application | Total Processing Minutes | Total Estimated Cost | License Cost |
| Application Volumes | | | 23310 | | | |
| Clean | | 80% | 18648 | | | |
| App opened, sorted, cashiered, deficiency determined | 18 | | | 335664 | | |
| Deficient | | | | | | |
| Initial Processing | 18 | | | | | |
| App opened, sorted, cleared after return | 8 | | | | | |
| Total Deficient processing | 26 | 20% | 121212 | 630302 | | |
| Total Clean and Deficient Processing | | | | 965966 | | |
| Direct Costs | | | | | | |
| Enforcement | | | | 143094 | | |
| Total Direct Costs | | | | 143094 | | |
| Total Application Processing and Other Direct Costs | | | | 1109060 | | |
| Overhead | | | | | | |
| T & D and Stats | | | | 13071 | | |
| Enforcement | | | | 312599 | | |
| Admin/MGT | | | | 440423 | | |
| Total Overhead | | | | 766093 | | |
| Total Costs | | | | 1875153 | \$3,750,307 | \$161 |

LICENSE RENEWAL APPLICATION

| 2020 License renewal | | | | | | |
|--|--|---|--|--------------------------|----------------------|--------------|
| Cost Category | Total Processing Minutes per Application | Percent Clean vs. Deficient Application | FY 14-15 to FY 17-18 Average Annual Application Volume | Total Processing Minutes | Total Estimated Cost | License Cost |
| Application Volumes | | | 25862 | | | |
| Clean | | | | | | |
| Online-no processing time | 0 | 95% | 0 | | | |
| Deficient | | | | | | |
| App opened, sorted, cashiered, deficiency cleared | 18 | 5% | 1293 | 23276 | | |
| Clean and Deficient Application Subtotal | | | | 23276 | | |
| Direct Cost - | | | | | | |
| CE Audits (40%) of one PY | | | | 42624 | | |
| CriminalConviction Unit | | | | 175824 | | |
| Discipline and Probation Unit | | | | 274089 | | |
| Total Direct Costs | | | | 492537 | | |
| Total Application Processing and Other Direct Costs | | | | 515813 | | |
| Overhead | | | | | | |
| Enforcement | | | | 597674 | | |
| Licensing | | | | 13701 | | |
| Admin/Mgt | | | | 488641 | | |
| Total Overhead | | | | 1100016 | | |
| Total Costs | | | | 1639105 | \$3,278,209 | \$127 |



Board of Behavioral Sciences

Memo

1625 North Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830, (916) 574-8625 Fax
www.bbs.ca.gov

To: Board Members
From: Steve Sodergren
Assistant Executive Officer
Date: May 2, 2019
Telephone: (916) 574-7847
Subject: Exam Vendor Update

On February 28th, 2019 Board staff submitted a contract for computer-based testing services to the Department of Consumer Affairs (DCA's) Contract Unit for review. This three-year contract with Pearson Vue will be for administering the California Law and Ethics examinations and the Licensed Marriage and Family Therapist (LMFT) Clinical examination for the Board. Staff is working closely with the Contract Unit staff to reach a July 1, 2019 contract initiation date.

Concurrently, Board staff has been conducting preliminary meetings with Pearson VUE and DCA's Office of Information Services (OIS) and Office of Professional Examination Services (OPES). These meetings are being held to ensure the coordination of a smooth transition from the current vendor to Pearson VUE. The transition start date is contingent upon the initiation of the contract, but the Board is planning for this transition to occur in late summer or early fall.

Upon final approval of the contract, the Board will begin notifying candidates of the details of the transition through the website, social media and email. There will be no delays in the scores for candidates during or after the transition.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 613 **VERSION:** INTRODUCED FEBRUARY 14, 2019

AUTHOR: LOW **SPONSOR:** AUTHOR

RECOMMENDED POSITION: SUPPORT

SUBJECT: PROFESSIONS AND VOCATIONS: REGULATORY FEES

Overview: This bill would allow the Board to increase any of its authorized fees once every four years by an amount up to the Consumer Price Index (CPI) for the preceding four years.

Existing Law:

- 1) Places certain licensing boards and bureaus under the Department of Consumer Affairs (DCA), including the Board of Behavioral Sciences (Board). (Business and Professions Code (BPC) §101)
- 2) Specifies that the “percentage change in the cost of living” means the percentage change from April 1 of the prior year to April 1 of the current year in the California Consumer Price Index for all items, as determined by the California Department of Industrial Relations. (Revenue and Taxation Code (RTC) §2212)
- 3) Sets maximum fees in statute that the Board may charge to cover regulatory costs for activities relating to licensure, including license and registration application, renewal, initial license issuance, examinations, examination rescoring, replacement, letters of good standing, and license retirement. (BPC §§4984.7, 4989.68, 4996.3, and 4999.120)
- 4) Sets fees in regulations that the Board currently charges (which may equal to or less than the statutory maximums) to cover regulatory costs for activities relating to licensure. (California Code of Regulations (CCR) Title 16, §§1816-1816.7)

This Bill:

- 1) Permits specified licensing boards and bureaus under DCA, including the Board of Behavioral Sciences, to increase any of its authorized fees once every four years by an amount up to the Consumer Price Index (CPI) for the preceding four years. (BPC §101.1(a))

- 2) Requires a board seeking to increase its fees by the CPI as specified above to provide its calculations and proposed fees to the director. The director must approve the fee increase except in the following circumstances (BPC §101.1(a)(1)):
 - a) The Board has unencumbered funds that are equal to more than the board's operating budget for the next two fiscal years; or
 - b) The fee would exceed the reasonable cost to the board to administer the provisions the fee is paying for; or
 - c) The director determines the fee increase would injure public health, safety, or welfare.
- 3) States that this adjustment of fees and their publication is not subject to the Administrative Procedure Act (meaning it is not subject to the regulation process, which would typically be used to increase fees). (BPC §101.1(a)(2))
- 4) Provides that the CPI adjustment is allowable for fees the Board is authorized to impose to cover regulatory costs. The CPI adjustment is not allowed for administrative fines, civil penalties, or criminal penalties. (BPC §101.1(b))

Comments:

- 1) **Author's Intent.** According to the author's office, the intent of this bill is to allow boards to raise their fees once every four years by the CPI without going through the rulemaking or legislative process. They note that because the legislative and rulemaking processes are cumbersome, boards tend to delay raising fees until absolutely necessary to support ongoing operations, and the resulting fee increase is then significant and controversial. They believe allowing a fee increase adjustment by the CPI will allow fees to adjust more modestly over time.
- 2) **Current Process to Increase Fees.** Currently, to raise a fee, the Board must go through the legislative and/or regulatory process, depending on whether the fee is being charged at its statutory maximum or not. Both processes take approximately 1 to 2 years and can involve a significant amount of staff time.
- 3) **Consumer Price Index.** The California Consumer Price Index is calculated by the California Department of Industrial Relations. That department defines the CPI as follows:

"The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a fixed market basket of goods and services. The CPI provides a way to compare what this market basket of goods and services costs this month with what the same market basket cost, say, a month or year ago."

The Department of Industrial Relations provides a calculator for the California CPI on its website. Staff used this online calculator to find the percent change in the CPI

for the previous two four-year periods (**Attachment A**). If this bill had been effect, the maximum allowable fee increases using this method would have been as follows:

- April 2010 – April 2014: 8.3%
- April 2014 – April 2018: 10.3%

The Board's fees vary depending on license type and the service being provided. For example, renewal fees currently range from \$75 - \$175 per year. Initial license fees range from \$80 - \$200. Fees for the California law and ethics exam are \$100, and fees for a replacement license or registration are \$20.

4) Current Board Fee Audit. The Board has not raised its fees since the 1990s (with the exception of establishing the LPCC licensing program and its corresponding fees, which was done in Fiscal Year 2011-2012). The Board is in the process of conducting a fee audit and expects to pursue legislation and regulations to raise fees within the next year. It is unlikely that this bill would allow the Board to avoid pursuing a fee increase via legislation or regulations this time but having a CPI adjustment option in the future may allow the Board to better keep pace with rising costs.

5) Recommended Position. At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended that the Board consider taking a "support" position on this bill.

6) Support and Opposition.

Support

- California Board of Accountancy
- California Pharmacists Association

Oppose

- California Orthopedic Association

7) History.

2019

04/25/19 In Senate. Read first time. To Com. on RLS. for assignment.

04/25/19 Read third time. Passed. Ordered to the Senate.

04/11/19 Read second time. Ordered to third reading.

04/10/19 From committee: Do pass. (Ayes 12. Noes 5.) (April 10).

04/02/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 6.) (April 2). Re-referred to Com. on APPR.

02/25/19 Referred to Com. on B. & P.

02/15/19 From printer. May be heard in committee March 17.

02/14/19 Read first time. To print.

8) Attachments:

Attachment A: California CPI (All Urban Consumers): April 2010-April 2014, and April 2014-April 2018

Attachment A

STATE OF CALIFORNIA

OFFICE OF THE DIRECTOR - RESEARCH UNIT CONSUMER PRICE INDEX CALCULATOR

| | | | |
|---------------------------|---------------------|---|----------------------------------|
| 1) Select an Index | California CPI | ▼ | |
| 2) Select index type | All Urban Consumers | ▼ | |
| 3) Select beginning month | April | ▼ | Beginning Index value |
| 4) Select beginning year | 2010 | ▼ | 227.007 |
| 5) Select ending month | April | ▼ | Ending Index Value |
| 6) Select ending year | 2014 | ▼ | 245.9 |

Based upon the Index, index type, and the time period you have specified, the percent change in the Consumer Price Index is equal to:

8.3%

STATE OF CALIFORNIA

OFFICE OF THE DIRECTOR - RESEARCH UNIT CONSUMER PRICE INDEX CALCULATOR

| | | | |
|---------------------------|---------------------|---|----------------------------------|
| 1) Select an Index | California CPI | ▼ | |
| 2) Select index type | All Urban Consumers | ▼ | |
| 3) Select beginning month | April | ▼ | Beginning Index value |
| 4) Select beginning year | 2014 | ▼ | 245.9 |
| 5) Select ending month | April | ▼ | Ending Index Value |
| 6) Select ending year | 2018 | ▼ | 271.21 |

Based upon the Index, index type, and the time period you have specified, the percent change in the Consumer Price Index is equal to:

10.3%

Introduced by Assembly Member Low

February 14, 2019

An act to add Section 101.1 to the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

legislative counsel's digest

AB 613, as introduced, Low. Professions and vocations: regulatory fees.

Existing law establishes the Department of Consumer Affairs, which is comprised of boards that are established for the purpose of regulating various professions and vocations, and generally authorizes a board to charge fees for the reasonable regulatory cost of administering the regulatory program for the profession or vocation. Existing law establishes the Professions and Vocations Fund in the State Treasury, which consists of specified special funds and accounts, some of which are continuously appropriated.

This bill would authorize each board within the department to increase every 4 years any fee authorized to be imposed by that board by an amount not to exceed the increase in the California Consumer Price Index for the preceding 4 years, subject to specified conditions. The bill would require the Director of Consumer Affairs to approve any fee increase proposed by a board except under specified circumstances. By authorizing an increase in the amount of fees deposited into a continuously appropriated fund, this bill would make an appropriation.

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

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

1 SECTION 1. Section 101.1 is added to the Business and
2 Professions Code, to read:

3 101.1. (a) Notwithstanding any other law, no more than once
4 every four years, any board listed in Section 101 may increase any
5 fee authorized to be imposed by that board by an amount not to
6 exceed the increase in the California Consumer Price Index, as
7 determined pursuant to Section 2212 of the Revenue and Taxation
8 Code, for the preceding four years in accordance with the
9 following:

10 (1) The board shall provide its calculations and proposed fee,
11 rounded to the nearest whole dollar, to the director and the director
12 shall approve the fee increase unless any of the following apply:

13 (A) The board has unencumbered funds in an amount that is
14 equal to more than the board’s operating budget for the next two
15 fiscal years.

16 (B) The fee would exceed the reasonable regulatory costs to the
17 board in administering the provisions for which the fee is
18 authorized.

19 (C) The director determines that the fee increase would be
20 injurious to the public health, safety, or welfare.

21 (2) The adjustment of fees and publication of the adjusted fee
22 list is not subject to the Administrative Procedure Act (Chapter
23 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
24 Title 2) of the Government Code.

25 (b) For purposes of this section, “fee” includes any fees
26 authorized to be imposed by a board for regulatory costs. “Fee”
27 does not include administrative fines, civil penalties, or criminal
28 penalties.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 769 **VERSION: INTRODUCED FEBRUARY 19, 2019**

AUTHOR: SMITH **SPONSOR: CALIFORNIA ASSOCIATION FOR
LICENSED PROFESSIONAL CLINICAL
COUNSELORS (CALPCC)**

RECOMMENDED POSITION: SUPPORT

**SUBJECT: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS:
LICENSED PROFESSIONAL CLINICAL COUNSELOR**

Summary:

This bill would allow Medi-Cal reimbursement for covered mental health services provided by a licensed professional clinical counselor employed by a federally qualified health center or a rural health clinic.

Existing Law:

- 1) Establishes that federally qualified health center (FQHCs) services and rural health clinic (RHC) services are covered Medi-Cal benefits that are reimbursed on a per-visit basis. (Welfare and Institutions Code (WIC) §14132.100(c))
- 2) Allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of service that it provides. (WIC §14132.100(e))
- 3) Defines a FQHC or RHC “visit” as a face-to-face encounter between an FQHC or RHC patient and one of the following (WIC §14132.100(g)):
 - A physician;
 - A physician assistant;
 - A nurse practitioner;
 - A certified nurse-midwife;
 - A clinical psychologist;
 - A licensed clinical social worker;
 - A visiting nurse;
 - A dental hygienist; or
 - A marriage and family therapist.

This Bill:

- 1) Adds a licensed professional clinical counselor to the list of health care professionals included in the definition of a visit to a FQHC or RHC that is eligible for Medi-Cal reimbursement. (WIC §14132.100(g)(2)(A))
- 2) Describes technical procedures for how an FQHC or RHC that employs licensed professional clinical counselors can apply for a rate adjustment and bill for services. (WIC §14132.100(g)(2)(B) and (C))

Comments:

- 1) **Background.** Currently, there are approximately 600 FQHCs and 350 RHCs in California. These clinics serve the uninsured and underinsured and are reimbursed by Medi-Cal on a “per visit” basis. Currently, psychologists, marriage and family therapists (LMFTs), and clinical social workers (LCSWs) are authorized for Medi-Cal reimbursement in these settings. However, LPCCs are not, creating a disincentive for these clinics to hire them.
- 2) **Intent.** The intent of this legislation is to allow FQHCs and RHCs to be able to hire a licensed professional clinical counselor and be reimbursed through Medi-Cal for covered mental health services. Under current law, only clinical psychologists, licensed clinical social workers, or marriage and family therapists may receive Medi-Cal reimbursement for covered services in such settings. The sponsor states that adding LPCCs to the list of Medi-Cal reimbursable provider types in these clinics will help rural areas meet the increase in demand for mental health services.

Marriage and family therapists are the most recent addition to the list of mental health providers whose services may be reimbursed in FQHCs and RHCs. AB 1863 (Chapter 610, Statutes of 2016) was signed into law in 2016. At that time, the bill’s author and sponsors similarly noted that the inability of marriage and family therapists to receive Medi-Cal reimbursement served as a disincentive for a FQHC or an RHC to consider hiring them, and that allowing services provided by LMFTs to be reimbursed would increase the availability of mental health services in rural areas.

3) Previous Related Legislation.

Previous Legislation Related to LMFTs

- AB 1785 (B. Lowenthal, 2012) proposed adding marriage and family therapists to the list of health care professionals that are able to provide Medi-Cal reimbursable services for an FQHC or RHC visit. The Board took a “support” position on AB 1785. However, the bill died in the Assembly Appropriations Committee.
- The bill was run again as AB 690 (Wood) in 2015. The Board took a “support” position on the bill; however, it died when it was held in committee. Its provisions

were amended into AB 858 (Wood), also in 2015. AB 858 was part of a series of six Medi-Cal related bills that were all vetoed by the Governor. In a combined veto message for all six bills, the Governor stated that the bills would require expansion or development of new benefits and procedures in the Medi-Cal program, and that he could not support any of them until the fiscal outlook for Medi-Cal stabilized.

- As mentioned above, the bill was again run in 2016 as AB 1863 (Wood). The Board took a “support” position on the bill. AB 1863 was signed into law; however, LPCCs were not included on the list of reimbursable providers.

Previous Legislation Related to LPCCs

- AB 1591 (Berman, 2017) was identical to the bill being considered today. The Board took a “support” position, however, the bill was vetoed by the Governor. In his veto message, he stated the following: *“The Department of Health Care Services is developing a new payment model for these health clinics that will eliminate the need to add specific providers to an approved list. Consequently, this bill is unnecessary.”*

The sponsor notes that the new payment model the Governor referred to was not approved, and in 2018, that project was terminated.

4) Recommended Position. At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended the Board consider taking a “support” position on this bill.

5) Support and Opposition.

Support

- California Association for Licensed Professional Clinical Counselors (CALPCC) (Sponsor)
- Association of California Healthcare Districts
- California Health+Advocates
- County Health Executives Association of California

Oppose

- None at this time.

6) History

2019

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|----------|---|
| 04/24/19 | In committee: Set, first hearing. Referred to APPR. suspense file. |
| 04/10/19 | From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (April 9). Re-referred to Com. on APPR. |
| 02/28/19 | Referred to Com. on HEALTH. |
| 02/20/19 | From printer. May be heard in committee March 22. |
| 02/19/19 | Read first time. To print. |

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**Introduced by Assembly Member Smith
(Coauthor: Assembly Member Berman)**

February 19, 2019

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

legislative counsel's digest

AB 769, as introduced, Smith. Federally qualified health centers and rural health clinics: licensed professional clinical counselor.

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 healthcare services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals. Existing law allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of service it provides.

This bill would additionally include a licensed professional clinical counselor within those health care professionals covered under that definition. The bill would require an FQHC or RHC that currently includes the cost of the services of a licensed professional clinical counselor for the purposes of establishing its FQHC or RHC rate to

apply to the department for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, would require the FQHC or RHC to bill for these services as a separate visit, as specified. The bill would require an FQHC or RHC that does not provide the services of a licensed professional clinical counselor, and later elects to add this service and bill these services as a separate visit, to process the addition of these services as a change in scope of service.

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

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

1 SECTION 1. Section 14132.100 of the Welfare and Institutions
2 Code is amended to read:
3 14132.100. (a) The federally qualified health center services
4 described in Section 1396d(a)(2)(C) of Title 42 of the United States
5 Code are covered benefits.
6 (b) The rural health clinic services described in Section
7 1396d(a)(2)(B) of Title 42 of the United States Code are covered
8 benefits.
9 (c) Federally qualified health center services and rural health
10 clinic services shall be reimbursed on a per-visit basis in
11 accordance with the definition of “visit” set forth in subdivision
12 (g).
13 (d) Effective October 1, 2004, and on each October 1 thereafter,
14 until no longer required by federal law, federally qualified health
15 center (FQHC) and rural health clinic (RHC) per-visit rates shall
16 be increased by the Medicare Economic Index applicable to
17 primary care services in the manner provided for in Section
18 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to
19 January 1, 2004, FQHC and RHC per-visit rates shall be adjusted
20 by the Medicare Economic Index in accordance with the
21 methodology set forth in the state plan in effect on October 1,
22 2001.
23 (e) (1) An FQHC or RHC may apply for an adjustment to its
24 per-visit rate based on a change in the scope of ~~services~~ *service*
25 provided by the FQHC or RHC. Rate changes based on a change
26 in the scope of ~~services~~ *service* provided by an FQHC or RHC
27 shall be evaluated in accordance with Medicare reasonable cost
28 principles, as set forth in Part 413 (commencing with Section

1 413.1) of Title 42 of the Code of Federal Regulations, or its
2 successor.

3 (2) Subject to the conditions set forth in subparagraphs (A) to
4 (D), inclusive, of paragraph (3), a change in scope of service means
5 any of the following:

6 (A) The addition of a new FQHC or RHC service that is not
7 incorporated in the baseline prospective payment system (PPS)
8 rate, or a deletion of an FQHC or RHC service that is incorporated
9 in the baseline PPS rate.

10 (B) A change in service due to amended regulatory requirements
11 or rules.

12 (C) A change in service resulting from relocating or remodeling
13 an FQHC or RHC.

14 (D) A change in types of services due to a change in applicable
15 technology and medical practice utilized by the center or clinic.

16 (E) An increase in service intensity attributable to changes in
17 the types of patients served, including, but not limited to,
18 populations with HIV or AIDS, or other chronic diseases, or
19 homeless, elderly, migrant, or other special populations.

20 (F) Any changes in any of the services described in subdivision
21 (a) or (b), or in the provider mix of an FQHC or RHC or one of
22 its sites.

23 (G) Changes in operating costs attributable to capital
24 expenditures associated with a modification of the scope of any
25 of the services described in subdivision (a) or (b), including new
26 or expanded service facilities, regulatory compliance, or changes
27 in technology or medical practices at the center or clinic.

28 (H) Indirect medical education adjustments and a direct graduate
29 medical education payment that reflects the costs of providing
30 teaching services to interns and residents.

31 (I) Any changes in the scope of a project approved by the federal
32 Health Resources and Services Administration (HRSA).

33 (3) A change in costs is not, in and of itself, ~~a scope of service~~
34 ~~change, a scope of service change~~, unless all of the following
35 apply:

36 (A) The increase or decrease in cost is attributable to an increase
37 or decrease in the scope of ~~services~~ *service* defined in subdivisions
38 (a) and (b), as applicable.

39 (B) The cost is allowable under Medicare reasonable cost
40 principles set forth in Part 413 (commencing with Section 413) of

1 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
2 Regulations, or its successor.

3 (C) The change in the ~~scope of services~~ *scope of service* is a
4 change in the type, intensity, duration, or amount of services, or
5 any combination thereof.

6 (D) The net change in the FQHC’s or RHC’s rate equals or
7 exceeds 1.75 percent for the affected FQHC or RHC site. For
8 FQHCs and RHCs that filed consolidated cost reports for multiple
9 sites to establish the initial prospective payment reimbursement
10 rate, the 1.75-percent threshold shall be applied to the average
11 per-visit rate of all sites for the purposes of calculating the cost
12 associated with a ~~scope of service~~ *scope of service* change. “Net
13 change” means the per-visit rate change attributable to the
14 cumulative effect of all increases and decreases for a particular
15 fiscal year.

16 (4) An FQHC or RHC may submit requests for ~~scope of service~~
17 *scope of service* changes once per fiscal year, only within 90 days
18 following the beginning of the FQHC’s or RHC’s fiscal year. Any
19 approved increase or decrease in the provider’s rate shall be
20 retroactive to the beginning of the FQHC’s or RHC’s fiscal year
21 in which the request is submitted.

22 (5) An FQHC or RHC shall submit a ~~scope of service~~ *scope of*
23 *service* rate change request within 90 days of the beginning of any
24 FQHC or RHC fiscal year occurring after the effective date of this
25 section, if, during the FQHC’s or RHC’s prior fiscal year, the
26 FQHC or RHC experienced a decrease in the ~~scope of services~~
27 *service* provided that the FQHC or RHC either knew or should
28 have known would have resulted in a significantly lower per-visit
29 rate. If an FQHC or RHC discontinues providing onsite pharmacy
30 or dental services, it shall submit a ~~scope of service~~ *scope of*
31 *service* rate change request within 90 days of the beginning of the
32 following fiscal year. The rate change shall be effective as provided
33 for in paragraph (4). As used in this paragraph, “significantly
34 lower” means an average per-visit rate decrease in excess of 2.5
35 percent.

36 (6) Notwithstanding paragraph (4), if the approved
37 ~~scope of service~~ *scope of service* change or changes were initially
38 implemented on or after the first day of an FQHC’s or RHC’s
39 fiscal year ending in calendar year 2001, but before the adoption
40 and issuance of written instructions for applying for a

1 ~~scope of service~~ *scope of service* change, the adjusted
2 reimbursement rate for that ~~scope of service change~~ *scope of*
3 *service* shall be made retroactive to the date the ~~scope of service~~
4 *scope of service* change was initially implemented.
5 ~~Scope of service~~ *Scope of service* changes under this paragraph
6 shall be required to be submitted within the later of 150 days after
7 the adoption and issuance of the written instructions by the
8 department, or 150 days after the end of the FQHC's or RHC's
9 fiscal year ending in 2003.

10 (7) All references in this subdivision to "fiscal year" shall be
11 construed to be references to the fiscal year of the individual FQHC
12 or RHC, as the case may be.

13 (f) (1) An FQHC or RHC may request a supplemental payment
14 if extraordinary circumstances beyond the control of the FQHC
15 or RHC occur after December 31, 2001, and PPS payments are
16 insufficient due to these extraordinary circumstances. Supplemental
17 payments arising from extraordinary circumstances under this
18 subdivision shall be solely and exclusively within the discretion
19 of the department and shall not be subject to subdivision (l). These
20 supplemental payments shall be determined separately from the
21 ~~scope of service~~ *scope of service* adjustments described in
22 subdivision (e). Extraordinary circumstances include, but are not
23 limited to, acts of nature, changes in applicable requirements in
24 the Health and Safety Code, changes in applicable licensure
25 requirements, and changes in applicable rules or regulations. Mere
26 inflation of costs alone, absent extraordinary circumstances, shall
27 not be grounds for supplemental payment. If an FQHC's or RHC's
28 PPS rate is sufficient to cover its overall costs, including those
29 associated with the extraordinary circumstances, then a
30 supplemental payment is not warranted.

31 (2) The department shall accept requests for supplemental
32 payment at any time throughout the prospective payment rate year.

33 (3) Requests for supplemental payments shall be submitted in
34 writing to the department and shall set forth the reasons for the
35 request. Each request shall be accompanied by sufficient
36 documentation to enable the department to act upon the request.
37 Documentation shall include the data necessary to demonstrate
38 that the circumstances for which supplemental payment is requested
39 meet the requirements set forth in this section. Documentation
40 shall include both of the following:

1 (A) A presentation of data to demonstrate reasons for the
2 FQHC's or RHC's request for a supplemental payment.

3 (B) Documentation showing the cost implications. The cost
4 impact shall be material and significant, two hundred thousand
5 dollars (\$200,000) or 1 percent of a facility's total costs, whichever
6 is less.

7 (4) A request shall be submitted for each affected year.

8 (5) Amounts granted for supplemental payment requests shall
9 be paid as lump-sum amounts for those years and not as revised
10 PPS rates, and shall be repaid by the FQHC or RHC to the extent
11 that it is not expended for the specified purposes.

12 (6) The department shall notify the provider of the department's
13 discretionary decision in writing.

14 (g) (1) An FQHC or RHC "visit" means a face-to-face
15 encounter between an FQHC or RHC patient and a physician,
16 physician assistant, nurse practitioner, certified nurse-midwife,
17 clinical psychologist, licensed clinical social worker, or a visiting
18 nurse. For purposes of this section, "physician" shall be interpreted
19 in a manner consistent with the federal Centers for Medicare and
20 Medicaid Services' Medicare Rural Health Clinic and Federally
21 Qualified Health Center Manual (Publication 27), or its successor,
22 only to the extent that it defines the professionals whose services
23 are reimbursable on a per-visit basis and not as to the types of
24 services that these professionals may render during these visits
25 and shall include a physician and surgeon, osteopath, podiatrist,
26 dentist, optometrist, and chiropractor. A visit shall also include a
27 face-to-face encounter between an FQHC or RHC patient and a
28 comprehensive perinatal practitioner, as defined in Section 51179.7
29 of Title 22 of the California Code of Regulations, providing
30 comprehensive perinatal services, a four-hour day of attendance
31 at an adult day health care center, and any other provider identified
32 in the state plan's definition of an FQHC or RHC visit.

33 (2) (A) A visit shall also include a face-to-face encounter
34 between an FQHC or RHC patient and a dental hygienist, a dental
35 hygienist in alternative practice, *a licensed professional clinical*
36 *counselor*, or a marriage and family therapist.

37 (B) Notwithstanding subdivision (e), if an FQHC or RHC that
38 currently includes the cost of the services of a dental hygienist in
39 alternative practice, *a licensed professional clinical counselor*, or
40 a marriage and family therapist for the purposes of establishing

1 its FQHC or RHC rate chooses to bill these services as a separate
2 visit, the FQHC or RHC shall apply for an adjustment to its
3 per-visit rate, and, after the rate adjustment has been approved by
4 the department, shall bill these services as a separate visit.
5 However, multiple encounters with dental—~~professionals~~
6 *professionals, licensed professional clinical counselors*, or marriage
7 and family therapists that take place on the same day shall
8 constitute a single visit. The department shall develop the
9 appropriate forms to determine which FQHC's or RHC's rates
10 shall be adjusted and to facilitate the calculation of the adjusted
11 rates. An FQHC's or RHC's application for, or the department's
12 approval of, a rate adjustment pursuant to this subparagraph shall
13 not constitute a change in scope of service within the meaning of
14 subdivision (e). An FQHC or RHC that applies for an adjustment
15 to its rate pursuant to this subparagraph may continue to bill for
16 all other FQHC or RHC visits at its existing per-visit rate, subject
17 to reconciliation, until the rate adjustment for visits between an
18 FQHC or RHC patient and a dental hygienist, a dental hygienist
19 in alternative practice, *a licensed professional clinical counselor*,
20 or a marriage and family therapist has been approved. Any
21 approved increase or decrease in the provider's rate shall be made
22 within six months after the date of receipt of the department's rate
23 adjustment forms pursuant to this subparagraph and shall be
24 retroactive to the beginning of the fiscal year in which the FQHC
25 or RHC submits the request, but in no case shall the effective date
26 be earlier than January 1, 2008.

27 (C) An FQHC or RHC that does not provide dental hygienist,
28 dental hygienist in alternative practice, *licensed professional*
29 *clinical counselor*, or marriage and family therapist services, and
30 later elects to add these services and bill these services as a separate
31 visit, shall process the addition of these services as a change in
32 scope of service pursuant to subdivision (e).

33 (3) Notwithstanding any other provision of this section, ~~no later~~
34 ~~than~~ by July 1, 2018, a visit shall include a marriage and family
35 therapist.

36 (h) If FQHC or RHC services are partially reimbursed by a
37 third-party payer, such as a managed care entity, as defined in
38 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code,
39 the Medicare Program, or the Child Health and Disability
40 Prevention (CHDP) Program, the department shall reimburse an

1 FQHC or RHC for the difference between its per-visit PPS rate
2 and receipts from other plans or programs on a contract-by-contract
3 basis and not in the aggregate, and may not include managed care
4 financial incentive payments that are required by federal law to
5 be excluded from the calculation.

6 (i) (1) Provided that the following entities are not operating as
7 intermittent clinics, as defined in subdivision (h) of Section 1206
8 of the Health and Safety Code, each entity shall have its
9 reimbursement rate established in accordance with one of the
10 methods outlined in paragraph (2) or (3), as selected by the FQHC
11 or RHC:

12 (A) An entity that first qualifies as an FQHC or RHC in 2001
13 or later.

14 (B) A newly licensed facility at a new location added to an
15 existing FQHC or RHC.

16 (C) An entity that is an existing FQHC or RHC that is relocated
17 to a new site.

18 (2) (A) An FQHC or RHC that adds a new licensed location to
19 its existing primary care license under paragraph (1) of subdivision
20 (b) of Section 1212 of the Health and Safety Code may elect to
21 have the reimbursement rate for the new location established in
22 accordance with paragraph (3), or notwithstanding subdivision
23 (e), an FQHC or RHC may choose to have one PPS rate for all
24 locations that appear on its primary care license determined by
25 submitting a change in scope of service request if both of the
26 following requirements are met:

27 (i) The change in scope of service request includes the costs
28 and visits for those locations for the first full fiscal year
29 immediately following the date the new location is added to the
30 FQHC's or RHC's existing licensee.

31 (ii) The FQHC or RHC submits the change in scope of service
32 request within 90 days after the FQHC's or RHC's first full fiscal
33 year.

34 (B) The FQHC's or RHC's single PPS rate for those locations
35 shall be calculated based on the total costs and total visits of those
36 locations and shall be determined based on the following:

37 (i) An audit in accordance with Section 14170.

38 (ii) Rate changes based on a change in scope of service request
39 shall be evaluated in accordance with Medicare reasonable cost
40 principles, as set forth in Part 413 (commencing with Section

1 413.1) of Title 42 of the Code of Federal Regulations, or its
2 successors.

3 (iii) Any approved increase or decrease in the provider’s rate
4 shall be retroactive to the beginning of the FQHC’s or RHC’s fiscal
5 year in which the request is submitted.

6 (C) Except as specified in subdivision (j), this paragraph does
7 not apply to a location that was added to an existing primary care
8 clinic license by the State Department of Public Health, whether
9 by a regional district office or the centralized application unit, prior
10 to January 1, 2017.

11 (3) If an FQHC or RHC does not elect to have the PPS rate
12 determined by a change in scope of service request, the FQHC or
13 RHC shall have the reimbursement rate established for any of the
14 entities identified in paragraph (1) or (2) in accordance with one
15 of the following methods at the election of the FQHC or RHC:

16 (A) The rate may be calculated on a per-visit basis in an amount
17 that is equal to the average of the per-visit rates of three comparable
18 FQHCs or RHCs located in the same or adjacent area with a similar
19 caseload.

20 (B) In the absence of three comparable FQHCs or RHCs with
21 a similar caseload, the rate may be calculated on a per-visit basis
22 in an amount that is equal to the average of the per-visit rates of
23 three comparable FQHCs or RHCs located in the same or an
24 adjacent service area, or in a reasonably similar geographic area
25 with respect to relevant social, ~~health care,~~ *healthcare*, and
26 economic characteristics.

27 (C) At a new entity’s one-time election, the department shall
28 establish a reimbursement rate, calculated on a per-visit basis, that
29 is equal to 100 percent of the projected allowable costs to the
30 FQHC or RHC of furnishing FQHC or RHC services during the
31 first 12 months of operation as an FQHC or RHC. After the first
32 12-month period, the projected per-visit rate shall be increased by
33 the Medicare Economic Index then in effect. The projected
34 allowable costs for the first 12 months shall be cost settled and the
35 prospective payment reimbursement rate shall be adjusted based
36 on actual and allowable cost per visit.

37 (D) The department may adopt any further and additional
38 methods of setting reimbursement rates for newly qualified FQHCs
39 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42
40 of the United States Code.

1 (4) In order for an FQHC or RHC to establish the comparability
2 of its caseload for purposes of subparagraph (A) or (B) of paragraph
3 (1), the department shall require that the FQHC or RHC submit
4 its most recent annual utilization report as submitted to the Office
5 of Statewide Health Planning and Development, unless the FQHC
6 or RHC was not required to file an annual utilization report. FQHCs
7 or RHCs that have experienced changes in their services or
8 caseload subsequent to the filing of the annual utilization report
9 may submit to the department a completed report in the format
10 applicable to the prior calendar year. FQHCs or RHCs that have
11 not previously submitted an annual utilization report shall submit
12 to the department a completed report in the format applicable to
13 the prior calendar year. The FQHC or RHC shall not be required
14 to submit the annual utilization report for the comparable FQHCs
15 or RHCs to the department, but shall be required to identify the
16 comparable FQHCs or RHCs.

17 (5) The rate for any newly qualified entity set forth under this
18 subdivision shall be effective retroactively to the later of the date
19 that the entity was first qualified by the applicable federal agency
20 as an FQHC or RHC, the date a new facility at a new location was
21 added to an existing FQHC or RHC, or the date on which an
22 existing FQHC or RHC was relocated to a new site. The FQHC
23 or RHC shall be permitted to continue billing for Medi-Cal covered
24 benefits on a fee-for-service basis under its existing provider
25 number until it is informed of its FQHC or RHC enrollment
26 approval, and the department shall reconcile the difference between
27 the fee-for-service payments and the FQHC's or RHC's prospective
28 payment rate at that time.

29 (j) (1) Visits occurring at an intermittent clinic site, as defined
30 in subdivision (h) of Section 1206 of the Health and Safety Code,
31 of an existing FQHC or RHC, in a mobile unit as defined by
32 paragraph (2) of subdivision (b) of Section 1765.105 of the Health
33 and Safety Code, or at the election of the FQHC or RHC and
34 subject to paragraph (2), a location added to an existing primary
35 care clinic license by the State Department of Public Health prior
36 to January 1, 2017, shall be billed by and reimbursed at the same
37 rate as the FQHC or RHC that either established the intermittent
38 clinic site or mobile unit, or that held the clinic license to which
39 the location was added prior to January 1, 2017.

1 (2) If an FQHC or RHC with at least one additional location on
2 its primary care clinic license that was added by the State
3 Department of Public Health prior to January 1, 2017, applies for
4 an adjustment to its per-visit rate based on a change in the scope
5 of ~~services~~ *service* provided by the FQHC or RHC as described
6 in subdivision (e), all locations on the FQHC or RHC's primary
7 care clinic license shall be subject to a ~~scope of service~~ *scope of*
8 *service* adjustment in accordance with either paragraph (2) or (3)
9 of subdivision (i), as selected by the FQHC or RHC.

10 (3) ~~Nothing in this subdivision precludes or~~ *This subdivision*
11 *does not preclude nor* otherwise limits the right of the FQHC or
12 RHC to request a ~~scope of service~~ *scope of service* adjustment to
13 the rate.

14 (k) An FQHC or RHC may elect to have pharmacy or dental
15 services reimbursed on a fee-for-service basis, utilizing the current
16 fee schedules established for those services. These costs shall be
17 adjusted out of the FQHC's or RHC's clinic base rate as
18 ~~scope of service~~ *scope of service* changes. An FQHC or RHC that
19 reverses its election under this subdivision shall revert to its prior
20 rate, subject to an increase to account for all Medicare Economic
21 Index increases occurring during the intervening time period, and
22 subject to any increase or decrease associated with applicable
23 ~~scope of service~~ *scope of service* adjustments as provided in
24 subdivision (e).

25 (l) Reimbursement for Drug Medi-Cal services shall be provided
26 pursuant to this subdivision.

27 (1) An FQHC or RHC may elect to have Drug Medi-Cal services
28 reimbursed directly from a county or the department under contract
29 with the FQHC or RHC pursuant to paragraph (4).

30 (2) (A) For an FQHC or RHC to receive reimbursement for
31 Drug Medi-Cal services directly from the county or the department
32 under contract with the FQHC or RHC pursuant to paragraph (4),
33 costs associated with providing Drug Medi-Cal services shall not
34 be included in the FQHC's or RHC's per-visit PPS rate. For
35 purposes of this subdivision, the costs associated with providing
36 Drug Medi-Cal services shall not be considered to be within the
37 FQHC's or RHC's clinic base PPS rate if in delivering Drug
38 Medi-Cal services the clinic uses different clinical staff at a
39 different location.

1 (B) If the FQHC or RHC does not use different clinical staff at
2 a different location to deliver Drug Medi-Cal services, the FQHC
3 or RHC shall submit documentation, in a manner determined by
4 the department, that the current per-visit PPS rate does not include
5 any costs related to rendering Drug Medi-Cal services, including
6 costs related to utilizing space in part of the FQHC's or RHC's
7 building, that are or were previously calculated as part of the
8 clinic's base PPS rate.

9 (3) If the costs associated with providing Drug Medi-Cal
10 services are within the FQHC's or RHC's clinic base PPS rate, as
11 determined by the department, the Drug Medi-Cal services costs
12 shall be adjusted out of the FQHC's or RHC's per-visit PPS rate
13 as a change in scope of service.

14 (A) An FQHC or RHC shall submit to the department a
15 ~~scope of service~~ *scope of service* change request to adjust the
16 FQHC's or RHC's clinic base PPS rate after the first full fiscal
17 year of rendering Drug Medi-Cal services outside of the PPS rate.
18 Notwithstanding subdivision (e), the ~~scope of service~~ *scope of*
19 *service* change request shall include a full fiscal year of activity
20 that does not include Drug Medi-Cal services costs.

21 (B) An FQHC or RHC may submit requests for ~~scope of service~~
22 *scope of service* change under this subdivision only within 90 days
23 following the beginning of the FQHC's or RHC's fiscal year. ~~Any~~
24 ~~scope of service~~ A *scope of service* change request under this
25 subdivision approved by the department shall be retroactive to the
26 first day that Drug Medi-Cal services were rendered and
27 reimbursement for Drug Medi-Cal services was received outside
28 of the PPS rate, but in no case shall the effective date be earlier
29 than January 1, 2018.

30 (C) The FQHC or RHC may bill for Drug Medi-Cal services
31 outside of the PPS rate when the FQHC or RHC obtains approval
32 as a Drug Medi-Cal provider and enters into a contract with a
33 county or the department to provide these services pursuant to
34 paragraph (4).

35 (D) Within 90 days of receipt of the request for a
36 ~~scope of service~~ *scope of service* change under this subdivision,
37 the department shall issue the FQHC or RHC an interim rate equal
38 to 90 percent of the FQHC's or RHC's projected allowable cost,
39 as determined by the department. An audit to determine the final
40 rate shall be performed in accordance with Section 14170.

1 (E) Rate changes based on a request for ~~scope of service~~ *scope*
2 *of service* change under this subdivision shall be evaluated in
3 accordance with Medicare reasonable cost principles, as set forth
4 in Part 413 (commencing with Section 413.1) of Title 42 of the
5 Code of Federal Regulations, or its successor.

6 (F) For purposes of recalculating the PPS rate, the FQHC or
7 RHC shall provide upon request to the department verifiable
8 documentation as to which employees spent time, and the actual
9 time spent, providing federally qualified health center services or
10 rural health center services and Drug Medi-Cal services.

11 (G) After the department approves the adjustment to the FQHC's
12 or RHC's clinic base PPS rate and the FQHC or RHC is approved
13 as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the
14 PPS rate for any Drug Medi-Cal services provided pursuant to a
15 contract entered into with a county or the department pursuant to
16 paragraph (4).

17 (H) An FQHC or RHC that reverses its election under this
18 subdivision shall revert to its prior PPS rate, subject to an increase
19 to account for all Medicare Economic Index increases occurring
20 during the intervening time period, and subject to any increase or
21 decrease associated with the applicable ~~scope of service~~ *scope of*
22 *service* adjustments as provided for in subdivision (e).

23 (4) Reimbursement for Drug Medi-Cal services shall be
24 determined according to subparagraph (A) or (B), depending on
25 whether the services are provided in a county that participates in
26 the Drug Medi-Cal organized delivery system (DMC-ODS).

27 (A) In a county that participates in the DMC-ODS, the FQHC
28 or RHC shall receive reimbursement pursuant to a mutually agreed
29 upon contract entered into between the county or county designee
30 and the FQHC or RHC. If the county or county designee refuses
31 to contract with the FQHC or RHC, the FQHC or RHC may follow
32 the contract denial process set forth in the Special Terms and
33 Conditions.

34 (B) In a county that does not participate in the DMC-ODS, the
35 FQHC or RHC shall receive reimbursement pursuant to a mutually
36 agreed upon contract entered into between the county and the
37 FQHC or RHC. If the county refuses to contract with the FQHC
38 or RHC, the FQHC or RHC may request to contract directly with
39 the department and shall be reimbursed for those services at the
40 Drug Medi-Cal fee-for-service rate.

1 (5) The department shall not reimburse an FQHC or RHC
2 pursuant to subdivision (h) for the difference between its per-visit
3 PPS rate and any payments for Drug Medi-Cal services made
4 pursuant to this subdivision.

5 (6) For purposes of this subdivision, the following definitions
6 shall apply:

7 (A) “Drug Medi-Cal organized delivery system” or
8 “DMC-ODS” means the Drug Medi-Cal organized delivery system
9 authorized under the California Medi-Cal 2020 Demonstration,
10 Number 11-W-00193/9, as approved by the federal Centers for
11 Medicare and Medicaid Services and described in the Special
12 Terms and Conditions.

13 (B) “Special Terms and Conditions” shall have the same
14 meaning as set forth in subdivision (o) of Section 14184.10.

15 (m) Reimbursement for specialty mental health services shall
16 be provided pursuant to this subdivision.

17 (1) An FQHC or RHC and one or more mental health plans that
18 contract with the department pursuant to Section 14712 may
19 mutually elect to enter into a contract to have the FQHC or RHC
20 provide specialty mental health services to Medi-Cal beneficiaries
21 as part of the mental health plan’s network.

22 (2) (A) For an FQHC or RHC to receive reimbursement for
23 specialty mental health services pursuant to a contract entered into
24 with the mental health plan under paragraph (1), the costs
25 associated with providing specialty mental health services shall
26 not be included in the FQHC’s or RHC’s per-visit PPS rate. For
27 purposes of this subdivision, the costs associated with providing
28 specialty mental health services shall not be considered to be within
29 the FQHC’s or RHC’s clinic base PPS rate if in delivering specialty
30 mental health services the clinic uses different clinical staff at a
31 different location.

32 (B) If the FQHC or RHC does not use different clinical staff at
33 a different location to deliver specialty mental health services, the
34 FQHC or RHC shall submit documentation, in a manner
35 determined by the department, that the current per-visit PPS rate
36 does not include any costs related to rendering specialty mental
37 health services, including costs related to utilizing space in part of
38 the FQHC’s or RHC’s building, that are or were previously
39 calculated as part of the clinic’s base PPS rate.

1 (3) If the costs associated with providing specialty mental health
2 services are within the FQHC's or RHC's clinic base PPS rate, as
3 determined by the department, the specialty mental health services
4 costs shall be adjusted out of the FQHC's or RHC's per-visit PPS
5 rate as a change in scope of service.

6 (A) An FQHC or RHC shall submit to the department a
7 ~~scope of service~~ *scope of service* change request to adjust the
8 FQHC's or RHC's clinic base PPS rate after the first full fiscal
9 year of rendering specialty mental health services outside of the
10 PPS rate. Notwithstanding subdivision (e), the ~~scope of service~~
11 *scope of service* change request shall include a full fiscal year of
12 activity that does not include specialty mental health costs.

13 (B) An FQHC or RHC may submit requests for a
14 ~~scope of service~~ *scope of service* change under this subdivision
15 only within 90 days following the beginning of the FQHC's or
16 RHC's fiscal year. Any ~~scope of service~~ *scope of service* change
17 request under this subdivision approved by the department shall
18 be retroactive to the first day that specialty mental health services
19 were rendered and reimbursement for specialty mental health
20 services was received outside of the PPS rate, but in no case shall
21 the effective date be earlier than January 1, 2018.

22 (C) The FQHC or RHC may bill for specialty mental health
23 services outside of the PPS rate when the FQHC or RHC contracts
24 with a mental health plan to provide these services pursuant to
25 paragraph (1).

26 (D) Within 90 days of receipt of the request for a
27 ~~scope in service~~ *scope of service* change under this subdivision,
28 the department shall issue the FQHC or RHC an interim rate equal
29 to 90 percent of the FQHC's or RHC's projected allowable cost,
30 as determined by the department. An audit to determine the final
31 rate shall be performed in accordance with Section 14170.

32 (E) Rate changes based on a request for ~~scope of service~~ *scope*
33 *of service* change under this subdivision shall be evaluated in
34 accordance with Medicare reasonable cost principles, as set forth
35 in Part 413 (commencing with Section 413.1) of Title 42 of the
36 Code of Federal Regulations, or its successor.

37 (F) For the purpose of recalculating the PPS rate, the FQHC or
38 RHC shall provide upon request to the department verifiable
39 documentation as to which employees spent time, and the actual

1 time spent, providing federally qualified health center services or
2 rural health center services and specialty mental health services.

3 (G) After the department approves the adjustment to the FQHC's
4 or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the
5 PPS rate for any specialty mental health services that are provided
6 pursuant to a contract entered into with a mental health plan
7 pursuant to paragraph (1).

8 (H) An FQHC or RHC that reverses its election under this
9 subdivision shall revert to its prior PPS rate, subject to an increase
10 to account for all Medicare Economic Index increases occurring
11 during the intervening time period, and subject to any increase or
12 decrease associated with the applicable ~~scope of service~~ *scope of*
13 *service* adjustments as provided for in subdivision (e).

14 (4) The department shall not reimburse an FQHC or RHC
15 pursuant to subdivision (h) for the difference between its per-visit
16 PPS rate and any payments made for specialty mental health
17 services under this subdivision.

18 (n) FQHCs and RHCs may appeal a grievance or complaint
19 concerning ratesetting, ~~scope of service~~ *scope of service* changes,
20 and settlement of cost report audits, in the manner prescribed by
21 Section 14171. The rights and remedies provided under this
22 subdivision are cumulative to the rights and remedies available
23 under all other provisions of law of this state.

24 (o) The department shall promptly seek all necessary federal
25 approvals in order to implement this section, including any
26 amendments to the state plan. To the extent that any element or
27 requirement of this section is not approved, the department shall
28 submit a request to the federal Centers for Medicare and Medicaid
29 Services for any waivers that would be necessary to implement
30 this section.

31 (p) The department shall implement this section only to the
32 extent that federal financial participation is available.

33 (q) Notwithstanding any other law, the director may, without
34 taking regulatory action pursuant to Chapter 3.5 (commencing
35 with Section 11340) of Part 1 of Division 3 of Title 2 of the
36 Government Code, implement, interpret, or make specific
37 subdivisions (l) and (m) by means of a provider bulletin or similar
38 instruction. The department shall notify and consult with interested
39 parties and appropriate stakeholders in implementing, interpreting,

1 or making specific the provisions of subdivisions (l) and (m),
2 including all of the following:

3 (1) Notifying provider representatives in writing of the proposed
4 action or change. The notice shall occur, and the applicable draft
5 provider bulletin or similar instruction, shall be made available at
6 least 10 business days prior to the meeting described in paragraph
7 (2).

8 (2) Scheduling at least one meeting with interested parties and
9 appropriate stakeholders to discuss the proposed action or change.

10 (3) Allowing for written input regarding the proposed action or
11 change, to which the department shall provide summary written
12 responses in conjunction with the issuance of the applicable final
13 written provider bulletin or similar instruction.

14 (4) Providing at least 60 days advance notice of the effective
15 date of the proposed action or change.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 1145 **VERSION:** INTRODUCED FEBRUARY 21, 2019

AUTHOR: GARCIA **SPONSOR:** AUTHOR

RECOMMENDED POSITION: SUPPORT

SUBJECT: CHILD ABUSE: REPORTABLE CONDUCT

Overview:

This bill would specify that voluntary acts of sodomy, oral copulation, and sexual penetration are not considered acts of sexual assault that must be reported by a mandated reporter as child abuse if there are no indicators of abuse, unless it is between a person age 21 or older and a minor under age 16.

Existing Law:

- 1) Establishes the Child Abuse and Neglect Reporting Act (CANRA) which requires a mandated reporter to make a report in instances in which he or she knows or reasonably suspects that a child has been the victim of child abuse or neglect. (Penal Code (PC) 11164 et seq)
- 2) Defines “sexual abuse” for the purposes of CANRA as sexual assault or exploitation. It further defines “sexual assault” as consisting of any of the following: rape, statutory rape, rape in concert, incest, sodomy, oral copulation, lewd or lascivious acts upon a child, sexual penetration, or child molestation. (PC §11165.1(a))
- 3) Except under certain specified circumstances, declares any person who participates in an act of sodomy or oral copulation with a person under age 18 shall be punished by up to one year in state prison or county jail. (PC §§ 286(b)(1), 287(b)(1))
- 4) Except under certain specified circumstances, declares any person over age 21 who participates in an act of sodomy or oral copulation with someone under age 16 is guilty of a felony. (PC §§ 286(b)(2), 287(b)(2))
- 5) States that a person who engages in unlawful sexual intercourse with a minor who is not more than three years older or three years younger, is guilty of a misdemeanor. (PC §261.5(b))

- 6) States that a person who engages in unlawful sexual intercourse with a minor who is more than three years younger is guilty of either a misdemeanor or a felony. (PC §261.5(c))
- 7) States that any person age 21 or older who engages in unlawful sexual intercourse with a minor under age 16 is guilty of either a misdemeanor or a felony. (PC §261.5(d))

This Bill:

- 1) Specifies that voluntary acts of sodomy, oral copulation, or sexual penetration are not considered to be mandated reports of sexual assault under CANRA if there are no indicators of abuse, unless the conduct is between a person age 21 or older and a minor under age 16. (PC §11165.1(a))

Comment:

- 1) **Intent.** The author's is attempting to clarify the law due to concerns and feedback that requirements for mandated reporters of child abuse are confusing, inconsistent, and discriminatory.

Some mandated reporters interpret the law to read that consensual sodomy and oral copulation is illegal with anyone under age 18, and that it requires a mandated report as sexual assault under CANRA. They argue that the same reporting standards do not apply to consensual heterosexual intercourse.

There are also contradictory opinions that the law does not read this way, and that sodomy and oral copulation are not treated differently from other acts in the code. However, lack of a clear answer leads to confusion about what is reportable and what is not.

Therefore, the author is seeking to make the law consistent by ensuring that all types of voluntary activities are treated equally for purposes of mandated reporting under CANRA.

- 2) **Background.** The Board examined this issue in 2013 when stakeholders expressed concern that consensual oral copulation and sodomy among minors were mandated reports under CANRA, while other types of consensual sexual activity were not.

However, at the same time, staffers at the Legislature contacted the Board to caution that there had been past legal opinions stating that this interpretation of CANRA was incorrect, and that amendments could potentially have ramifications for family planning agencies.

The Board was concerned about a potential legal misinterpretation of CANRA, but at the same time saw this as a valid effort. Therefore, it directed staff to obtain a legal opinion from the DCA legal office.

3) DCA Legal Opinion. In its legal opinion (**Attachment A**), DCA found that CANRA does not require a mandated reporter to report incidents of consensual sex between minors of a similar age for any actions described in PC Section 11165.1, unless there is reasonable suspicion of force, exploitation, or other abuse. DCA also found the following, based on past court cases:

- Courts have found that the legislative intent of the reporting law is to leave the distinction between abusive and non-abusive sexual relations to the judgment of professionals who deal with children.
- Review of other legal cases has found that the law does not require reporting of consensual sexual activities between similarly-aged minors for any sexual acts unless there is evidence of abuse.

4) Board of Psychology Action. The Board of Psychology sought an opinion from the Attorney General's (AG's) Office on the laws regarding mandated reporting, specifically whether consensual sexual conduct between minors of a like age differs depending upon the type of sexual conduct described by the minor.

The Board of Psychology asked the AG to resolve the following legal questions:

1. The Child Abuse and Neglect Reporting Act (CANRA; Pen. Code, sec. 11164 et seq.) requires "mandated reporters" to report instances of child sexual abuse, assault, and exploitation to specified law enforcement and/or child protection agencies. Does this requirement include the mandatory reporting of voluntary acts of sexual intercourse, oral copulation, or sodomy between minors of a like age?
2. Under CANRA is the activity of mobile device "sexting," between minors of a like age, a form of reportable sexual exploitation?
3. Does CANRA require a mandated reporter to relay third-party reports of downloading, streaming, or otherwise accessing child pornography through electronic or digital media?

The opinion request was sent to the AG by Assemblywoman Garcia in February 2015. However, a related case is currently under review by the California Supreme Court, and the AG's office suspended the opinion until the litigation is concluded. There is no estimated timeline of when this may occur.

5) Previous Legislation. The author has made two past attempts at clarifying this issue:

- AB 1505 (Garcia, 2014) would have specified that consensual acts of sodomy and oral copulation are not acts of sexual assault that must be reported by a mandated reporter, unless it involved either a person over age 21 or a minor under age 16. At its April 2014 meeting, the Policy and Advocacy Committee

recommended that the Board take a “support” position on this bill. However, AB 1505 died before the Board was able to take a position on it.

- AB 832 (Garcia, 2015) was very similar to today’s bill. The Board took a “support if amended” position and asked for an amendment clarifying that only non-abusive sexual conduct would not be reportable. The author subsequently made this amendment, and that requested amendment is also included in today’s bill. AB 832 died on the Assembly floor.

6) Recommended Position. At its meeting on April 5, 2019, the Policy and Advocacy Committee discussed the bill and recommended that the Board consider taking a “support” position. In addition, the Committee directed staff to reach out to the author’s office to discuss the possibility of also clarifying the reportability of filming, “sexting”, or similar use of technology between minors, as it noted there is also a lack of clarity in law regarding those activities.

Staff discussed this concern with the author’s office, and they expressed a willingness to consider including it. They indicated that they would discuss the idea with other members and stakeholders. However, they also noted that the bill, as currently written, was encountering some challenges in the committee process at the legislature.

7) Support and Opposition.

Support:

- California Psychological Association
- California Public Defenders Association

Opposition

- Unknown at this time.

8) History

2019

04/24/19 In committee: Hearing postponed by committee.

04/10/19 In committee: Set, first hearing. Hearing canceled at the request of author.

04/02/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 5. Noes 2.) (April 2). Re-referred to Com. on APPR.

03/07/19 Referred to Com. on PUB. S.

02/22/19 From printer. May be heard in committee March 24.

02/21/19 Read first time. To print.

9) Attachments

Attachment A: DCA Legal Opinion: Evaluation of CANRA Reform Proposal Related to Reporting of Consensual Sex Between Minors

Attachment B: Relevant Code Sections: Penal Code Sections 261.5, 286, 287, 288, and 289

Attachment C: CAMFT Article: "Reporting Consensual Activity Between Minors: The Confusion Unraveled," by Cathy Atkins, Revised May 2013

Attachment D: Santa Clara County Child Abuse Council "Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors"

Attachment E: Santa Clara County information sheet for mandated reporters: "Mandated Reporters: When Must you Report Consensual Sexual Activity Involving Minors?"

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MEMORANDUM

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| DATE | April 11, 2013 |
| TO | Kim Madsen Members of the Board of Behavioral Sciences |
| FROM | DIANNE R. DOBBS Senior Staff Counsel, Legal Affairs |
| SUBJECT | Evaluation of CANRA Reform Proposal Related to Reporting of Consensual Sex Between Minors |

Following presentation by Benjamin E. Caldwell, PsyD of a proposal to amend portions of the Child Abuse and Neglect Reporting Act ("CANRA") at the board meeting on February 28, 2013, the board requested a legal opinion on the proposal. The proposal seeks to amend CANRA to remove sodomy and oral copulation from the definition of sexual abuse, assault or exploitation. The purpose of the modification is to address concerns of mandated reporting in situations of consensual acts falling within these definitions when the actors are minors of like age under the law and the actions do not otherwise suggest other indications of abuse or neglect.

QUESTIONS PRESENTED

1. As written does Penal Code section 11165.1 require practitioners to report all conduct by minors that fall under the definition of sodomy and oral copulation?
2. Does the legal interpretation of CANRA warrant support of the proposed amendments?

SHORT ANSWERS

1. No. Court interpretation of CANRA dating back to 1986, and followed as recently as 2005 confirms that minors under and over age 14 can lawfully engage in consensual sexual activities with minors of a like age, and that not all sexual conduct involving a minor necessarily constitutes a violation of the law. That as such, a mandated reporter is required to report only those conditions and situations where the reporter has reason to know or suspects resulted from sexual conduct between the minor and an older adolescent or an adult and those contacts which resulted from undue influence, cohesion, use of force or other indicators of abuse.

2. No. Because practitioners are not required to report any non-abusive consensual sexual activities between minors of like age, amendment of the law is not necessary and should not be supported.

STATEMENT OF FACTS/BACKGROUND

1. Benjamin Caldwell PhD, ("Dr. Caldwell") Legislative and Advocacy Committee Chair of the American Association of Marriage and Family Therapy – California Division seeks to amend CANRA and is seeking the support of the Board of Behavioral Sciences ("Board").
2. Dr. Caldwell claims that CANRA's inclusion of sodomy and oral copulation in the definition of sexual assault found in Penal Code section 11165.1¹ requires mandated reporters to report all homosexual activities meeting these definitions whether or not the acts are consensual and not otherwise suggestive of abuse.
3. The Senior Legislative Assistant of Assembly member Tom Ammiano believes that Dr. Caldwell and others are misinterpreting CANRA.

ANALYSIS

CANRA does not require a mandated reporter to report incidents of consensual sex between minors of similar age, as provided in section 261.5, absent reasonable suspicion of force, exploitation or other indications of abuse. The California Court of Appeal decided this issue in its 1988 ruling in *Planned Parenthood v. Van De Kamp*. *Planned Parenthood v. Van De Kamp* (1988) 181 Cal.App.3e 245. In that case, Planned Parenthood sought to enjoin implementation of CANRA following an opinion of the Attorney General which provided that the inclusion of section 288 in the definition of sexual assault found in section 11165.1 (a) meant that all sexual activities between and with minors under age 14 was reportable. 67 Ops. Cal. Atty. Gen. 235 (1984).

In nullifying the AG's opinion, the court explored the legislative history and intent of CANRA and held that the legislative intent of the reporting law was to leave the distinction between abusive and non-abusive sexual relations to the judgment of those professionals who deal with children and who are by virtue of their training and experience particularly well suited to such judgment. The court reasoned that while the voluntary sexual conduct among minors under the age of 14 may be ill advised, it is not encompassed by section 288, and that the inclusion of that section in the reporting law does not mandate reporting of such activities. Id at 276.

¹ All further citations are to the Penal Code unless otherwise specified.

After the court's ruling in *Planned Parenthood*, the Legislature amended CANRA and did nothing to nullify or change the effect of the court's decision. As such, the Legislature is deemed to have approved the interpretation because where a statute has been construed by judicial decision and that construction is not altered by subsequent legislation, it must be presumed that the Legislature is aware of the judicial construction and approved of it. See *People v. Stockton* (1988) 203 Cal.App.3d 225, citing *Wilkoff v. Superior Ct.*

Following *Planned Parenthood* several other Court of Appeal cases adopted the reasoning of the court including *People v. Stockton* later in 1988, and most recently with *People v. Davis* in 2005. All these cases discuss the CANRA reporting requirements in the context of section 288 which relates to lewd and lascivious conduct with minors under 14. Though none of the cases discuss any of the other acts which also constitute sexual assault under section 11165.1(a), the same reasoning applies to those acts in that absent other indications of abuse, the law does not require the reporting of consensual sexual activities between minors of similar age for any of these acts. This interpretation is consistent with the well settled legal principle that statutes are to be construed with reference to the entire system of law of which they are a part, including the various codes, and harmonized wherever possible to achieve a reasonable result. *Cossack v. City of Los Angeles* (1974) 11 Cal.3d 726, 732.

Dr. Caldwell claims that section 11165.1(a) requires mandated reporters to report all minors engaged in sodomy and oral copulation even where the conduct is consensual and is devoid of evidence of abuse is not supported by the law. All conduct enumerated in section 11165.1(a) must be treated the same for purposes of reporting. To interpret the law otherwise would be against the intent of the legislature to leave the distinction between abusive and non-abusive sexual relations to the judgment of the professionals. An interpretation that would require the reporting of all sodomy and oral copulation without reasonable suspicion of abuse would lead to an absurd result. The court in *Planned Parenthood* said it best when it stated, "...statutes must be construed in a reasonable and commonsense manner consistent with their apparent purpose and the legislative intent underlying them, practical rather than technical, and promoting a wise policy rather than mischief or absurdity. Even a statute's literal terms will not be given effect if to do so would yield an unreasonable or mischievous result." *Planned Parenthood* at 245. Therefore, sexual conduct of minors that meet the definition of sodomy and oral copulation must be treated as all other sexual conduct noted in section 11165.1(a) and is only reported if the acts are nonconsensual, abusive or involves minors of disparate ages, conduct between minors and adults, and situations where there is reasonable suspicion of undue influence, coercion, force or other indicators of abuse.

Section 11165.1(b) further outlines limited examples of conduct which qualifies as sexual assault. There is also no evidence that any of the examples in that section would lead to a discriminatory result to justify removal of sodomy or oral copulation from subsection (a).

CONCLUSION

It is our opinion that CANRA does not require mandated reporters to report consensual sex between minors of like age for any of the actions noted in section 11165.1 unless the practitioner reasonably suspects that the conduct resulted from force, undue influence, coercion, or other indicators of abuse. Accordingly, it is not necessary to amend the statute to remove sodomy and oral copulation, as those acts are not treated differently from other acts outlined in the code.

DOREATHEA JOHNSON
Deputy Director, Legal Affairs



By: DIANNE R. DOBBS
Senior Staff Counsel
Legal Affairs

ATTACHMENT B RELEVANT CODE SECTIONS

Penal Code (PC) §261.5

(a) Unlawful sexual intercourse is an act of sexual intercourse accomplished with a person who is not the spouse of the perpetrator, if the person is a minor. For the purposes of this section, a “minor” is a person under the age of 18 years and an “adult” is a person who is at least 18 years of age.

(b) Any person who engages in an act of unlawful sexual intercourse with a minor who is not more than three years older or three years younger than the perpetrator, is guilty of a misdemeanor.

(c) Any person who engages in an act of unlawful sexual intercourse with a minor who is more than three years younger than the perpetrator is guilty of either a misdemeanor or a felony, and shall be punished by imprisonment in a county jail not exceeding one year, or by imprisonment pursuant to subdivision (h) of Section 1170.

(d) Any person 21 years of age or older who engages in an act of unlawful sexual intercourse with a minor who is under 16 years of age is guilty of either a misdemeanor or a felony, and shall be punished by imprisonment in a county jail not exceeding one year, or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

(e) (1) Notwithstanding any other provision of this section, an adult who engages in an act of sexual intercourse with a minor in violation of this section may be liable for civil penalties in the following amounts:

(A) An adult who engages in an act of unlawful sexual intercourse with a minor less than two years younger than the adult is liable for a civil penalty not to exceed two thousand dollars (\$2,000).

(B) An adult who engages in an act of unlawful sexual intercourse with a minor at least two years younger than the adult is liable for a civil penalty not to exceed five thousand dollars (\$5,000).

(C) An adult who engages in an act of unlawful sexual intercourse with a minor at least three years younger than the adult is liable for a civil penalty not to exceed ten thousand dollars (\$10,000).

(D) An adult over the age of 21 years who engages in an act of unlawful sexual intercourse with a minor under 16 years of age is liable for a civil penalty not to exceed twenty-five thousand dollars (\$25,000).

(2) The district attorney may bring actions to recover civil penalties pursuant to this subdivision. From the amounts collected for each case, an amount equal to the costs of pursuing the action shall be deposited with the treasurer of the county in which the judgment was entered, and the remainder shall be deposited in the Underage Pregnancy Prevention Fund, which is hereby created in the State Treasury. Amounts deposited in the Underage Pregnancy Prevention Fund may be used only for the purpose of preventing underage pregnancy upon appropriation by the Legislature.

(3) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section with the proceeds of this fine to be used in accordance with Section 1463.23. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

PC §286.

(a) Sodomy is sexual conduct consisting of contact between the penis of one person and the anus of another person. Any sexual penetration, however slight, is sufficient to complete the crime of sodomy.

(b) (1) Except as provided in Section 288, any person who participates in an act of sodomy with another person who is under 18 years of age shall be punished by imprisonment in the state prison, or in a county jail for not more than one year.

(2) Except as provided in Section 288, any person over 21 years of age who participates in an act of sodomy with another person who is under 16 years of age shall be guilty of a felony.

(c) (1) Any person who participates in an act of sodomy with another person who is under 14 years of age and more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(2) (A) Any person who commits an act of sodomy when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of sodomy with another person who is under 14 years of age when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for 9, 11, or 13 years.

(C) Any person who commits an act of sodomy with another person who is a minor 14 years of age or older when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for 7, 9, or 11 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(3) Any person who commits an act of sodomy where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(d) (1) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person or where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for five, seven, or nine years.

(2) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy upon a victim who is under 14 years of age, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 10, 12, or 14 years.

(3) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of sodomy upon a victim who is a minor 14 years of age or older, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 7, 9, or 11 years.

(4) This subdivision does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(e) Any person who participates in an act of sodomy with any person of any age while confined in any state prison, as defined in Section 4504, or in any local detention facility, as defined in Section 6031.4, shall be punished by imprisonment in the state prison, or in a county jail for not more than one year.

(f) Any person who commits an act of sodomy, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act, shall be punished by imprisonment in the state prison for three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the sexual penetration served a professional purpose when it served no professional purpose.

(g) Except as provided in subdivision (h), a person who commits an act of sodomy, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison for three, six, or eight years. Notwithstanding the existence of a conservatorship pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving consent.

(h) Any person who commits an act of sodomy, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for not more than one year. Notwithstanding the existence of a conservatorship pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(i) Any person who commits an act of sodomy, where the victim is prevented from resisting by an intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for three, six, or eight years.

(j) Any person who commits an act of sodomy, where the victim submits under the belief that the person committing the act is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for three, six, or eight years.

(k) Any person who commits an act of sodomy, where the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(l) As used in subdivisions (c) and (d), "threatening to retaliate" means a threat to kidnap or falsely imprison, or inflict extreme pain, serious bodily injury, or death.

(m) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section, with the proceeds of this fine to be used in accordance with Section 1463.23. The court, however, shall take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

PC §287

(a) Oral copulation is the act of copulating the mouth of one person with the sexual organ or anus of another person.

(b) (1) Except as provided in Section 288, any person who participates in an act of oral copulation with another person who is under 18 years of age shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year.

(2) Except as provided in Section 288, any person over 21 years of age who participates in an act of oral copulation with another person who is under 16 years of age is guilty of a felony.

(c) (1) Any person who participates in an act of oral copulation with another person who is under 14 years of age and more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(2) (A) Any person who commits an act of oral copulation when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of oral copulation upon a person who is under 14 years of age, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(C) Any person who commits an act of oral copulation upon a minor who is 14 years of age or older, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 6, 8, or 10 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(3) Any person who commits an act of oral copulation where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(d) (1) Any person who, while voluntarily acting in concert with another person, either personally or by aiding and abetting that other person, commits an act of oral copulation (A) when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, or (B) where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, or (C) where the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison for five, seven, or nine years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime described under paragraph (3), that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(2) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of oral copulation upon a victim who is under 14 years of age, when the act is accomplished against the

victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 10, 12, or 14 years.

(3) Any person who, while voluntarily acting in concert with another person, either personally or aiding and abetting that other person, commits an act of oral copulation upon a victim who is a minor 14 years of age or older, when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(4) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(e) Any person who participates in an act of oral copulation while confined in any state prison, as defined in Section 4504 or in any local detention facility as defined in Section 6031.4, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year.

(f) Any person who commits an act of oral copulation, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act, shall be punished by imprisonment in the state prison for a period of three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the oral copulation served a professional purpose when it served no professional purpose.

(g) Except as provided in subdivision (h), any person who commits an act of oral copulation, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, shall be punished by imprisonment in the state prison, for three, six, or eight years. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving consent.

(h) Any person who commits an act of oral copulation, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act, and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(i) Any person who commits an act of oral copulation, where the victim is prevented from resisting by any intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(j) Any person who commits an act of oral copulation, where the victim submits under the belief that the person committing the act is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(k) Any person who commits an act of oral copulation, where the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(l) As used in subdivisions (c) and (d), "threatening to retaliate" means a threat to kidnap or falsely imprison, or to inflict extreme pain, serious bodily injury, or death.

(m) In addition to any punishment imposed under this section, the judge may assess a fine not to exceed seventy dollars (\$70) against any person who violates this section, with the proceeds of this fine to be used in accordance with Section 1463.23. The court shall, however, take into consideration the defendant's ability to pay, and no defendant shall be denied probation because of his or her inability to pay the fine permitted under this subdivision.

(Added by renumbering Section 288a by Stats. 2018, Ch. 423, Sec. 49. (SB 1494)
Effective January 1, 2019.)

PC §288

(a) Except as provided in subdivision (i), a person who willfully and lewdly commits any lewd or lascivious act, including any of the acts constituting other crimes provided for in Part 1, upon or with the body, or any part or member thereof, of a child who is under the age of 14 years, with the intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of that person or the child, is guilty of a felony and shall be punished by imprisonment in the state prison for three, six, or eight years.

(b) (1) A person who commits an act described in subdivision (a) by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, is guilty of a felony and shall be punished by imprisonment in the state prison for 5, 8, or 10 years.

(2) A person who is a caretaker and commits an act described in subdivision (a) upon a dependent person by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, with the intent described in subdivision (a), is guilty of a felony and shall be punished by imprisonment in the state prison for 5, 8, or 10 years.

(c) (1) A person who commits an act described in subdivision (a) with the intent described in that subdivision, and the victim is a child of 14 or 15 years, and that person is at least 10 years older than the child, is guilty of a public offense and shall be punished by imprisonment in the state prison for one, two, or three years, or by imprisonment in a county jail for not more than one year. In determining whether the person is at least 10 years older than the child, the difference in age shall be measured from the birth date of the person to the birth date of the child.

(2) A person who is a caretaker and commits an act described in subdivision (a) upon a dependent person, with the intent described in subdivision (a), is guilty of a public offense and shall be punished by imprisonment in the state prison for one, two, or three years, or by imprisonment in a county jail for not more than one year.

(d) In any arrest or prosecution under this section or Section 288.5, the peace officer, district attorney, and the court shall consider the needs of the child victim or dependent person and shall do whatever is necessary, within existing budgetary resources, and constitutionally permissible to prevent psychological harm to the child victim or to prevent psychological harm to the dependent person victim resulting from participation in the court process.

(e) (1) Upon the conviction of a person for a violation of subdivision (a) or (b), the court may, in addition to any other penalty or fine imposed, order the defendant to pay an

additional fine not to exceed ten thousand dollars (\$10,000). In setting the amount of the fine, the court shall consider any relevant factors, including, but not limited to, the seriousness and gravity of the offense, the circumstances of its commission, whether the defendant derived any economic gain as a result of the crime, and the extent to which the victim suffered economic losses as a result of the crime. Every fine imposed and collected under this section shall be deposited in the Victim-Witness Assistance Fund to be available for appropriation to fund child sexual exploitation and child sexual abuse victim counseling centers and prevention programs pursuant to Section 13837.

(2) If the court orders a fine imposed pursuant to this subdivision, the actual administrative cost of collecting that fine, not to exceed 2 percent of the total amount paid, may be paid into the general fund of the county treasury for the use and benefit of the county.

(f) For purposes of paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c), the following definitions apply:

(1) "Caretaker" means an owner, operator, administrator, employee, independent contractor, agent, or volunteer of any of the following public or private facilities when the facilities provide care for elder or dependent persons:

(A) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(B) Clinics.

(C) Home health agencies.

(D) Adult day health care centers.

(E) Secondary schools that serve dependent persons and postsecondary educational institutions that serve dependent persons or elders.

(F) Sheltered workshops.

(G) Camps.

(H) Community care facilities, as defined by Section 1402 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.

(I) Respite care facilities.

(J) Foster homes.

(K) Regional centers for persons with developmental disabilities.

(L) A home health agency licensed in accordance with Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(M) An agency that supplies in-home supportive services.

(N) Board and care facilities.

(O) Any other protective or public assistance agency that provides health services or social services to elder or dependent persons, including, but not limited to, in-home supportive services, as defined in Section 14005.14 of the Welfare and Institutions Code.

(P) Private residences.

(2) "Board and care facilities" means licensed or unlicensed facilities that provide assistance with one or more of the following activities:

(A) Bathing.

(B) Dressing.

(C) Grooming.

(D) Medication storage.

(E) Medical dispensation.

(F) Money management.

(3) "Dependent person" means a person, regardless of whether the person lives independently, who has a physical or mental impairment that substantially restricts his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have significantly diminished because of age. "Dependent person" includes a person who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

(g) Paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) apply to the owners, operators, administrators, employees, independent contractors, agents, or volunteers working at these public or private facilities and only to the extent that the individuals personally commit, conspire, aid, abet, or facilitate any act prohibited by paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c).

(h) Paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) do not apply to a caretaker who is a spouse of, or who is in an equivalent domestic relationship with, the dependent person under care.

(i) (1) A person convicted of a violation of subdivision (a) shall be imprisoned in the state prison for life with the possibility of parole if the defendant personally inflicted bodily harm upon the victim.

(2) The penalty provided in this subdivision shall only apply if the fact that the defendant personally inflicted bodily harm upon the victim is pled and proved.

(3) As used in this subdivision, "bodily harm" means any substantial physical injury resulting from the use of force that is more than the force necessary to commit the offense.

(Added by Stats. 2006, Ch. 337, Sec. 9. Effective September 20, 2006.)

PC §289

(a) (1) (A) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person shall be punished by imprisonment in the state prison for three, six, or eight years.

(B) Any person who commits an act of sexual penetration upon a child who is under 14 years of age, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 8, 10, or 12 years.

(C) Any person who commits an act of sexual penetration upon a minor who is 14 years of age or older, when the act is accomplished against the victim's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person, shall be punished by imprisonment in the state prison for 6, 8, or 10 years.

(D) This paragraph does not preclude prosecution under Section 269, Section 288.7, or any other provision of law.

(2) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, shall be punished by imprisonment in the state prison for three, six, or eight years.

(b) Except as provided in subdivision (c), any person who commits an act of sexual penetration, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act or causing the act to be committed, shall be punished by imprisonment in the state prison for three, six, or eight

years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(c) Any person who commits an act of sexual penetration, and the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act or causing the act to be committed and both the defendant and the victim are at the time confined in a state hospital for the care and treatment of the mentally disordered or in any other public or private facility for the care and treatment of the mentally disordered approved by a county mental health director, shall be punished by imprisonment in the state prison, or in a county jail for a period of not more than one year. Notwithstanding the existence of a conservatorship pursuant to the provisions of the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime, that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent.

(d) Any person who commits an act of sexual penetration, and the victim is at the time unconscious of the nature of the act and this is known to the person committing the act or causing the act to be committed, shall be punished by imprisonment in the state prison for three, six, or eight years. As used in this subdivision, "unconscious of the nature of the act" means incapable of resisting because the victim meets one of the following conditions:

(1) Was unconscious or asleep.

(2) Was not aware, knowing, perceiving, or cognizant that the act occurred.

(3) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraud in fact.

(4) Was not aware, knowing, perceiving, or cognizant of the essential characteristics of the act due to the perpetrator's fraudulent representation that the sexual penetration served a professional purpose when it served no professional purpose.

(e) Any person who commits an act of sexual penetration when the victim is prevented from resisting by any intoxicating or anesthetic substance, or any controlled substance, and this condition was known, or reasonably should have been known by the accused, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(f) Any person who commits an act of sexual penetration when the victim submits under the belief that the person committing the act or causing the act to be committed is someone known to the victim other than the accused, and this belief is induced by any artifice, pretense, or concealment practiced by the accused, with intent to induce the belief, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

(g) Any person who commits an act of sexual penetration when the act is accomplished against the victim's will by threatening to use the authority of a public official to incarcerate, arrest, or deport the victim or another, and the victim has a reasonable belief that the perpetrator is a public official, shall be punished by imprisonment in the state prison for a period of three, six, or eight years.

As used in this subdivision, "public official" means a person employed by a governmental agency who has the authority, as part of that position, to incarcerate, arrest, or deport another. The perpetrator does not actually have to be a public official.

(h) Except as provided in Section 288, any person who participates in an act of sexual penetration with another person who is under 18 years of age shall be punished by imprisonment in the state prison or in a county jail for a period of not more than one year.

(i) Except as provided in Section 288, any person over 21 years of age who participates in an act of sexual penetration with another person who is under 16 years of age shall be guilty of a felony.

(j) Any person who participates in an act of sexual penetration with another person who is under 14 years of age and who is more than 10 years younger than he or she shall be punished by imprisonment in the state prison for three, six, or eight years.

(k) As used in this section:

(1) "Sexual penetration" is the act of causing the penetration, however slight, of the genital or anal opening of any person or causing another person to so penetrate the defendant's or another person's genital or anal opening for the purpose of sexual arousal, gratification, or abuse by any foreign object, substance, instrument, or device, or by any unknown object.

(2) "Foreign object, substance, instrument, or device" shall include any part of the body, except a sexual organ.

(3) "Unknown object" shall include any foreign object, substance, instrument, or device, or any part of the body, including a penis, when it is not known whether penetration was by a penis or by a foreign object, substance, instrument, or device, or by any other part of the body.

(l) As used in subdivision (a), “threatening to retaliate” means a threat to kidnap or falsely imprison, or inflict extreme pain, serious bodily injury or death.

(m) As used in this section, “victim” includes any person who the defendant causes to penetrate the genital or anal opening of the defendant or another person or whose genital or anal opening is caused to be penetrated by the defendant or another person and who otherwise qualifies as a victim under the requirements of this section.

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Reporting Consensual Activity Between Minors:

The Confusion Unraveled

CATHERINE ATKINS, STAFF ATTORNEY
(Revised May 2013)

Time and time again, there seems to be much confusion with regard to whether an MFT must, or is even permitted to, report consensual sexual activity involving minors. The information below applies only to consensual sexual activity-not incest, date rape or any situation in which the minor did not fully consent to the sexual activity. Involuntary sexual activity involving minors, and incest involving a minor (even when voluntary), is always a mandatory report.

Below is a chart which identifies the various ages of children and consensual sexual activity at issue¹:

| "Child" refers to the person that the mandated child abuse reporter is involved with. | Definitions and Comments | Mandatory Report | Not Mandatory Report |
|---|--------------------------|------------------|----------------------|
|---|--------------------------|------------------|----------------------|

A. Child younger than 14 years old

| | | | |
|--|--|---|---|
| 1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary & consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship. | See, <i>Planned Parenthood Affiliates of California v. John K. Van De Kamp</i> (1986) 181 Cal. App. 3d 245 (1986); See also, <i>In re Jerry M.</i> 59 Cal. App. 4th 289. | | X |
| 2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship. | | X | |

| <i>"Child" refers to the person that the mandated child abuse reporter is involved with.</i> | Definitions and Comments | Mandatory Report | Not Mandatory Report |
|--|--|-------------------------|-----------------------------|
| 3. Partner is 14 years or older. | | X | |
| 4. Lewd & Lascivious acts committed by a partner of any age. | The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or sexual desires of the perpetrator or the child". This behavior is generally of an exploitative nature; for instance, "flashing" a minor-exposing one's genitals to a minor. | X | |
| 5. Partner is alleged spouse and over 14 years of age. | The appropriate authority will determine the legality of the marriage. | X | |

B. Child 14 or 15 years old

| | | | |
|--|--|---|---|
| 1. Partner is less than 14 | | X | |
| 2. Unlawful Sexual Intercourse with a partner older than 14 and less than 21 years of age & there is no indication of abuse or evidence of an exploitive relationship. | | | X |
| 3. Unlawful Sexual Intercourse with a partner older than 21 years of age. | | X | |

| <i>"Child" refers to the person that the mandated child abuse reporter is involved with.</i> | Definitions and Comments | Mandatory Report | Not Mandatory Report |
|--|--|-------------------------|-----------------------------|
| 4. Lewd & Lascivious acts committed by a partner more than 10 years older than the child. | The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or gratifying the lust, passions, or sexual desires of the perpetrator or the child". This behavior is generally of an exploitative nature; for instance, 'flashing' a minor-exposing one's genitals to a minor. | X | |
| 5. Partner is alleged spouse and over 21 years of age. | The appropriate authority will determine the legality of the marriage. | X | |

C. Child 16 or 17 years old

| | | | |
|---|--|---|---|
| 1. Partner is less than 14 | | X | |
| 2. Unlawful Sexual Intercourse with a partner older than 14 & there is no indication of an exploitive relationship. | | | X |
| 3. Unlawful Sexual Intercourse with a partner older than 14 & there is evidence of an exploitive relationship. | | X | |
| 4. Partner is alleged spouse and there is evidence of an exploitive relationship. | The appropriate authority will determine the legality of the marriage. | X | |

D. Oral Copulation and Sodomy of Child under the age of 18

Historically most county agencies and professional associations stated that under Penal Code section 11165.1, all sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age, was a mandatory report.

However, on April 11, 2013, the Board of Behavioral Sciences (BBS) released an evaluation of the Child Abuse and Neglect Reporting Act (CANRA), specifically answering the question: "Did Penal Code 11165.1 require practitioners to report all conduct by minors that fall under the definition of sodomy and oral copulation?"

Counsel to the BBS stated, in summary, that court interpretations throughout the years confirmed that minors can lawfully engage in consensual sex with other minors *of like age*, without the necessity of a mandatory report. Counsel further stated that while the cases cited in her analysis did not directly discuss oral copulation and sodomy between minors, the same reasoning applied and as such, practitioners were not required to report all conduct by minors that fell under the definition of sodomy and oral copulation.

So what does this mean? When a provider learns of consensual, non-abusive sexual activity between two minors, the provider would:

1. Utilize the chart above to determine if the ages are "of like ages."
2. If there is a mandatory report, based on the ages above, for intercourse, certainly there would be a mandatory report for oral copulation or sodomy.
3. However, if there is no mandatory report, based on the ages above, according to the BBS, there would be no mandatory report necessary in the case of oral copulation or sodomy either.
4. Forced, coerced, and/or non-consensual sexual activity is always a mandatory report.

NOTE: It is important to note that the recent BBS evaluation is the BBS' interpretation of law. While the BBS evaluation would be a good evidentiary resource in defense of a provider who is challenged in court for not making a mandatory report for consensual oral copulation or sodomy, the laws regarding mandatory reporting have not changed. Since state law regarding reporting of consensual oral copulation and sodomy has not changed and this exact issue has not been examined by the courts, the conservative approach, in order to gain immunity from suit under CANRA, would be to continue to report those types of consensual acts between minors.

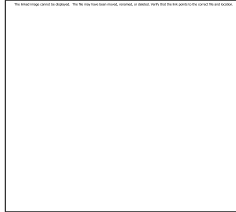
This information is intended to provide guidelines for addressing difficult legal dilemmas. It is not intended to address every situation that could potentially arise, nor is it intended to be a substitute for independent legal advice or consultation. When using such information as a guide, be aware that laws, regulations and technical standards change over time, and thus one should verify and update any references or information contained herein. ☞

REFERENCES

- 1 This chart was adapted from the Child Abuse Council of Santa Clara County found at www.cacsc.org.



Catherine L. Atkins, JD, is a Staff Attorney and the Deputy Executive Director at CAMFT. Cathy is available to answer members' questions regarding legal, ethical, and licensure issues.



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Child Abuse Reporting Guidelines for Sexual Activity Between and with Minors

Santa Clara County Child Abuse Council

This is a guide for mandated reporters and the information contained in this document is designed to assist those mandated by California Child Abuse Reporting Laws to determine their reporting responsibilities. It is not intended to be and should not be considered legal advice. In the event there are questions regarding reporting responsibilities in a specific case, the advice of legal counsel should be sought. This guide incorporates changes in the Child Abuse Reporting Law, effective January, 1998. For more detailed information refer to Penal Code Section 11164 & 11165.1 et al.

I. INVOLUNTARY SEXUAL ACTIVITY is always reportable.

II. INCEST, even if voluntary is always reportable. Incest is a marriage or act of intercourse between parents and children; ancestors and descendants of every degree; brothers and sisters of half and whole blood and uncles and nieces or aunts and nephews. (Family Code, § 2200.)

III. VOLUNTARY SEXUAL ACTIVITY may or may not be reportable. Even if the behavior is voluntary, there are circumstances where the behavior is abusive, either by Penal Code definition or because of an exploitive relationship and this behavior must be reported. Review **either** section A, B or C **and** section D. In addition, if there is reasonable suspicion of sexual abuse prior to the consensual activity, the abuse must be reported.

| "Child" refers to the person that the mandated child abuse reporter is involved with. | Definitions and Comments | Mandatory Report | Not Mandatory Report |
|--|--|------------------|----------------------|
| A. Child younger than 14 years old | | | |
| 1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary & | See, <i>Planned Parenthood Affiliates of California v. John K. Van De Kamp</i> (1986) 181 Cal. App. 3d 245 | | X |

| | | | |
|--|--|---|---|
| consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship. | (1986) & <i>In re Jerry M.</i> 59 Cal. App. 4th 289 | | |
| 2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship. | | X | |
| 3. Partner is 14 years or older. | | X | |
| 4. Lewd & Lascivious acts committed by a partner of any age. | The perpetrator has the intent of "Arousing, appealing to or gratifying the lust, passions, or sexual desires of the perpetrator or the child".? | X | |
| 5. Partner is alleged spouse and over 14 years of age. | The appropriate authority will determine the legality of the marriage. | X | |
| B. Child 14 or 15 years old | | | |
| 1. Partner is less than 14 | | X | |
| 2. Unlawful Sexual Intercourse with a partner older than 14 and less than 21 years of age & there is no indication of abuse or evidence of an exploitive relationship. | | | X |
| 3. Unlawful Sexual Intercourse with a partner older than 21 years of age. | | X | |
| 4. Lewd & Lascivious acts | The perpetrator has the | X | |

| | | | |
|--|---|---|---|
| committed by a partner more than 10 years older than the child. | intent of "Arousing, appealing to or gratifying the lust, passions, or gratifying the lust, passions, or sexual desires of the perpetrator or the child". | | |
| 5. Partner is alleged spouse and over 21 years of age. | The appropriate authority will determine the legality of the marriage. | X | |
| C. Child 16 or 17 years old | | | |
| 1. Partner is less than 14 | | X | |
| 2. Unlawful Sexual Intercourse with a partner older than 14 & there is no indication of an exploitive relationship. | | | X |
| 3. Unlawful Sexual Intercourse with a partner older than 14 & there is evidence of an exploitive relationship. | | X | |
| 4. Partner is alleged spouse and there is evidence of an exploitive relationship. | The appropriate authority will determine the legality of the marriage. | X | |
| D. Child under the age of 18 | | | |
| 1. Sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age. | | X | |

Mandated reports of sexual activity must be reported to either The Department of Family & Children's Services (DFCS) or to the appropriate police jurisdiction. This information will then be cross-reported to the other agency. Reporting does not necessarily mean that a civil or criminal proceeding will be initiated against the suspected abuser.

Failure to report known or reasonable suspicion of child abuse, including sexual abuse, is a misdemeanor. Mandated reporters are provided immunity from civil or criminal liability as a result of making a mandated report of child abuse.

Child Abuse Council, Interagency Collaboration Committee (3/12/98). Reviewed February 2008..
Adapted from Orange County Reporting Guidelines

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MANDATED REPORTERS: WHEN MUST YOU REPORT *CONSENSUAL* SEXUAL ACTIVITY INVOLVING MINORS?

The question of whether the Child Abuse and Neglect Reporting Act (CANRA) (Penal Code §§ 11165 - 11174) requires designated professionals to report consensual sexual activity involving minors remains a “hopelessly blurred” area of the law. On the one hand, *Planned Parenthood v. Van de Kamp* (1986) 181 Cal.App.3d 245 holds that laws which require the reporting of voluntary, nonabusive sexual behavior between minors of a similar age violate a minor’s right to sexual privacy. On the other hand, *People v. Stockton Pregnancy Control Medical Clinic, Inc.* (1988) 203 Cal.App.3d 225, as well as legislative changes in 1997, affirm that certain types of sexual conduct involving minors still must be reported even if consensual. (See AB 327, Stats. 1997, c. 83.) The following guidelines are designed to synthesize conflicting legal authority and provide mandated reporters with reasonable guidance.

- ☞ **Both children are under age 14? No report is required** unless there is disparate age, intimidation, coercion, exploitation or bribery.

- ☞ **One child is under age 14, the other child is age 14 - 17? Yes, a report is required.** Penal Code sections 11165.1(a) and 288(a) afford special protection to children under age 14.

- ☞ **Both children are ages 14 - 17? No report is required**, unless the sexual activity involves incest (see Penal Code § 285, Family Code 2200) or there is evidence of abuse or an exploitative relationship.

- ☞ **The child is age 14 - 17, the other person 18 or older? No report is required**, unless the sexual activity involves one of the following: 1. Incest (see Penal Code § 285, Family Code 2200); 2. Unlawful Sexual Intercourse (also known as “Statutory Rape”) involving a person over age 21 with a child age 14 or 15 (see Penal Code § 261.5(d)); and 3. Lewd and Lascivious Acts involving a child age 14 or 15 and a person who is at least ten years older than the child (see Penal Code § 288(c)(1)).

While consensual sexual intercourse between a child (a person under age 18) and an adult (a person age 18 or older) is still a crime and thus subject to prosecution, California law only requires that it be reported if the child is under age 16 and the adult is over age 21. (See Penal Code § 261.5(a).)

Note: Sodomy (Penal Code § 286); Oral Copulation (Penal Code § 288a) and Penetration by Foreign Object (Penal Code § 289) (which includes a penetration by a finger) are still listed as reportable offenses under Penal Code § 11165.1, but recent cases such as *People v. Hofsheier* (2006) 37 Cal. 4th 1185 and *Lawrence v. Texas* (2003) 539 U.S. 558 cast doubt on the constitutionality of treating these types of consensual sexual activity different from sexual intercourse.

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Introduced by Assembly Member Cristina Garcia

February 21, 2019

An act to amend Section 11165.1 of the Penal Code, relating to crimes.

legislative counsel's digest

AB 1145, as introduced, Cristina Garcia. Child abuse: reportable conduct.

The Child Abuse and Neglect Reporting Act requires a mandated reporter, as defined, to make a report to a specified agency whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. Existing law provides that “child abuse or neglect” for these purposes includes “sexual assault,” that includes, among other things, the crimes of sodomy, oral copulation, and sexual penetration.

This bill would provide that “sexual assault” for these purposes does not include voluntary sodomy, oral copulation, or sexual penetration, if there are no indicators of abuse, unless that conduct is between a person who is 21 years of age or older and a minor who is under 16 years of age.

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

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

1 SECTION 1. Section 11165.1 of the Penal Code is amended
2 to read:

3 11165.1. As used in this article, “sexual abuse” means sexual
4 assault or sexual exploitation as defined by the following:

5 (a) “Sexual assault” means conduct in violation of one or more
6 of the following sections: Section 261 (rape), subdivision (d) of
7 Section 261.5 (statutory rape), Section 264.1 (rape in concert),
8 Section 285 (incest), Section 286 (sodomy), Section 287 or former
9 Section 288a (oral copulation), subdivision (a) or ~~(b)~~, (b) of, or
10 paragraph (1) of subdivision (c) ~~of~~ of, Section 288 (lewd or
11 lascivious acts upon a child), Section 289 (sexual penetration), or
12 Section 647.6 (child molestation). *“Sexual assault” for the*
13 *purposes of this article does not include voluntary conduct in*
14 *violation of Section 286, 287, or 289, or former Section 288a, if*
15 *there are no indicators of abuse, unless the conduct is between a*
16 *person 21 years of age or older and a minor who is under 16 years*
17 *of age.*

18 (b) Conduct described as “sexual assault” includes, but is not
19 limited to, all of the following:

20 (1) Penetration, however slight, of the vagina or anal opening
21 of one person by the penis of another person, whether or not there
22 is the emission of semen.

23 (2) Sexual contact between the genitals or anal opening of one
24 person and the mouth or tongue of another person.

25 (3) Intrusion by one person into the genitals or anal opening of
26 another person, including the use of an object for this purpose,
27 except that, it does not include acts performed for a valid medical
28 purpose.

29 (4) The intentional touching of the genitals or intimate parts,
30 including the breasts, genital area, groin, inner thighs, and buttocks,
31 or the clothing covering them, of a child, or of the perpetrator by
32 a child, for purposes of sexual arousal or gratification, except that
33 it does not include acts which may reasonably be construed to be
34 normal caretaker responsibilities; interactions with, or
35 demonstrations of affection for, the child; or acts performed for a
36 valid medical purpose.

37 (5) The intentional masturbation of the perpetrator’s genitals in
38 the presence of a child.

1 (c) “Sexual exploitation” refers to any of the following:

2 (1) Conduct involving matter depicting a minor engaged in
3 obscene acts in violation of Section 311.2 (preparing, selling, or
4 distributing obscene matter) or subdivision (a) of Section 311.4
5 (employment of minor to perform obscene acts).

6 (2) A person who knowingly promotes, aids, or assists, employs,
7 uses, persuades, induces, or coerces a child, or a person responsible
8 for a child’s welfare, who knowingly permits or encourages a child
9 to engage in, or assist others to engage in, prostitution or a live
10 performance involving obscene sexual conduct, or to either pose
11 or model alone or with others for purposes of preparing a film,
12 photograph, negative, slide, drawing, painting, or other pictorial
13 depiction, involving obscene sexual conduct. For the purpose of
14 this section, “person responsible for a child’s welfare” means a
15 parent, guardian, foster parent, or a licensed administrator or
16 employee of a public or private residential home, residential school,
17 or other residential institution.

18 (3) A person who depicts a child in, or who knowingly develops,
19 duplicates, prints, downloads, streams, accesses through any
20 electronic or digital media, or exchanges, a film, photograph,
21 videotape, video recording, negative, or slide in which a child is
22 engaged in an act of obscene sexual conduct, except for those
23 activities by law enforcement and prosecution agencies and other
24 persons described in subdivisions (c) and (e) of Section 311.3.

25 (d) “Commercial sexual exploitation” refers to either of the
26 following:

27 (1) The sexual trafficking of a child, as described in subdivision
28 (c) of Section 236.1.

29 (2) The provision of food, shelter, or payment to a child in
30 exchange for the performance of any sexual act described in this
31 section or subdivision (c) of Section 236.1.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 1540

VERSION: AMENDED APRIL 25, 2019

AUTHOR: HOLDEN

SPONSOR: CERTIFICATION BOARD FOR MUSIC THERAPISTS

RECOMMENDED POSITION: NEUTRAL

SUBJECT: MUSIC THERAPY

Overview:

This bill seeks to define music therapy in statute and to provide guidance to consumers and agencies regarding the education and training requirements of a qualified music therapist.

Existing Law:

- 1) Defines unfair competition as any unlawful, unfair, or fraudulent business act or practice and any unfair, deceptive, untrue, or misleading advertising. (BPC §17200)
- 2) Several state agencies define music therapy in their regulations.
 - The California Department of Education was the most recent agency to do this, adopting a definition for music therapy as it relates to special education in July 2014. It utilizes the Certification Board for Music Therapists (CBMT) definition and recognizes their certification credential. (5 CCR (California Code of Regulations) §3051.21)
 - The CCR also defines music therapy under its regulations on Licensing and Certification of Health Facilities, when discussing skilled nursing facilities, immediate care facilities, adult day health centers, and general acute care hospitals. (22 CCR §§ 70055, 72069, 73065, 76105, 78065)
 - The Department of Mental Health regulations include a definition when discussing mental health rehabilitation centers. (9 CCR §782.36)
 - The Public Health title of the CCR defines music therapy when describing vender number codes. (17 CCR 54342)

There is some variance in the definitions of music therapy across these regulations, and some have obsolete references to credentialing agencies that no longer exist.

This Bill:

- 1) Establishes the Music Therapy Act. (BPC Chapter 10.7, §§ 4650-4656)
- 2) States that it is the intent of the Legislature to provide a statutory definition of music therapy and to enable consumers and agencies to more easily identify qualified music therapists. (BPC §4652)
- 3) Defines “music therapy” as the clinical and evidence-based use of music therapy interventions in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational settings to address physical, emotional, cognitive, and social needs of individuals within a therapeutic relationship. (BPC §4653)
- 4) Includes the following in the scope of music therapy (BPC §4653):
 - a) Development of music therapy treatment plans specific to the needs and strengths of the client, who may be seen individually or in groups; and
 - b) Establishment of goals, objectives, and potential strategies of music therapy services appropriate for the client and setting.
- 5) Defines music therapy interventions as including the following: music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. (BPC §4653)
- 6) Prohibits referring to oneself as a “Board Certified Music Therapist” unless the person has completed all of the following (BPC §4654):
 - a) Has a bachelor’s degree, equivalent, or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA) using current standards, beginning with those adopted on April 1, 2015.
 - b) Completes at least 1,200 hours of supervised clinical work through pre-internship training at an approved degree program and internship training through an approved national roster or university-affiliated internship program or equivalent.
 - c) Completes the current certification requirements (beginning with those adopted on April 1, 2015) established by the Certification Board for Music Therapists for the “Music Therapist – Board Certified” credential.
- 7) States that this act does not authorize someone engaging in music therapy to state or imply that they provide mental health counseling, psychotherapy, or occupational

therapy. Also states that the use of music does not imply or suggest that a person is a Board-Certified Music Therapist. (BPC §4655)

- 8) States that it is an unfair business practice for a person to use the title “Board Certified Music Therapist” unless they actually are certified. (BPC §4656)
- 9) States that the bill shall not be construed to require a music therapist currently employed by the State of California to obtain certification as a Board-Certified Music Therapist. (BCP §4657)

Comments:

- 1) **Author’s Intent.** The author is seeking to create a uniform definition for music therapy in statute to ensure continuity and uniformity of service. They note that several agencies have established definitions of music therapy in regulation. However, the definitions are inconsistent and sometimes refer to obsolete entities. The goal of this bill is to protect consumers from harm and misrepresentation from practitioners who are not board-certified music therapists and who are not practicing under the Certified Board for Music Therapists’ Code of Professional Practice.
- 2) **Existing Certification Process.** Two organizations are jointly involved in the certification process for music therapists. They are the American Music Therapy Association and the Certification Board for Music Therapists.

American Music Therapy Association (AMTA): The AMTA approves music therapy college and university programs. Once a bachelor’s degree or higher is completed from an approved program and the 1,200 hours of clinical training requirements are met, an applicant is eligible to take the national board certification exam.

Certification Board for Music Therapists (CBMT): This agency is fully accredited and certifies music therapists to practice nationally. It offers a credential title of Music Therapist – Board Certified (MT-BC). It states its purpose is to provide an objective national standard that can be used as a measure of professionalism.

The CBMT administers its own board certification examination. Once passed, the certification is valid for five years. To recertify after this time, the exam must either be passed again, or continuing education must be completed. The certification board has a code of professional practice that all its certified music therapists must follow, and it includes disciplinary measures.

- 3) **Scope of Practice.** The AMTA and the CBMT have jointly developed a definition of the scope of music therapy practice. This document, “Scope of Music Therapy Practice (2015)” can be found in **Attachment A**.

The document defines music therapy practice as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages

and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. It states that music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas.

- 4) Single Specialty Recognition.** Music therapy is one of several sub-types of specialty therapies. Many of these specialty therapies have an independent certification board that will issue a certification or credential if specified requirements are met. Examples of other specialties are dance and movement therapy (certified by the Dance/Movement Therapy Certification Board), and art therapy (certified by the Art Therapy Credentials Board).
- 5) Effect on Board Licensees.** This bill contains language stating that the use of music therapy is not restricted to any profession. This would permit Board licensees who use music therapy to continue doing so, as long as they do not state that they are a Board-Certified Music Therapist (unless they actually do hold that certification).

The bill also protects the Board's practice acts by stating that a person engaging in music therapy cannot state or imply that they practice mental health counseling or psychotherapy if they don't have a license.

- 6) Previous Legislation.** AB 1279 (Holden, 2015) was very similar to this bill. The Board had decided to be neutral on that bill.

AB 1279 was vetoed by Governor Jerry Brown, who stated the following in his veto message:

"I am returning Assembly Bill 1279 without my signature. This bill establishes the "Music Therapy Act" and regulates when a person may use the title of "Board Certified Music Therapist." Generally, I have been very reluctant to add licensing or title statutes to the laws of California. This bill appears to be unnecessary as the Certification Board for Music Therapists, a private sector group, already has defined standards for board certification. Why have the state now add another violin to the orchestra?"

- 7) Recommended Position.** At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended a "neutral" position on this legislation.

A minor amendment was added since that time, to state that the bill does not require a music therapist currently employed by the State of California to obtain certification as a Board-Certified Music Therapist.

- 8) Support and Opposition.**

Support

- Certification Board for Music Therapists (Sponsor)

Oppose

- American Federation of State, County and Municipal Employees

9) History.

2019

| | |
|----------|--|
| 04/25/19 | Read third time and amended. Ordered to third reading. |
| 04/10/19 | Read second time. Ordered to third reading. |
| 04/09/19 | From committee: Do pass. (Ayes 20. Noes 0.) (April 9). |
| 03/14/19 | Referred to Com. on B. & P. |
| 02/25/19 | Read first time. |
| 02/23/19 | From printer. May be heard in committee March 25. |
| 02/22/19 | Introduced. To print. |

10) Attachments.

Attachment A: Scope of Music Therapy Practice, 2015 (American Music Therapy Association, Certification Board for Music Therapists)

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American Music Therapy Association
8455 Colesville Rd., Ste. 1000
Silver Spring, MD 20910
Tel. (301) 589-3300
Fax (301) 589-5175
www.musictherapy.org

Certification Board for Music Therapists
506 East Lancaster Avenue, Suite 102
Downingtown, PA 19335
800-765-CBMT (2268)
Fax (610) 269-9232
www.cbmt.org

Scope of Music Therapy Practice

2015

Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing functions without risk of harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

Assumptions

The scope of music therapy practice is based on the values of non-maleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.
- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

Music Therapy Practice

Music therapy means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;

- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

Potential for Harm

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).
- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

Definition of Governing Bodies

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

Education and Clinical Training Requirements

A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA-approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

Board Certification Requirements

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual. The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

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AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.

AMTA is a 501(c)3 non-profit organization and accepts contributions which support its mission. Contributions are tax deductible as allowed by law.

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ASSEMBLY BILL

No. 1540

Introduced by Assembly Member Holden

February 22, 2019

An act to add Chapter 10.7 (commencing with Section 4650) to Division 2 of the Business and Professions Code, relating to music therapy.

legislative counsel's digest

AB 1540, as amended, Holden. Music therapy.

Existing law provides for the licensure and regulation of various healing arts licensees by boards within the Department of Consumer Affairs.

Existing law defines “unfair competition” to mean and include any unlawful, unfair, or fraudulent business act or practice and unfair, deceptive, untrue, or misleading advertising. Under existing law, a person who engages in unfair competition is liable for a civil penalty not to exceed \$2,500 for each violation.

Existing law establishes the State Department of Public Health and sets forth its powers and duties over the regulation of health facilities and adult day health care centers, including, but not limited to, adopting regulations setting forth applicable staffing standards. Existing regulations of the department applicable to skilled nursing facilities define “music therapist” as a person who has a bachelor’s degree in music therapy and who is registered or eligible for registration by the National Association for Music Therapy, now known as the American Music Therapy Association.

This bill would prohibit a person who provides music therapy, as defined, from using the title of “Board Certified Music Therapist” unless the person has completed specified education and clinical training requirements. The bill would also establish that it is an unfair business practice for a person to use the title “Board Certified Music Therapist” if they do not meet those requirements. The bill would prohibit its provisions from being construed to authorize a person engaged in music therapy to state or imply that they provide mental health counseling, psychotherapy, or occupational therapy for which a license is required, as provided. *The bill would further prohibit its provisions from being construed to require a music therapist currently employed by the State of California to obtain certification as a Board Certified Music Therapist.*

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

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

1 SECTION 1. Chapter 10.7 (commencing with Section 4650)
2 is added to Division 2 of the Business and Professions Code, to
3 read:

4
5 **Chapter 10.7. Music Therapy**
6

7 4650. This chapter shall be known, and may be cited, as the
8 Music Therapy Act.

9 4651. The Legislature finds and declares the following:

10 (a) Existing national certification of music therapists requires
11 the therapist to have graduated with a bachelor’s degree or its
12 equivalent, or higher, from a music therapy degree program
13 approved by the American Music Therapy Association (AMTA),
14 successful completion of a minimum of 1,200 hours of supervised
15 clinical work through preinternship training at an approved degree
16 program, and internship training through approved national roster
17 or university affiliated internship programs, or an equivalent.

18 (b) Upon successful completion of the AMTA academic and
19 clinical training requirements or its international equivalent, an
20 individual is eligible to sit for the national board certification exam
21 administered by the Certification Board for Music Therapists

1 (CBMT), an independent, nonprofit corporation fully accredited
2 by the National Commission for Certifying Agencies.

3 (c) The CBMT grants the Music Therapist-Board Certified
4 (MT-BC) credential to music therapists who have demonstrated
5 the knowledge, skills, and abilities for competence in the current
6 practice of music therapy. The purpose of board certification in
7 music therapy is to provide an objective national standard that can
8 be used as a measure of professionalism and competence by
9 interested agencies, groups, and individuals.

10 (d) The MT-BC is awarded by the CBMT to an individual upon
11 successful completion of an academic and clinical training program
12 approved by the AMTA or an international equivalent and
13 successful completion of an objective written examination
14 demonstrating current competency in the profession of music
15 therapy. The CBMT administers this examination, which is based
16 on a nationwide music therapy practice analysis that is reviewed
17 and updated every five years to reflect current clinical practice.

18 (e) Once certified, a music therapist must adhere to the CBMT
19 Code of Professional Practice and recertify every five years through
20 either a program of continuing education or reexamination.

21 4652. It is the intent of the Legislature that this chapter do the
22 following:

23 (a) Provide a statutory definition of music therapy.

24 (b) Enable consumers and state and local agencies to more easily
25 identify qualified music therapists.

26 4653. As used in this chapter:

27 (a) “Music therapy” means the clinical and evidence-based use
28 of music therapy interventions in developmental, rehabilitative,
29 habilitative, medical, mental health, preventive, wellness care, or
30 educational settings to address physical, emotional, cognitive, and
31 social needs of individuals within a therapeutic relationship. Music
32 therapy includes the following:

33 (1) The development of music therapy treatment plans specific
34 to the needs and strengths of the client who may be seen
35 individually or in groups.

36 (2) Music therapy plans shall establish goals, objectives, and
37 potential strategies of the music therapy services appropriate for
38 the client and setting.

39 (b) “Music therapy interventions” include, but are not limited
40 to, music improvisation, receptive music listening, song writing,

1 lyric discussion, music and imagery, singing, music performance,
2 learning through music, music combined with other arts,
3 music-assisted relaxation, music-based patient education, electronic
4 music technology, adapted music intervention, and movement to
5 music.

6 4654. An individual who provides music therapy shall not refer
7 to oneself using the title of “Board Certified Music Therapist”
8 unless the individual has completed all of the following:

9 (a) ~~A bachelors~~ *bachelor’s* degree or its equivalent, or higher,
10 from a music therapy degree program approved by the American
11 Music Therapy Association using current standards, beginning
12 with those adopted on April 1, 2015.

13 (b) A minimum of 1,200 hours of supervised clinical work
14 through preinternship training at an approved degree program and
15 internship training through an approved national roster or university
16 affiliated internship program, or the equivalent.

17 (c) The current requirements for certification, beginning with
18 those adopted on April 1, 2015, established by the Certification
19 Board for Music Therapists for the Music Therapist-Board Certified
20 credential.

21 4655. This chapter shall not be construed to authorize a person
22 engaged in music therapy to state or imply that they provide mental
23 health counseling, psychotherapy, or occupational therapy for
24 which a license is required under this division. While the use of
25 music is not restricted to any profession, the use of music shall not
26 imply or suggest that the person is a Board Certified Music
27 Therapist, if they do not meet the criteria specified in Section 4654.

28 4656. It is an unfair business practice within the meaning of
29 Chapter 5 (commencing with Section 17200) of Part 2 of Division
30 7, for a person to use the title “Board Certified Music Therapist”
31 if they do not meet the requirements of Section 4654.

32 4657. *This chapter shall not be construed to require a music*
33 *therapist currently employed by the State of California to obtain*
34 *certification as a Board Certified Music Therapist.*

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 1651 **VERSION:** AMENDED MARCH 27, 2019

AUTHOR: MEDINA **SPONSOR:** CALIFORNIA ASSOCIATION OF
SCHOOL PSYCHOLOGISTS (CASP)

RECOMMENDED POSITION: SUPPORT IF AMENDED

SUBJECT: LICENSED EDUCATIONAL PSYCHOLOGISTS: SUPERVISION OF ASSOCIATES AND
TRAINEES

Summary:

This bill would allow applicants for licensure as a marriage and family therapist, professional clinical counselor, or clinical social worker to gain some supervised experience hours under a licensed educational psychologist (LEP).

Existing Law:

- 1) Requires individuals seeking licensure as a marriage and family therapist (LMFT), clinical social worker (LCSW), or professional clinical counselor (LPCC) to register with the Board as an associate and gain 3,000 hours of post-graduate supervised experience. (Business and Professions Code (BPC) §§4980.43, 4996.23, and 4999.46)
- 2) Sets various requirements for supervisors of this experience, including that they must be actively licensed in California as an LPCC, LMFT, LCSW, psychologist, or physician/surgeon certified in psychiatry by the American Board of Psychiatry and Neurology. (BPC §§4980.03(g), 4996.20, 4999.12(h))
- 3) Requires supervisors of associate marriage and family therapists (AMFTs) and associate professional clinical counselors (APCCs) who do not hold the same license as the associate's intended field of licensure to have sufficient experience, training, and education to competently practice in that field. (California Code of Regulations (CCR) Title 16, §§1821(b)(2), 1833.1(a)(2)) Requires associate clinical social workers (ASWs) to gain at least 1,700 of their required 3,000 hours of supervised experience under an LCSW. (BPC §4996.23(d)(1))
- 4) Requires individuals seeking licensure as an educational psychologist (LEP) to meet certain education and experience requirements, including obtaining a master's degree in psychology, school psychology, or equivalent field, 60 semester hours of postgraduate work in pupil personnel services, two years full time experience as a

credentialed school psychologist, an additional year of supervised experience, and passage of a licensing exam. (BPC §4989.20)

- 5) Defines the scope of practice for licensed educational psychologists, including providing psychological counseling for individuals, groups, and families. (BPC §4989.14(e))

This Bill:

- 1) Would permit the Board's educational psychologist (LEP) licensees to be supervisors of marriage and family therapist and professional clinical counselor associates and trainees, and associate clinical social workers, if they meet all of the Board's other requirements to supervise. (BPC §§4980.03, 4996.20, and 4999.12)
- 2) Limits hours that may be gained under supervision of an LEP to no more than 1,200 hours. (BPC §§4980.43, 4996.23, 4999.46)
- 3) Adds unprofessional conduct provisions into LEP statute related to supervision of unlicensed persons. (BPC §4989.54)

Comments:

- 1) **Intent** The sponsor (the California Association of School Psychologists (CASP)) states that a 2011 law change shifted the responsibility to provide special education students' mental health services from county mental health departments to school districts.

The mental health services that school districts provide to students with disabilities are called Educationally Related Mental Health Services (ERMHS). ERMHS can occur in both educational and clinical settings, and the purpose is to provide mental health support so that students can access their educational programs.

CASP notes that many school districts are employing BBS associates (AMFTs, ASWs, and APCCs) to provide ERMHS, and that the law requires ERMHS service providers to be supervised by someone with a pupil personnel services (PPS) credential. LEPs have a PPS credential and training in the educational system, but they are currently not permitted to supervise BBS associates. They point out that currently allowed supervisors of BBS associates, (LMFTs, LPCCs, LCSWs, psychologists, and psychiatrists) do not necessarily have a PPS credential or the specialized educational system experience that LEPs have.

- 2) **LEP Supervision Settings.** This bill would permit LEPs to supervise a BBS associate for up to 1,200 of the required experience hours.

The rationale for allowing LEPs to serve as supervisors is that they have qualifications to supervise in ERMHS settings that other types of supervisors are

unlikely to have. However, the bill does not limit LEP supervision to ERMHS settings. The Board may wish to discuss whether LEP supervision should be limited to ERMHS settings, and if the limit is applied, how to identify an ERMHS setting.

- 3) Previous Discussion.** CASP previously presented this bill proposal to the Policy and Advocacy Committee and the full Board. **Attachment A** shows CASP's summary of their previous presentation.

At one of the committee meetings, there was a question of whether allowing LEPs to supervise associates would affect California licensees' ability to seek licensure in another state. In response, staff surveyed several states to determine the impact. Those findings are shown in **Attachment B**.

- 4) Recommended Position.** At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended that the Board consider taking a "support if amended" position on this bill. It recommended that the bill be amended to limit LEP supervision of associates to ERMHS services only.

Staff has been in ongoing communication with the sponsors, and they are working on language to make this amendment.

- 5) Support and Opposition.**

Support

California Association of School Psychologists (Sponsor)

Oppose

None at this time.

- 6) History.**

2019

04/24/19 From committee: Do pass. To Consent Calendar. (Ayes 18. Noes 0.) (April 24).

04/02/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 19. Noes 0.) (April 2). Re-referred to Com. on APPR.

03/28/19 Re-referred to Com. on B. & P.

03/27/19 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.

03/18/19 Referred to Com. on B. & P.

02/25/19 Read first time.

02/23/19 From printer. May be heard in committee March 25.

02/22/19 Introduced. To print.

- 7) Attachments.**

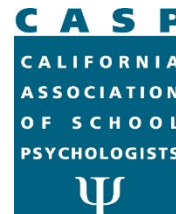
Attachment A: CASP Presentation Summary: LEPs as BBS Supervisors

Attachment B: BBS Staff Research: LEP Supervision – Affect on License Portability to Other States

Attachment C: Support Letter from Dr. Julia ‘Judy’ Johnson, LEP, ABSNP, dated April 2, 2019

Attachment D: LEP Scope of Practice

ATTACHMENT A



LEPs as BBS Supervisors

Summary Information

Presentation Committee

Christopher C. Jones, CAGS, LEP Wendell Callahan, PhD, LEP
Kristin Makena, MA, LEP Jenny Ponzuric, MA, LEP

1. The purpose of this presentation is to request the support of the BBS in the California Association of School Psychologists (CASPP) efforts to make changes to the regulations regarding supervision.
2. The proposed changes to the supervision regulations would allow LEPs to supervise BBS Associates who are providing educationally related mental health services in educational and clinical settings.
3. Current BBS regulations do not allow the supervision of BBS Associates by LEPs.
4. AB114 changed the provision of mental health services for students in special education from the Department of Mental Health to Local Education Agencies (school districts).
5. These services are called Educationally Related Mental Health Services or ERMHS, and occur in both educational and clinical settings (within the scope of practice of LEPs).
6. The purpose of ERMHS is to provide mental health support so students can access their educational programs, which requires an intimate knowledge of disabilities, special education, and the impact in the classroom.
7. Many school districts use BBS Associates to provide ERMHS.
8. Education Code requires that ERMHS service providers have a Pupil Personnel Services credential or alternative training/licensure that would allow them to deliver these services.
9. Education Code requires ERMHS service providers be supervised by someone with a PPS or Administrative credential.
10. LEPs are the most qualified and logical choice for this position because of their training in mental health and education.
11. Many school districts hire other BBS licensees to manage ERMHS programs because they can provide the BBS required supervision to BBS Associates.
12. Many BBS licensees do not have PPS credentials or experience with special education or the educational system.
13. Licensees and Associates in schools and other settings that provide ERMHS exposes them to the most comprehensive and relevant information available and will train them to be successful professionals in a manner that cannot happen without having expertise in both education and mental health.

Education and Training of School Psychologists and LEPs

All LEPs are or were school psychologists. Most LEPs keep their PPS credentials current.

Requirements for school psychology programs:

1. A minimum of three years of full-time graduate study (or the equivalent) beyond the bachelor's degree.
2. Programs require anywhere between 450-600 hours of pre-practicum fieldwork during the first two years of graduate study.
3. 1,200 clock hours of supervised practice, 600 of which must be in a school setting.
4. A Master's Degree and Specialist Degree, or a PhD, and a Pupil Personnel Services credential to practice school psychology.

LEP Requirements:

1. 2 years of full time experience as a credentialed school psychologist working in schools
2. 1 year of graduate level internship or 1 year as a school psychologist working under the direction of an LEP
3. To be eligible for the LEP, candidates have completed a minimum of 3600 hours of work

Job description of school psychologists and LEPs:

1. A school psychologist is a credentialed professional whose primary objective is the application of scientific principles of learning and behavior (social-emotional functioning) to ameliorate school-related problems and to facilitate the learning and development of children in the public schools.
 - a. Consultation with school administrators concerning appropriate learning objectives for children, planning of developmental and remedial programs for pupils in regular and special school programs, and the development of educational experimentation and evaluation.
 - b. Consultation with teachers (school staff) in the development and implementation of classroom methods and procedures designed to facilitate pupil learning and to overcome learning and behavior disorders (challenges).
 - c. Consultation with parents (and caregivers) to assist in understanding the learning and adjustment processes of children.
 - d. Consultation with community agencies, such as probation departments, mental health clinics, and welfare departments, concerning pupils who are being served by such community agencies.
 - e. Consultation and supervision of pupil personnel services workers.
 - f. Psychoeducational assessment and diagnosis of specific learning and behavioral disabilities, including, but not limited to, case study evaluation, recommendations for remediation or placement, and periodic reevaluation of such children.
 - g. Psychological counseling of, and other therapeutic techniques with, children and parents, including parent education.
2. A Licensed Educational Psychologist (LEP) is a mental health professional licensed by the Board of Behavioral Sciences to provide services within the scope of practices set forth by the Board in a clinical or educational setting. All LEPs are or were School Psychologists.
 - a. Educational evaluation.
 - b. Diagnosis of psychological disorders related to academic learning processes.
 - c. Administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.
 - d. Interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.
 - e. Providing psychological counseling for individuals, groups, and families.
 - f. Consultation with other educators and parents on issues of social development and behavioral and academic difficulties.
 - g. Conducting psychoeducational assessments for the purposes of identifying special needs
 - h. Developing treatment programs and strategies to address problems of adjustment.
 - i. Coordinating intervention strategies for management of individual crises.

ATTACHMENT B
BBS Staff Research: LEP Supervision – Affect on License Portability to Other States

Florida

This state has two methods to apply for licensure: by examination, or by endorsement.

For those applying for licensure by endorsement, allowing LEP supervision of associates is not expected to be an issue. These individuals must be licensed in their state for 3 of the past 5 years in good standing. The State of Florida will verify that the applicant has been independently licensed in the same profession, and that the license is current.

According to Florida staff, allowing LEP supervision may be problematic for those applying for licensure by examination. A review of Florida's licensing laws appears to support this. LCSW, LMFT, and licensed mental health counselor applicants in Florida must be supervised by someone of the same license type "or the equivalent who is a qualified supervisor as determined by the board." A regulation specifying who is a qualified supervisor appears to consider LCSWs, LMFTs, mental health counselors, and psychologists (for mental health counselors only) with certain education and experience to be equivalent qualified supervisors.

Texas

Board staff was unable to reach anyone representing the state licensing boards in Texas. A review of their regulations revealed the following:

- For marriage and family therapists, the Texas Administrative Code states the following:
 - *"If an applicant has been licensed as a marriage and family therapist in a United States jurisdiction for the 5 years immediately preceding the application, the supervised clinical experience requirements will be considered to have been met. If licensed for any other 5-year period, the board will determine whether clinical experience requirements have been met."* (Texas Administrative Code §801.142(2)(B))

- For social workers, the Texas Administrative Code states the following:
 - *"If an applicant for a license has held a substantially equivalent license in good standing in another jurisdiction for at least five years immediately preceding the date of application, the applicant will be deemed to have met the experience requirement under this chapter. If the applicant has been licensed or certified in another jurisdiction for fewer than five years preceding the date of application, the applicant must meet current Texas licensing requirements."* (Texas Administrative Code §781.401(a))

- The regulations for professional counselors in Texas states the following:
 - *“For all internships physically completed in a state or jurisdiction other than Texas, the supervisor must be a person licensed or certified by the state or jurisdiction in a profession that provides counseling and who has the academic training and experience to supervise the counseling services offered by the intern.” (Texas Administrative Code §681.93(b))*

Arizona

A representative from Arizona stated that if an applicant is using experience from another state and the clinical supervision was in compliance with the requirements from that state, they typically accept it.

The Arizona Board of Behavioral Health Examiners regulations state that the following (R46-212.02(2)):

“...The Board may grant an exemption for supervised work experience acquired outside of Arizona if the Board determines that:

- a. Clinical supervision was provided by a behavioral health professional qualified by education, training, and experience to provide supervision; and*
- b. The behavioral health professional providing the supervision met one of the following:*
 - i. Complied with the educational requirements specified in R4-6-214,*
 - ii. Complied with the clinical supervisor requirements of the state in which the supervision occurred, or*
 - iii. Was approved to provide supervision to the applicant by the state in which the supervision occurred.”*

Washington

Staff corresponded with the program manager of the State of Washington’s licensed counselors program, which includes licensed mental health counselors, licensed marriage and family therapists, licensed independent clinical social workers, and licensed advanced social workers. They indicated that they may not be able to accept supervised experience provided by an LEP.

Licensure candidates in Washington must obtain supervision from someone who meets their approved supervisor requirements. A psychologist license is one of the eligible licenses to be an approved supervisor. However, the minimum degree requirement for a psychologist license in Washington is a doctoral degree. Therefore, they note that someone with a master’s-level educational psychologist license from California would not be equivalent to their psychologist license and would not be eligible to be an approved supervisor.

New York

A representative from the New York State Board for Mental Health Practitioners states that if experience gained under supervision of an LEP was authorized under California law, then they would accept it, as long as the hours are post-degree and are direct client contact hours. This would apply for their LMFT, LCSW, and licensed mental health counselor licenses.

Oregon

The State of Oregon has indicated that they accept graduate level mental health licensees as appropriate supervisors.

Colorado

Colorado has two paths to licensure for marriage and family therapists: by endorsement or by examination.

For the licensure by examination pathway, it is unclear if supervision by an LEP in another state would be acceptable, as the regulation states the board will consider experience gained under an individual who is not a marriage and family therapist if the other state does not have a marriage and family therapist license and if the supervisor can document competency in marriage and family therapy to the satisfaction of the board. (CRS §12-43-504)

For the licensure by endorsement pathway, it appears that supervision under an LEP would be accepted. The regulation states that the applicant must attest to two years of post-master's practice in individual and marriage and family therapy under supervision in the jurisdiction or attests to two years of active practice of marriage and family therapy. (CRS §12-43-206)

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ATTACHMENT C

April 2, 2019

The Honorable Philip Chen
Assembly Business and Professions Committee
State Capitol, Room 4177
Sacramento, CA 95814

AB 1651 (Medina)
Business & Professions Committee
Hearing Date: April 2, 2019
Position: SUPPORT

Dear Assembly Member Philip Chen:

As one of your constituents I am asking for your support of AB 1651 (Medina), the Licensed Educational Psychologist (LEP) Supervisor bill, and respectfully requests your Aye vote when this measure is heard April 2 in the Assembly Business and Professions Committee.

AB 1651 would allow a Licensed Educational Psychologist (LEP) to act as a supervisor of associate marriage and family therapists (AMFTs), associate clinical social workers (ASWs), and associate professional clinical counselors (APCCs) who are providing educationally related mental health services in educational and clinical settings.

School psychologists are mental health professionals who have specialized training in both psychology and education. They use their training and skills to team with educators, parents, and other mental health professionals to ensure that every child overcomes barriers and learns in a safe, healthy and supportive environment. A school psychologist can also add another level to their education and become a Licensed Educational Psychologist (LEP) which is a mental health professional licensed by the Board of Behavioral Sciences to provide services in a clinical or educational setting.

AB 1651 should be supported for several reasons. First, school districts are the responsible entity for ensuring that students with disabilities, as designated by their Individualized Educational Plan (IEP), receive the mental health services necessary to benefit from an educational program. As student mental health needs grow so do the demands on appropriately trained staff. Current statute and Board of Behavioral Sciences (BBS) regulations do not allow the supervision of BBS Associates by Licensed Educational Psychologists (LEPs), even when the associates are providing educationally related mental health services. AB 1651 would change the statutory provisions related to BBS supervision of Associates to allow LEPs to supervise BBS Associates who are providing educationally related mental health services in educational and clinical setting.

Second, by allowing LEP to supervise a BBS Associates in the school setting this helps schools address the mental health staff shortage in the school system and provides the Associate an opportunity to gain professional experience in multiple settings including the educationally related mental health services (ERMHS) setting.

For these reasons, I urge your Aye vote.

Sincerely and With Thanks,

Dr. Julia 'Judy' Johnson, LEP, ABSNP
Asst. Professor, Azusa Pacific University

Copy: Assembly Member Medina

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ATTACHMENT D
LEP Scope of Practice

BUSINESS AND PROFESSIONS CODE §4989.14. SCOPE OF PRACTICE

The practice of educational psychology is the performance of any of the following professional functions pertaining to academic learning processes or the educational system or both:

- (a) Educational evaluation.
- (b) Diagnosis of psychological disorders related to academic learning processes.
- (c) Administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.
- (d) Interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.
- (e) Providing psychological counseling for individuals, groups, and families.
- (f) Consultation with other educators and parents on issues of social development and behavioral and academic difficulties.
- (g) Conducting psychoeducational assessments for the purposes of identifying special needs.
- (h) Developing treatment programs and strategies to address problems of adjustment.
- (i) Coordinating intervention strategies for management of individual crises.

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ASSEMBLY BILL

No. 1651

Introduced by Assembly Member Medina

February 22, 2019

An act to amend Sections 4980.03, ~~4980.43~~, 4980.44, 4980.48, 4989.54, 4996.20, 4996.23, ~~and 4999.12~~ *4999.12*, and *4999.46* of the Business and Professions Code, relating to healing arts.

legislative counsel's digest

AB 1651, as amended, Medina. Licensed educational psychologists: supervision of associates and trainees.

Existing

(1) *Existing* law, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act, provides for the licensure and regulation of the practices of marriage and family therapy, clinical social work, and professional clinical counseling, respectively, by the Board of Behavioral Sciences. A violation of any of those acts is a misdemeanor. Under those acts, certain unlicensed persons, including an applicant for licensure, an associate, an intern, or a trainee, are authorized to perform specified services under the supervision of a healing arts practitioner who is included in the definition of “Supervisor.”

This bill would expand the definition of “supervisor” under each of those acts to include a licensed educational psychologist who has provided psychological counseling pursuant to the Educational Psychologist Practice Act.

(2) *The Licensed Marriage and Family Therapist Act and the Licensed Professional Clinical Counselor Act require applicants for*

licensure under those acts to comply with specified educational and experience requirements, including, but not limited to, hours of supervised experience, and sets forth terms, conditions, and limitations for those hours of experience. Existing law authorizes preregistered postdegree hours of experience to be credited towards licensure under either of those acts if certain terms, conditions, and limitations on those hours of experience are met, including a specified amount of supervised experience.

This bill would limit the number of preregisterd postdegree hours that an applicant may credit towards licensure under those provisions for experience gained under the supervision of a licensed educational psychologist to a maximum of 1,200 hours.

Existing

(3) *Existing law, the Educational Psychologist Practice Act, provides for the licensure and regulation of the practice of educational psychology by the board, and authorizes the board to deny a license or suspend or revoke the license of a licensee if ~~he or she is~~ they are guilty of unprofessional conduct, which is defined to include various acts.*

This bill would expand the definition of unprofessional conduct to include certain acts relating to the supervision by a licensed educational psychologist, including the supervision of an unlicensed person under the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, or the Licensed Professional Clinical Counselor Act. By expanding the list of acts that constitute unprofessional conduct, a violation of which is a misdemeanor, the bill would expand the scope of a crime, thereby imposing a state-mandated local program.

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

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

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

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

- 1 SECTION 1. Section 4980.03 of the Business and Professions
- 2 Code is amended to read:
- 3 4980.03. (a) “Board,” as used in this chapter, means the Board
- 4 of Behavioral Sciences.

1 (b) “Associate,” as used in this chapter, means an unlicensed
2 person who has earned a master’s or doctoral degree qualifying
3 the person for licensure and is registered with the board as an
4 associate.

5 (c) “Trainee,” as used in this chapter, means an unlicensed
6 person who is currently enrolled in a master’s or doctoral degree
7 program, as specified in Sections 4980.36 and 4980.37, that is
8 designed to qualify the person for licensure under this chapter, and
9 who has completed no less than 12 semester units or 18 quarter

10 units of coursework in any qualifying degree program.

11 (d) “Applicant for licensure,” as used in this chapter, means an
12 unlicensed person who has completed the required education and
13 required hours of supervised experience for licensure.

14 (e) “Advertise,” as used in this chapter, includes, but is not
15 limited to, any public communication, as defined in subdivision
16 (a) of Section 651, the issuance of any card, sign, or device to any
17 person, or the causing, permitting, or allowing of any sign or
18 marking on, or in, any building or structure, or in any newspaper
19 or magazine or in any directory, or any printed matter whatsoever,
20 with or without any limiting qualification. Signs within religious
21 buildings or notices in church bulletins mailed to a congregation
22 shall not be construed as advertising within the meaning of this
23 chapter.

24 (f) “Experience,” as used in this chapter, means experience in
25 interpersonal relationships, psychotherapy, marriage and family
26 therapy, direct clinical counseling, and nonclinical practice that
27 satisfies the requirements for licensure as a marriage and family
28 therapist.

29 (g) “Supervisor,” as used in this chapter, means an individual
30 who meets all of the following requirements:

31 (1) Has held an active license for at least two years within the
32 five-year period immediately preceding any supervision as either:

33 (A) A licensed professional clinical counselor, licensed marriage
34 and family therapist, psychologist licensed pursuant to Chapter
35 6.6 (commencing with Section 2900), licensed clinical social
36 worker, licensed educational psychologist, or equivalent
37 out-of-state license.

38 (B) A physician and surgeon who is certified in psychiatry by
39 the American Board of Psychiatry and Neurology or an out-of-state

1 licensed physician and surgeon who is certified in psychiatry by
2 the American Board of Psychiatry and Neurology.

3 (2) If the supervisor is a licensed professional clinical counselor,
4 the person has completed the additional training and education
5 requirements specified in subparagraphs (A) to (C), inclusive, of
6 paragraph (3) of subdivision (a) of Section 4999.20.

7 (3) For at least two years within the five-year period immediately
8 preceding any supervision, has practiced psychotherapy, provided
9 psychological counseling pursuant to subdivision (e) of Section
10 4989.14, or provided direct clinical supervision of psychotherapy
11 performed by marriage and family therapist trainees, associate
12 marriage and family therapists, associate professional clinical
13 counselors, or associate clinical social workers. Supervision of
14 psychotherapy performed by a social work intern or a professional
15 clinical counselor trainee shall be accepted if the supervision
16 provided is substantially equivalent to the supervision required for
17 registrants.

18 (4) Has received training in supervision as specified in this
19 chapter and by regulation.

20 (5) Has not provided therapeutic services to the supervisee.

21 (6) Has and maintains a current and active license that is not
22 under suspension or probation as one of the following:

23 (A) A marriage and family therapist, professional clinical
24 counselor, clinical social worker, or licensed educational
25 psychologist, issued by the board.

26 (B) A psychologist licensed pursuant to Chapter 6.6
27 (commencing with Section 2900).

28 (C) A physician and surgeon who is certified in psychiatry by
29 the American Board of Psychiatry and Neurology.

30 (7) Is not a spouse, domestic partner, or relative of the
31 supervisee.

32 (8) Does not currently have or previously had a personal,
33 professional, or business relationship with the supervisee that
34 undermines the authority or effectiveness of the supervision.

35 (h) "Client centered advocacy," as used in this chapter, includes,
36 but is not limited to, researching, identifying, and accessing
37 resources, or other activities, related to obtaining or providing
38 services and supports for clients or groups of clients receiving
39 psychotherapy or counseling services.

1 *SEC. 2. Section 4980.43 of the Business and Professions Code*
2 *is amended to read:*

3 4980.43. (a) Except as provided in subdivision (b), all
4 applicants shall have an active associate registration with the board
5 in order to gain postdegree hours of supervised experience.

6 (b) (1) Preregistered postdegree hours of experience shall be
7 credited toward licensure if all of the following apply:

8 (A) The registration applicant applies for the associate
9 registration and the board receives the application within 90 days
10 of the granting of the qualifying master's degree or doctoral degree.

11 (B) For applicants completing graduate study on or after January
12 1, 2020, the experience is obtained at a workplace that, prior to
13 the registration applicant gaining supervised experience hours,
14 requires completed Live Scan fingerprinting. The applicant shall
15 provide the board with a copy of that completed State of California
16 "Request for Live Scan Service" form with his or her application
17 for licensure.

18 (C) The board subsequently grants the associate registration.

19 (2) The applicant shall not be employed or volunteer in a private
20 practice until ~~he or she~~ *the applicant* has been issued an associate
21 registration by the board.

22 (c) Supervised experience that is obtained for purposes of
23 qualifying for licensure shall be related to the practice of marriage
24 and family therapy and comply with the following:

25 (1) A minimum of 3,000 hours completed during a period of at
26 least 104 weeks.

27 (2) A maximum of 40 hours in any seven consecutive days.

28 (3) A minimum of 1,700 hours obtained after the qualifying
29 master's or doctoral degree was awarded.

30 (4) A maximum of 1,300 hours obtained prior to the award date
31 of the qualifying master's or doctoral degree.

32 (5) A maximum of 750 hours of counseling and direct supervisor
33 contact prior to the award date of the qualifying master's or
34 doctoral degree.

35 (6) Hours of experience shall not be gained prior to completing
36 either 12 semester units or 18 quarter units of graduate instruction.

37 (7) Hours of experience shall not have been gained more than
38 six years prior to the date the application for licensure was received
39 by the board, except that up to 500 hours of clinical experience
40 gained in the supervised practicum required by subdivision (c) of

1 Section 4980.37 and subparagraph (B) of paragraph (1) of
2 subdivision (d) of Section 4980.36 shall be exempt from this
3 six-year requirement.

4 (8) A minimum of 1,750 hours of direct clinical counseling with
5 individuals, groups, couples, or families, that includes not less than
6 500 total hours of experience in diagnosing and treating couples,
7 families, and children.

8 (9) *A maximum of 1,200 hours gained under the supervision of*
9 *a licensed educational psychologist.*

10 ~~(9)~~

11 (10) A maximum of 1,250 hours of nonclinical practice,
12 consisting of direct supervisor contact, administering and
13 evaluating psychological tests, writing clinical reports, writing
14 progress or process notes, client centered advocacy, and workshops,
15 seminars, training sessions, or conferences directly related to
16 marriage and family therapy that have been approved by the
17 applicant’s supervisor.

18 ~~(10)~~

19 (11) It is anticipated and encouraged that hours of experience
20 will include working with elders and dependent adults who have
21 physical or mental limitations that restrict their ability to carry out
22 normal activities or protect their rights.

23 This subdivision shall only apply to hours gained on and after
24 January 1, 2010.

25 (d) An individual who submits an application for licensure
26 between January 1, 2016, and December 31, 2020, may
27 alternatively qualify under the experience requirements of this
28 section that were in place on January 1, 2015.

29 ~~SEC. 2.~~

30 *SEC. 3.* Section 4980.44 of the Business and Professions Code
31 is amended to read:

32 4980.44. An associate marriage and family therapist employed
33 under this chapter shall comply with the following requirements:

34 (a) Inform each client or patient prior to performing any mental
35 health and related services that the person is an unlicensed
36 registered associate marriage and family therapist, provide the
37 person’s registration number and the name of the person’s
38 employer, and indicate whether the person is under the supervision
39 of a licensed marriage and family therapist, licensed clinical social
40 worker, licensed professional clinical counselor, psychologist

1 licensed pursuant to Chapter 6.6 (commencing with Section 2900),
2 licensed educational psychologist, or a licensed physician and
3 surgeon certified in psychiatry by the American Board of
4 Psychiatry and Neurology.

5 (b) (1) Any advertisement by or on behalf of a registered
6 associate marriage and family therapist shall include, at a
7 minimum, all of the following information:

8 (A) That the person is a registered associate marriage and family
9 therapist.

10 (B) The associate's registration number.

11 (C) The name of the person's employer.

12 (D) That the person is supervised by a licensed person.

13 (2) The abbreviation "AMFT" shall not be used in an
14 advertisement unless the title "registered associate marriage and
15 family therapist" appears in the advertisement.

16 ~~SEC. 3.~~

17 *SEC. 4.* Section 4980.48 of the Business and Professions Code
18 is amended to read:

19 4980.48. (a) A trainee shall, prior to performing any
20 professional services, inform each client or patient that the trainee
21 is an unlicensed marriage and family therapist trainee, provide the
22 name of the trainee's employer, and indicate whether the trainee
23 is under the supervision of a licensed marriage and family therapist,
24 a licensed clinical social worker, a licensed professional clinical
25 counselor, a licensed psychologist, a licensed physician certified
26 in psychiatry by the American Board of Psychiatry and Neurology,
27 or a licensed educational psychologist.

28 (b) Any person that advertises services performed by a trainee
29 shall include the trainee's name, the supervisor's license
30 designation or abbreviation, and the supervisor's license number.

31 (c) Any advertisement by or on behalf of a marriage and family
32 therapist trainee shall include, at a minimum, all of the following
33 information:

34 (1) That the trainee is a marriage and family therapist trainee.

35 (2) The name of the trainee's employer.

36 (3) That the trainee is supervised by a licensed person.

37 ~~SEC. 4.~~

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

1 4989.54. The board may deny a license or may suspend or
2 revoke the license of a licensee if the person has been guilty of
3 unprofessional conduct. Unprofessional conduct includes, but is
4 not limited to, the following:

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

7 (1) The record of conviction shall be conclusive evidence only
8 of the fact that the conviction occurred.

9 (2) The board may inquire into the circumstances surrounding
10 the commission of the crime in order to fix the degree of discipline
11 or to determine if the conviction is substantially related to the
12 qualifications, functions, or duties of a licensee under this chapter.

13 (3) A plea or verdict of guilty or a conviction following a plea
14 of nolo contendere made to a charge substantially related to the
15 qualifications, functions, or duties of a licensee under this chapter
16 shall be deemed to be a conviction within the meaning of this
17 section.

18 (4) The board may order a license suspended or revoked, or
19 may decline to issue a license when the time for appeal has elapsed,
20 or the judgment of conviction has been affirmed on appeal, or
21 when an order granting probation is made suspending the
22 imposition of sentence, irrespective of a subsequent order under
23 Section 1203.4 of the Penal Code allowing the person to withdraw
24 a plea of guilty and enter a plea of not guilty or setting aside the
25 verdict of guilty or dismissing the accusation, information, or
26 indictment.

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

31 (c) Administering to themselves a controlled substance or using
32 any of the dangerous drugs specified in Section 4022 or an
33 alcoholic beverage to the extent, or in a manner, as to be dangerous
34 or injurious to themselves or to any other person or to the public
35 or to the extent that the use impairs their ability to safely perform
36 the functions authorized by the license. The board shall deny an
37 application for a license or revoke the license of any person, other
38 than one who is licensed as a physician and surgeon, who uses or
39 offers to use drugs in the course of performing educational
40 psychology.

- 1 (d) Failure to comply with the consent provisions in Section
2 2290.5.
- 3 (e) Advertising in a manner that is false, fraudulent, misleading,
4 or deceptive, as defined in Section 651.
- 5 (f) Violating, attempting to violate, or conspiring to violate any
6 of the provisions of this chapter or any regulation adopted by the
7 board.
- 8 (g) Commission of any dishonest, corrupt, or fraudulent act
9 substantially related to the qualifications, functions, or duties of a
10 licensee.
- 11 (h) Denial of licensure, revocation, suspension, restriction, or
12 any other disciplinary action imposed by another state or territory
13 or possession of the United States or by any other governmental
14 agency, on a license, certificate, or registration to practice
15 educational psychology or any other healing art. A certified copy
16 of the disciplinary action, decision, or judgment shall be conclusive
17 evidence of that action.
- 18 (i) Revocation, suspension, or restriction by the board of a
19 license, certificate, or registration to practice as an educational
20 psychologist, a clinical social worker, professional clinical
21 counselor, or marriage and family therapist.
- 22 (j) Failure to keep records consistent with sound clinical
23 judgment, the standards of the profession, and the nature of the
24 services being rendered.
- 25 (k) Gross negligence or incompetence in the practice of
26 educational psychology.
- 27 (l) Misrepresentation as to the type or status of a license held
28 by the licensee or otherwise misrepresenting or permitting
29 misrepresentation of the licensee's education, professional
30 qualifications, or professional affiliations to any person or entity.
- 31 (m) Intentionally or recklessly causing physical or emotional
32 harm to any client.
- 33 (n) Engaging in sexual relations with a client or a former client
34 within two years following termination of professional services,
35 soliciting sexual relations with a client, or committing an act of
36 sexual abuse or sexual misconduct with a client or committing an
37 act punishable as a sexually related crime, if that act or solicitation
38 is substantially related to the qualifications, functions, or duties of
39 a licensed educational psychologist.

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

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

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

13 (r) Performing, holding oneself out as being able to perform,
14 offering to perform, or permitting any unlicensed person under
15 supervision to perform, any professional services beyond the scope
16 of the license authorized by this chapter or beyond the person's
17 field or fields of competence as established by the person's
18 education, training, or experience. For purposes of this subdivision,
19 "unlicensed person" includes, but is not limited to, an applicant
20 for licensure, an associate, an intern, or a trainee under the Licensed
21 Marriage and Family Therapist Act (Chapter 13 (commencing
22 with Section 4980)), the Clinical Social Worker Practice Act
23 (Chapter 14 (commencing with Section 4991)), or the Licensed
24 Professional Clinical Counselor Act (Chapter 16 (commencing
25 with Section 4999.10)).

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

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

35 (u) When employed by another person or agency, encouraging,
36 either orally or in writing, the employer's or agency's clientele to
37 utilize the person's private practice for further counseling without
38 the approval of the employing agency or administration.

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

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

4 (x) Willful violation of Chapter 1 (commencing with Section
5 123100) of Part 1 of Division 106 of the Health and Safety Code.

6 (y) (1) Engaging in an act described in Section 261, 286, 287,
7 or 289 of, or former Section 288a of, the Penal Code with a minor
8 or an act described in Section 288 or 288.5 of the Penal Code
9 regardless of whether the act occurred prior to or after the time the
10 registration or license was issued by the board. An act described
11 in this subdivision occurring prior to the effective date of this
12 subdivision shall constitute unprofessional conduct and shall
13 subject the licensee to refusal, suspension, or revocation of a license
14 under this section.

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

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

26 (aa) Impersonation of another by any licensee or applicant for
27 a license, or, in the case of a licensee, allowing any other person
28 to use the person's license.

29 (ab) Permitting an unlicensed person under the licensee's
30 supervision or control to perform, or permitting that person to hold
31 themselves out as competent to perform, mental health services
32 beyond the unlicensed person's level of education, training, or
33 experience. For purposes of this subdivision, "unlicensed person"
34 is defined as in subdivision (r).

35 (ac) Any conduct in the supervision of an unlicensed person,
36 including an unlicensed person identified in subdivision (ab), by
37 a licensee that violates this chapter, the Licensed Marriage and
38 Family Therapist Act (Chapter 13 (commencing with Section
39 4980)), the Clinical Social Worker Practice Act (Chapter 14
40 (commencing with Section 4991)), the Licensed Professional

1 Clinical Counselor Act (Chapter 16 (commencing with Section
2 4999.10)), or any rules or regulations adopted by the board pursuant
3 to those provisions. For purposes of this subdivision, “unlicensed
4 person” is defined as in subdivision (r).

5 (ad) The violation of any statute or regulation governing the
6 gaining and supervision of experience of an unlicensed person
7 required by the Licensed Marriage and Family Therapist Act
8 (Chapter 13 (commencing with Section 4980)), the Clinical Social
9 Worker Practice Act (Chapter 14 (commencing with Section
10 4991)), or the Licensed Professional Clinical Counselor Act
11 (Chapter 16 (commencing with Section 4999.10)).

12 ~~SEC. 5.~~

13 *SEC. 6.* Section 4996.20 of the Business and Professions Code
14 is amended to read:

15 4996.20. (a) “Supervisor,” as used in this chapter, means an
16 individual who meets all of the following requirements:

17 (1) Has held an active license for at least two years within the
18 five-year period immediately preceding any supervision as either:

19 (A) A licensed professional clinical counselor, licensed marriage
20 and family therapist, psychologist licensed pursuant to Chapter
21 6.6 (commencing with Section 2900), licensed clinical social
22 worker, licensed educational psychologist, or equivalent
23 out-of-state license.

24 (B) A physician and surgeon who is certified in psychiatry by
25 the American Board of Psychiatry and Neurology or an out-of-state
26 licensed physician and surgeon who is certified in psychiatry by
27 the American Board of Psychiatry and Neurology.

28 (2) For at least two years within the five-year period immediately
29 preceding any supervision, has practiced psychotherapy, provided
30 psychological counseling pursuant to subdivision (e) of Section
31 4989.14, or provided direct clinical supervision of psychotherapy
32 performed by associate clinical social workers, associate marriage
33 and family therapists or trainees, or associate professional clinical
34 counselors. Supervision of psychotherapy performed by a social
35 work intern or a professional clinical counselor trainee shall be
36 accepted if the supervision provided is substantially equivalent to
37 the supervision required for registrants.

38 (3) Has received training in supervision as specified in this
39 chapter and by regulation.

40 (4) Has not provided therapeutic services to the supervisee.

- 1 (5) Has and maintains a current and active license that is not
2 under suspension or probation as one of the following:
- 3 (A) A marriage and family therapist, professional clinical
4 counselor, clinical social worker, or licensed educational
5 psychologist issued by the board.
- 6 (B) A psychologist licensed pursuant to Chapter 6.6
7 (commencing with Section 2900).
- 8 (C) A physician and surgeon who is certified in psychiatry by
9 the American Board of Psychiatry and Neurology.
- 10 (6) Is not a spouse, domestic partner, or relative of the
11 supervisee.
- 12 (7) Does not currently have or previously had a personal,
13 professional, or business relationship with the supervisee that
14 undermines the authority or effectiveness of the supervision.
- 15 (b) As used in this chapter, the term “supervision” means
16 responsibility for, and control of, the quality of mental health and
17 related services provided by the supervisee. Consultation or peer
18 discussion shall not be considered supervision and shall not qualify
19 as supervised experience.
- 20 “Supervision” includes, but is not limited to, all of the following:
- 21 (1) Ensuring the extent, kind, and quality of counseling
22 performed is consistent with the education, training, and experience
23 of the supervisee.
- 24 (2) Monitoring and evaluating the supervisee’s assessment,
25 diagnosis, and treatment decisions and providing regular feedback.
- 26 (3) Monitoring and evaluating the supervisee’s ability to provide
27 services at the site or sites where the supervisee is practicing and
28 to the particular clientele being served.
- 29 (4) Monitoring and addressing clinical dynamics, including, but
30 not limited to, countertransference-, intrapsychic-, interpersonal-,
31 or trauma-related issues that may affect the supervisory or the
32 practitioner-patient relationship.
- 33 (5) Ensuring the supervisee’s compliance with laws and
34 regulations governing the practice of clinical social work.
- 35 (6) Reviewing the supervisee’s progress notes, process notes,
36 and other patient treatment records, as deemed appropriate by the
37 supervisor.
- 38 (7) With the client’s written consent, providing direct
39 observation or review of audio or video recordings of the

1 supervisee’s counseling or therapy, as deemed appropriate by the
2 supervisor.

3 ~~SEC. 6.~~

4 *SEC. 7.* Section 4996.23 of the Business and Professions Code
5 is amended to read:

6 4996.23. (a) To qualify for licensure, each applicant shall
7 complete 3,000 hours of post-master’s degree supervised
8 experience related to the practice of clinical social work. Except
9 as provided in subdivision (b), experience shall not be gained until
10 the applicant is registered as an associate clinical social worker.

11 (b) Preregistered postdegree hours of experience shall be
12 credited toward licensure if all of the following apply:

13 (1) The registration applicant applies for the associate
14 registration and the board receives the application within 90 days
15 of the granting of the qualifying master’s or doctoral degree.

16 (2) For applicants completing graduate study on or after January
17 1, 2020, the experience is obtained at a workplace that, prior to
18 the registration applicant gaining supervised experience hours,
19 requires completed live scan fingerprinting. The applicant shall
20 provide the board with a copy of that completed “State of
21 California Request for Live Scan Service” form with the
22 application for licensure.

23 (3) The board subsequently grants the associate registration.

24 (c) The applicant shall not be employed or volunteer in a private
25 practice until the applicant has been issued an associate registration
26 by the board.

27 (d) The experience shall be as follows:

28 (1) (A) At least 1,700 hours shall be gained under the
29 supervision of a licensed clinical social worker. The remaining
30 required supervised experience may be gained under the
31 supervision of a physician and surgeon who is certified in
32 psychiatry by the American Board of Psychiatry and Neurology,
33 licensed professional clinical counselor, licensed marriage and
34 family therapist, psychologist licensed pursuant to Chapter 6.6
35 (commencing with Section 2900), licensed educational
36 psychologist, or licensed clinical social worker.

37 (B) The number of hours gained under the supervision of a
38 licensed educational psychologist shall not exceed 1,200 hours.

39 (2) A minimum of 2,000 hours in clinical psychosocial
40 diagnosis, assessment, and treatment, including psychotherapy or

1 counseling; however, at least 750 hours shall be face-to-face
2 individual or group psychotherapy provided in the context of
3 clinical social work services.

4 (3) A maximum of 1,000 hours in client centered advocacy,
5 consultation, evaluation, research, direct supervisor contact, and
6 workshops, seminars, training sessions, or conferences directly
7 related to clinical social work that have been approved by the
8 applicant's supervisor.

9 (4) A minimum of two years of supervised experience is required
10 to be obtained over a period of not less than 104 weeks and shall
11 have been gained within the six years immediately preceding the
12 date on which the application for licensure was received by the
13 board.

14 (5) No more than 40 hours of experience may be credited in
15 any seven consecutive days.

16 (6) For hours gained on or after January 1, 2010, no more than
17 six hours of supervision, whether individual, triadic, or group
18 supervision, shall be credited during any single week.

19 (e) An individual who submits an application for licensure
20 between January 1, 2016, and December 31, 2020, may
21 alternatively qualify under the experience requirements of this
22 section that were in place on January 1, 2015.

23 ~~SEC. 7.~~

24 *SEC. 8.* Section 4999.12 of the Business and Professions Code
25 is amended to read:

26 4999.12. For purposes of this chapter, the following terms have
27 the following meanings:

28 (a) "Board" means the Board of Behavioral Sciences.

29 (b) "Accredited" means a school, college, or university
30 accredited by a regional or national institutional accrediting agency
31 that is recognized by the United States Department of Education.

32 (c) "Approved" means a school, college, or university that
33 possessed unconditional approval by the Bureau for Private
34 Postsecondary Education at the time of the applicant's graduation
35 from the school, college, or university.

36 (d) "Applicant for licensure" means an unlicensed person who
37 has completed the required education and required hours of
38 supervised experience for licensure.

1 (e) “Licensed professional clinical counselor” or “LPCC” means
2 a person licensed under this chapter to practice professional clinical
3 counseling, as defined in Section 4999.20.

4 (f) “Associate” means an unlicensed person who meets the
5 requirements of Section 4999.42 and is registered with the board.

6 (g) “Clinical counselor trainee” means an unlicensed person
7 who is currently enrolled in a master’s or doctoral degree program,
8 as specified in Section 4999.32 or 4999.33, that is designed to
9 qualify the person for licensure and who has completed no less
10 than 12 semester units or 18 quarter units of coursework in any
11 qualifying degree program.

12 (h) “Supervisor” means an individual who meets all of the
13 following requirements:

14 (1) Has held an active license for at least two years within the
15 five-year period immediately preceding any supervision as either:

16 (A) A licensed professional clinical counselor, licensed marriage
17 and family therapist, psychologist licensed pursuant to Chapter
18 6.6 (commencing with Section 2900), licensed clinical social
19 worker, licensed educational psychologist, or equivalent
20 out-of-state license.

21 (B) A physician and surgeon who is certified in psychiatry by
22 the American Board of Psychiatry and Neurology, or an out-of-state
23 licensed physician and surgeon who is certified in psychiatry by
24 the American Board of Psychiatry and Neurology.

25 (2) If the individual is a licensed professional clinical counselor
26 seeking to supervise an associate marriage and family therapist, a
27 marriage and family therapist trainee, or an associate professional
28 clinical counselor or licensee seeking experience to treat couples
29 and families pursuant to subparagraph (B) of paragraph (3) of
30 subdivision (a) of Section 4999.20, the individual shall meet the
31 additional training and education requirements in subparagraphs
32 (A) to (C), inclusive, of paragraph (3) of subdivision (a) of Section
33 4999.20.

34 (3) For at least two years within the five-year period immediately
35 preceding any supervision, has practiced psychotherapy, provided
36 psychological counseling pursuant to subdivision (e) of Section
37 4989.14, or provided direct clinical supervision of psychotherapy
38 performed by marriage and family therapist trainees, associate
39 marriage and family therapists, associate professional clinical
40 counselors, or associate clinical social workers. Supervision of

1 psychotherapy performed by a social work intern or a professional
2 clinical counselor trainee shall be accepted if the supervision
3 provided is substantially equivalent to the supervision required for
4 registrants.

5 (4) Has received training in supervision as specified in this
6 chapter and by regulation.

7 (5) Has not provided therapeutic services to the supervisee.

8 (6) Has and maintains a current and active license that is not
9 under suspension or probation as one of the following:

10 (A) A marriage and family therapist, professional clinical
11 counselor, clinical social worker, or licensed educational
12 psychologist issued by the board.

13 (B) A psychologist licensed pursuant to Chapter 6.6
14 (commencing with Section 2900).

15 (C) A physician and surgeon who is certified in psychiatry by
16 the American Board of Psychiatry and Neurology.

17 (7) Is not a spouse, domestic partner, or relative of the
18 supervisee.

19 (8) Does not currently have or previously had a personal,
20 professional, or business relationship with the supervisee that
21 undermines the authority or effectiveness of the supervision.

22 (i) “Client centered advocacy” includes, but is not limited to,
23 researching, identifying, and accessing resources, or other activities,
24 related to obtaining or providing services and supports for clients
25 or groups of clients receiving psychotherapy or counseling services.

26 (j) “Advertising” or “advertise” includes, but is not limited to,
27 the issuance of any card, sign, or device to any person, or the
28 causing, permitting, or allowing of any sign or marking on, or in,
29 any building or structure, or in any newspaper or magazine or in
30 any directory, or any printed matter whatsoever, with or without
31 any limiting qualification. It also includes business solicitations
32 communicated by radio or television broadcasting. Signs within
33 church buildings or notices in church bulletins mailed to a
34 congregation shall not be construed as advertising within the
35 meaning of this chapter.

36 (k) “Referral” means evaluating and identifying the needs of a
37 client to determine whether it is advisable to refer the client to
38 other specialists, informing the client of that judgment, and
39 communicating that determination as requested or deemed
40 appropriate to referral sources.

1 (l) “Research” means a systematic effort to collect, analyze, and
2 interpret quantitative and qualitative data that describes how social
3 characteristics, behavior, emotion, cognitions, disabilities, mental
4 disorders, and interpersonal transactions among individuals and
5 organizations interact.

6 (m) “Supervision” means responsibility for, and control of, the
7 quality of mental health and related services provided by the
8 supervisee. Consultation or peer discussion shall not be considered
9 supervision and shall not qualify as supervised experience.
10 Supervision includes, but is not limited to, all of the following:

11 (1) Ensuring the extent, kind, and quality of counseling
12 performed is consistent with the education, training, and experience
13 of the supervisee.

14 (2) Monitoring and evaluating the supervisee’s assessment,
15 diagnosis, and treatment decisions and providing regular feedback.

16 (3) Monitoring and evaluating the supervisee’s ability to provide
17 services at the site or sites where the supervisee is practicing and
18 to the particular clientele being served.

19 (4) Monitoring and addressing clinical dynamics, including, but
20 not limited to, countertransference-, intrapsychic-, interpersonal-,
21 or trauma-related issues that may affect the supervisory or the
22 practitioner-patient relationship.

23 (5) Ensuring the supervisee’s compliance with laws and
24 regulations governing the practice of licensed professional clinical
25 counseling.

26 (6) Reviewing the supervisee’s progress notes, process notes,
27 and other patient treatment records, as deemed appropriate by the
28 supervisor.

29 (7) With the client’s written consent, providing direct
30 observation or review of audio or video recordings of the
31 supervisee’s counseling or therapy, as deemed appropriate by the
32 supervisor.

33 (n) “Clinical setting” means any setting that meets both of the
34 following requirements:

35 (1) Lawfully and regularly provides mental health counseling
36 or psychotherapy.

37 (2) Provides oversight to ensure that the associate’s work meets
38 the experience and supervision requirements set forth in this
39 chapter and in regulation and is within the scope of practice of the
40 profession.

1 (o) “Community mental health setting,” means a clinical setting
2 that meets all of the following requirements:

3 (1) Lawfully and regularly provides mental health counseling
4 or psychotherapy.

5 (2) Clients routinely receive psychopharmacological
6 interventions in conjunction with psychotherapy, counseling, or
7 other psycho-social interventions.

8 (3) Clients receive coordinated care that includes the
9 collaboration of mental health providers.

10 (4) Is not a private practice.

11 *SEC. 9. Section 4999.46 of the Business and Professions Code*
12 *is amended to read:*

13 4999.46. (a) Except as provided in subdivision (b), all
14 applicants shall have an active associate registration with the board
15 in order to gain postdegree hours of supervised experience.

16 (b) (1) Preregistered postdegree hours of experience shall be
17 credited toward licensure if all of the following apply:

18 (A) The registration applicant applies for the associate
19 registration and the board receives the application within 90 days
20 of the granting of the qualifying master’s degree or doctoral degree.

21 (B) For applicants completing graduate study on or after January
22 1, 2020, the experience is obtained at a workplace that, prior to
23 the registration applicant gaining supervised experience hours,
24 requires completed Live Scan fingerprinting. The applicant shall
25 provide the board with a copy of that completed State of California
26 “Request for Live Scan Service” form with ~~his or her~~ *their*
27 application for licensure.

28 (C) The board subsequently grants the associate registration.

29 (2) The applicant shall not be employed or volunteer in a private
30 practice until ~~he or she has~~ *they have* been issued an associate
31 registration by the board.

32 (c) Supervised experience that is obtained for the purposes of
33 qualifying for licensure shall be related to the practice of
34 professional clinical counseling and comply with the following:

35 (1) A minimum of 3,000 postdegree hours performed over a
36 period of not less than two years (104 weeks).

37 (2) Not more than 40 hours in any seven consecutive days.

38 (3) Not less than 1,750 hours of direct clinical counseling with
39 individuals, groups, couples, or families using a variety of

1 psychotherapeutic techniques and recognized counseling
2 interventions.

3 (4) Not less than 150 hours of clinical experience in a hospital
4 or community mental health setting, as defined in Section 4999.12.

5 (5) A maximum of 1,250 hours of nonclinical practice,
6 consisting of direct supervisor contact, administering and
7 evaluating psychological tests, writing clinical reports, writing
8 progress or process notes, client centered advocacy, and workshops,
9 seminars, training sessions, or conferences directly related to
10 professional clinical counseling that have been approved by the
11 applicant’s supervisor.

12 (6) *A maximum of 1,200 hours gained under the supervision of*
13 *a licensed educational psychologist.*

14 (d) An individual who submits an application for licensure
15 between January 1, 2016, and December 31, 2020, may
16 alternatively qualify under the experience requirements of this
17 section that were in place on January 1, 2015.

18 (e) Experience hours shall not have been gained more than six
19 years prior to the date the application for licensure was received
20 by the board.

21 ~~SEC. 8.~~

22 *SEC. 10.* No reimbursement is required by this act pursuant
23 to Section 6 of Article XIII B of the California Constitution because
24 the only costs that may be incurred by a local agency or school
25 district will be incurred because this act creates a new crime or
26 infraction, eliminates a crime or infraction, or changes the penalty
27 for a crime or infraction, within the meaning of Section 17556 of
28 the Government Code, or changes the definition of a crime within
29 the meaning of Section 6 of Article XIII B of the California
30 Constitution.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 10

VERSION: AMENDED JANUARY 23, 2019

AUTHOR: BEALL

SPONSOR:

- STEINBERG INSTITUTE
- MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION (MHSOAC)
- LOS ANGELES COUNTY BOARD OF SUPERVISORS

RECOMMENDED POSITION: SUPPORT

SUBJECT: MENTAL HEALTH SERVICES: PEER, PARENT, TRANSITION-AGE, AND FAMILY SUPPORT SPECIALIST CERTIFICATION

Overview:

This bill requires the State Department of Health Care Services (DHCS) to establish a certification body for adult, parent, transition-age youth, and family peer support specialists. It also requires DHCS to amend the state's Medicaid plan to include these providers as a provider type within the Medi-Cal program.

Existing Law:

- 1) States that certain essential mental health and substance use disorder services are covered Medi-Cal benefits effective January 1, 2014. (Welfare and Institutions Code (WIC) §14132.03)

This Bill:

- 1) Establishes the Peer, Parent, Transition-Age, and Family Support Specialist Certification Act of 2019. (WIC Article 1.4, §§ 14045.10 – 14045.27))
- 2) Outlines the expected achievements of the peer, parent, transition-age, and family support specialist certification program, including providing increased family support, providing a continuum of services in conjunction with other community mental health or substance use disorder treatment, and collaborating with others providing care or support. (BPC §14045.12)
- 3) Defines “peer support specialist services” as culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and maintenance of

skills learned in other support services. The services shall include support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified adult, transition-age youth, family, or parent peer support specialist. (WIC§14045.13(k))

- 4) By July 1, 2020, requires the State Department of Health Care Services (DHCS) to establish a certification body for adult, parent, transition-age youth, and family peer support specialists. (WIC §14045.14)
- 5) Requires the certifying body to define responsibilities and practice guidelines for each type of peer support specialist using best practice materials, and to determine curriculum and core competencies including, at a minimum, the following (WIC §14045.14):
 - Hope, recovery, and wellness
 - Advocacy
 - The role of consumers and family members
 - Psychiatric rehabilitation skills and service delivery, and addiction recovery principals
 - Cultural competence training
 - Trauma-informed care
 - Group facilitation skills
 - Self-awareness and self-care
 - Co-occurring disorders of mental health and substance use
 - Conflict resolution
 - Professional boundaries and ethics
 - Safety and crisis planning
 - Navigation of and referral to other services
 - Documenting skills and standards
 - Study and test-taking skills
 - Confidentiality
- 6) Requires the certification body to specify training requirements, including core competency based training and specialized training. (WIC §14045.14)
- 7) Requires the certification body to establish a code of ethics, a process for certification renewal, continuing education requirements for certification renewal, a process for investigation of complaints and corrective action, and a process for an individual already employed as a peer support specialist to obtain the new certification. (WIC §14045.14)
- 8) Provides minimum requirements for adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists to include the following (WIC §§14045.15, 14045.16, 14045.17, 14045.18):

- Is at least age 18
 - Have or had a self-disclosed primary diagnosis of mental illness and/or substance use disorder (adult and transition-age only) or has a family member experiencing one of these (family only) or is a parent (parent only).
 - Has or is receiving mental health or substance use disorder services. (adult and transition-age only)
 - Is willing to share his/her experience
 - Demonstrates leadership/advocacy skills
 - Is strongly dedicated to recovery
 - Agrees in writing to follow a code of ethics
 - Successfully completes the required curriculum and training
 - Passes an approved certification exam (adult and family peer support specialists only)
 - Meets all applicable federal requirements
 - Completes any required continuing education, training, and recertification requirements to maintain certification
- 9)** States that this Act does not imply that a certification-holder is qualified or authorized to diagnose an illness, prescribe medication, or provide clinical services. It also does not alter the scope of practice for a health care professional or authorize delivery of services in a setting or manner not authorized under the Business and Professions Code or Health and Safety Code. (WIC §14045.19)
- 10)** Requires DHCS to consult with the Office of Statewide Health Planning and Development (OSHPD), peer support and family organizations, mental health and substance use disorder treatment organizations, the County Behavioral Health Directors Association of California, and the California Behavioral Health Planning Council to implement this program. This includes holding stakeholder meetings at least quarterly. (WIC §14045.20)
- 11)** Requires DHCS to amend its Medicaid state plan to include each category of certified peer support specialist as a provider type, and to include peer support specialist services as a distinct service type which may be provided to eligible Medi-Cal beneficiaries. (WIC §14045.22)
- 12)** Allows DHCS to use Mental Health Services Act Funds to develop and administer the certification program. (WIC §14045.23)
- 13)** Allows DHCS to establish certification fees. (WIC §14045.25)
- 14)** Allows DHCS to implement this law via notices, plan letters, bulletins, or similar instructions, without regulations, until regulations are adopted. Regulations must be adopted by July 1, 2022 (WIC §14045.27)

Comments:

- 1) **Intent of This Bill.** According to the author's office, the goal of this bill is twofold:
 - Require DHCS to establish a certification program for peer support providers; and
 - Provides increased family support and wraparound services.

The author notes that California lags behind the rest of the country in implementing a peer support specialist certification program. Currently, the Department of Veteran's Affairs and 48 states either have or are developing such a program.

- 2) **Examples of Requirements in Other States.**

Several other states recognize certified peer counselors. Staff surveyed a few of these states to determine their requirements.

Washington

The state of Washington allows peer counselors to work in various settings, such as community clinics, hospitals, and crisis teams. Peer counselors must be supervised by a mental health professional. Examples of things they may do include assisting an individual in identifying services that promote recovery, share their own recovery stories, advocacy, and modeling skills in recovery and self-management.

To become a peer counselor in Washington, a person must be accepted as a training applicant. They must complete a 40-hour training program and pass a state exam.

Tennessee

According to the State of Tennessee's Department of Mental Health and Substance Abuse Services, Certified Peer Recovery Specialists must complete an extensive application. If accepted, they complete a 40-hour training program and 75 hours of supervised peer recovery service. They must be supervised by a mental health professional or a qualified alcohol and drug abuse treatment professional.

New Mexico

The State of New Mexico offers peer support specialist certification. Applicants must demonstrate 2 years of recovery, complete a written application, complete 40 hours of supervised experience, complete required training, and pass an examination.

- 3) **Scope of Practice and Scope of Practice Exclusions.** This bill appears to outline a scope of practice for peer support specialists, although somewhat

indirectly, in WIC §§14045.12, and 14045.13(l) (via a definition of “peer support specialist services.”

The Board may wish to review and discuss §14045.19, which contains language that excludes “providing clinical services” from work that peer support specialists are qualified or authorized to do. The Board may wish to determine whether the language in that section provides sufficient protection of the Board’s practice acts. For similar bills in the past, the Board has at times recommended the following more specific language:

“Any services that fall under the scope of practice of the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code), the Educational Psychologist Practice Act (Chapter 13.5 (commencing with Section 4989.10) of Division 2 of the Business and Professions Code), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code), and the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code), which are not performed in an exempt setting as defined in Sections 4980.01, 4996.14, and 4999.22 of the Business and Professions Code, shall only be performed by a licensee or a registrant of the Board of Behavioral Sciences or other appropriately licensed professional, such as a licensed psychologist or board certified psychiatrist.”

- 4) **Identification of Supervisors.** The bill does not mention supervision requirements for peer support specialists or specify the amount of supervision that would be needed. Past versions of the bill have identified acceptable supervisors but left out LPCCs. The Board may want to recommend that LMFTs, LCSWs, and LPCCs be specified as acceptable supervisors.
- 5) **Fingerprinting Not Required for Certification.** This bill does not specify fingerprinting as a requirement to obtain certification as a peer support specialist.
- 6) **Previous Legislation.** The Board has considered similar bill proposals in recent years:
 - **SB 906** (2018, Beall) was very similar to this bill. The Board took a “support if amended” position on SB 906, requesting the following amendments:
 - An amendment to include LPCCs as acceptable supervisors of peer support specialists (SB 906 included psychologists, LCSWs, and LMFTs as allowable supervisors, but omitted LPCCs); and
 - An amendment to require that peer support specialists be fingerprinted.

SB 906 was vetoed by Governor Brown. In his veto message, the Governor stated the following: *“Currently, peer support specialists are used as providers in Medi-Cal without a state certificate. This bill imposes a costly new program*

which will permit some of these individuals to continue providing services but shut others out. I urge the stakeholders and the department to improve upon the existing framework while allowing all peer support specialists to continue to work.”

- SB 614 (2015-2016, Leno) proposed a similar program, although some modifications have been made. The Board took a “support if amended” position on SB 614, asking for a clear exclusion of psychotherapy services, a better-defined scope of services, and the inclusion of LPCCs as acceptable supervisors. SB 614 was ultimately gut-and-amended to address a different topic.

- 7) Recommended Position.** The Policy and Advocacy Committee discussed this bill at its April 5, 2019 meeting. It recommended that the Board consider taking a “support” position. It also directed staff to discuss the concerns in Items 3-5 above (scope of practice exclusions, identification of supervisors, and fingerprinting).

Staff contacted the author’s office to discuss the three items in question, and obtained the following feedback:

- Scope of practice exclusions: Staff shared the language presented in Item 3 above. The author’s office expressed a willingness to review and consider the language.
- Identification of supervisors: The author’s office indicated that the lack of identification of appropriate supervisors for peer support specialists was an oversight. They were understanding of the Board’s desire for LPCCs to also be considered appropriate supervisors, along with LMFTs and LCSWs.
- Fingerprinting: The author’s office indicated that the bill permits DHCS to include a fingerprinting requirement via regulations if it chooses.

8) Support and Opposition.

Support

Mental Health Services Oversight and Accountability Commission (co-sponsor)
Los Angeles County Board of Supervisors (co-sponsor)
Steinberg Institute (co-sponsor)
Anti-Recidivism Coalition
Association of California Healthcare Districts
Association of Community Human Service Agencies
Association of Regional Center Agencies
Bay Area Community Services
California Academy of Child and Adolescent Psychiatry
California Alliance of Child and Family Services
California Association of Alcohol and Drug Program Executives, Inc.

California Association of Local Behavioral Health Boards and Commissions
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Association of Veteran Service Agencies
California Behavioral Health Planning Council
California Coalition for Mental Health
California Council of Community Behavioral Health Agencies
California Hospital Association
California Society of Addiction Medicine
California State Association of Counties
California State Council of the Service Employees International Union
City College of San Francisco
City of San Jose
City of Santa Monica
Community Clinic Association of Los Angeles County
Community Mental Health Certificate Program at City College of San Francisco
Corporation for Supportive Housing
County Behavioral Health Directors Association of California
County of Santa Clara
County Welfare Directors Association
Crestwood Behavioral Health, Inc.
Depression and Bipolar Support Alliance
Didi Hirsch Mental Health Services
Disability Rights California
Juvenile Court Judges of California
Mental Health America of California
Mental Health America of Los Angeles
Mental Health America of Northern California
Mental Health Association of San Francisco
National Association of Social Workers, California Chapter
Pacific Clinics
Project Return Peer Support Network
Seneca Family of Agencies
The Arc and United Cerebral Palsy California Collaboration
Ventura County Board of Supervisors
Western Center on Law and Poverty
Several individuals

Oppose

None at this time.

9) History.

2019

04/08/19 April 8 hearing: Placed on APPR. suspense file.

04/02/19 Set for hearing April 8.

03/28/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0. Page 490.) (March 27). Re-referred to Com. on APPR.
03/13/19 Set for hearing March 27.
01/23/19 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
01/16/19 Referred to Com. on HEALTH.
12/04/18 From printer. May be acted upon on or after January 3.
12/03/18 Introduced. Read first time. To Com. on RLS. for assignment. To print.

10) Attachments.

Attachment A: *"Peer Certification: What are we Waiting For?"* by the California Mental Health Planning Council, February 2015

Attachment B: Executive Summary from *"Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers," Working Well Together, 2013*



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WHAT ARE WE WAITING FOR?

- **Advocacy**
- **Evaluation**
- **Inclusion**

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*Examining the Opportunities, Barriers, and Precedents for the Official
Recognition and Certification of Peer Specialists in California.*

February 2015

¹ “When you talk to people who have been through these programs and ask them what helped them, it is not the drugs, not the diagnosis. It's the lasting, one-on-one relationships with adults who listen....”

¹ <http://www.npr.org/blogs/health/2014/10/20/356640026/halting-schizophrenia-before-it-starts>

Leading the Way, yet Lagging Behind:

California is accustomed to being at the forefront of progressive, compassionate policy and legislation. Voters passed the Mental Health Services Act because they couldn't stand to see the misery of unaddressed mental illness and the state was an early adopter of parity laws and Medicaid expansion. As a state, we have been proud of our leadership. So, where has California lagged behind? California has yet to follow the example of 31 other states and the Veterans Administration in establishing and utilizing a standardized curriculum and certification protocol for Peer Specialists' services.

Peers are persons with lived experience as consumers and family members or caretakers of individuals living with mental illness. Their experiences make Peer Specialists invaluable members of a service team. Employment and certification simultaneously bridges the gap between those that need it and those that can best provide it while reinforcing the peer provider's own wellness and sense of purpose.

Right now, more than half of the United States has a Peer Certification Program in place – people practicing, producing, and billing. Making a difference in the lives of people they intimately understand because they have already staved off the same potential devastation. Because if you ask somebody struggling with a life-altering, all-consuming episode of any type of mental distress if they have sought help yet, the response - more often than not - would be *“they don't understand”* or *“I just can't deal with the process of getting that help”*. California has not been able to summon up the political will it would take to make the most basic and meaningful connection with somebody who needs it the most.

“A leader is not someone who stands before you, but someone who stands with you²”

What are Peer Specialists?

Peer Specialists are empathetic guides and coaches who understand and model the process of recovery and healing while offering moral support and encouragement to people who need it. Moral support and encouragement have proven to result in greater compliance with treatment/services, better health function, lower usage of emergency departments, fewer medications and prescriptions, and a higher sense of purpose and connectedness on the part of the consumer.

Peer Specialists also model and train on communication between health care provider and consumer in order to educate both on potential barriers or side effects of existing medications or treatment plans. In a world where primary care intersects with mental health care, but

² Native American Proverb

medical records are not necessarily shared, this alone is huge. Bridging that gap becomes one of the single highest predictors of effective treatment plans and positive outcomes. In a population with mortality rates that average 25 years sooner than non-SMI groups - for conditions that could be easily managed or cured - this one benefit alone is worth the investment.

It might be easier to describe Peer specialists by defining what they are NOT. Peer Specialists differ from Case Managers in that they do not identify resources, arrange for social or supportive services, or facilitate job trainings, educational opportunities, or living arrangements. They are not certified to offer medical advice or diagnoses, psychiatric or otherwise, or suggest, prescribe, or manage medications. Their function is not to “do for” but rather to “do with” and ultimately model and train wellness principles and self-sufficiency.

What is Peer Specialist Certification?

Peer Specialist Certification is an official recognition by a certifying body that the practitioner has met qualifications that include lived experience and training from a standardized curriculum on mental health issues. The standardized curriculum has been approved by the certifying body and includes a mandatory number of hours of training in various topics pertaining to mental health care, coaching, and ethics. The “specialist” designation is conferred when additional hours of training specific to special populations or age groups has been completed and the candidate has demonstrated thorough knowledge, skills, and ability within that subgroup.

The standardized curriculum includes topics such as documentation, boundaries and ethics, communication skills, working with specific populations, developing wellness plans, systems of care, principles of practices (i.e., engagement, strength-based planning, WRAP plans, case management); and advocacy, to name a few. At this time, there are several courses available through the community college system, but not on a statewide basis. Working Well Together has compiled an excellent comprehensive report - *Certification of Consumer, Youth, Family, and Parent Providers; A Review of the Research* – which provides detailed information, background, and context.³

Why Certification?

*“Regardless of the means selected to demonstrate competency, it is critical that the core competencies of a peer (knowledge, skills, job tasks, and performance domains of the profession) are identified according to a recognized process, such as a job task analysis or role delineation study. **This is because –all other program requirements, policies, and standards must tie back to the core competencies of the profession being credentialed.**”⁴*

³ http://www.inspiredatwork.net/uploads/WWT_Peer_Certification_Research_Report_FINAL_6.20.12__1_.pdf

⁴ Hendry, P., Hill, T., Rosenthal, H. Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services. ACMHA: The College for Behavioral Health Leadership and Optum, 2014

Defining and standardizing the classification of Peer Specialist through certification prevents engagement outside one's expertise. Like any other profession, the certification defines the level of care and services so that the parameters established by the standardized curriculum and certification requirements are respected and understood statewide. Any hiring organization can expect these levels of qualifications, training, and expertise in the person they hire and can plan their organizational functions around the duties encompassed by that expertise. It also provides guidance to the peer practitioner through an established code of ethics. This means that roles and functions of other providers will not be usurped or second-guessed by the Peer Specialists.

The role of the certified peer specialist is to encourage partners and lead through example on the best ways to advocate for oneself. Sometimes it is not enough to suggest resources and make recommendations for services – sometimes you have to walk the walk along with the person for the first few steps, or even the first few miles. In this respect, the Peer Specialist is the Sherpa of the mental health care world. As partners, they teach participants how to communicate with care providers, navigate insurance companies and bureaucracies, and lessen the anxieties that arise from these various interactions. As models, they demonstrate that recovery *is* possible.

The Time is Now

First and foremost, the time is now because Affordable Health Care, Mental Health Parity, Coordinated Care Initiative, and potentially even the Public Safety Realignment create workforce shortages, particularly in the area of rehabilitative services. The time is now because recognizing the value of Peer Specialists does not translate into standardized training, skill sets, duties, or pay scales. This will make it difficult to operationalize and maintain utilization on a scale sufficient to meet the workforce needs or government standards and requirements for reimbursement. In other words “failing to plan is planning to fail”.

The Center for Medicaid Services gave California permission to amend its State Plan to include Peer Providers in 2007, stating “*We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service*”⁵.

The time is now because the state is starting to fully understand the concept and value of peer services as part of both mental health care and the larger arena of primary care. Examples of this are their inclusion in the SB 82 (Steinberg) Investment in Mental Health and Wellness Act

⁵ Center for Medicare and Medicaid Services; SMDL #07-011; August 15, 2007

grant requirements for mobile crisis teams; the intent in the original Prop 63 language to include peers, family members, and parent providers as part of the MHSA workforce; and a one-time dedicated state budget allocation of training funds to the Office of Statewide Health Planning and Development for peers to be trained as mobile crisis team members. All of these components will be working together as part of the larger mental health network of care, but run the risk of operating at disparate training levels, scope of work, code of ethics, and pay levels from county to county.

Finally, the time is now because trying to standardize the classification after a piecemeal acceptance is put into place is inefficient and uninformative to potential employers. Moreover, it is unfair to people who are willing to share their expertise and demonstrate their commitment to this important and effective aspect of care and services.

To draw a timely comparison, the classification of drug and alcohol counselors, which often has a strong peer component as part of the qualifications for employment, received an early welcome into the workforce. However, this acceptance was unaccompanied by any defined training, experience, or education requirements. There has been an attempt to retroactively achieve some standardization across the lines, but proponents are finding that, due to the unstructured engagement of their services, there is no uniform requirement or skill level across treatment sites. Worse, there is a reluctance to champion a certification process, due to potential hardships and setbacks created for current successful peer employees who might not meet certification standards after the fact.

Is it Cost-Effective?

In Alameda County, a Peer Mentoring pilot project provided 40 hours of training to 26 peers called “The Art of Facilitating Self-Determination” and matched them with people recently released from psychiatric hospitals. Those accepting a peer mentor experienced a 72% reduction in readmissions to the hospital. The cost savings for Alameda County was over a million dollars with an initial investment of \$238K- making a 470% return on investment⁶.

The Pew Trusts reported recently “In Georgia, a 2003 study compared patients diagnosed with schizophrenia, bipolar disorder and major depression whose treatment had included peer support, with patients who received traditional day treatment services without peers. The patients who had peer support had better health outcomes—and at a lower cost. The average annual cost of day treatment services is \$6,400 per person, while support services cost about \$1,000.”⁷

⁶ <http://www.oshpd.ca.gov/HWDD/pdfs/wet/PowerPoint-Peer-Support-Specialist-A-Galvez-S-Kuehn.pdf>

⁷ <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage>; last accessed 11/5/2014

Who Employs Peer Specialists?

Between October 2013 and January 2015, the Advocacy Committee of the California Mental Health Planning Council (CMHPC) heard presentations from Peer Specialist Advocates and Peer-run programs throughout the state. The programs represented different models ranging from peer-run respite to peer partners in health care, but all of them reported positive outcomes for the participants, cost savings for their respective counties, and a bolstering of their own wellness commitment. Here is a brief review of a few of the models the Advocacy Committee heard from.

Health Navigators USC

The Peer Health navigator connects consumers to mental health, primary care, substance use, and specialty health care services; teaches them how to advocate for themselves and effectively communicate their needs; create a follow-up plan and other self-management skills through a “modeling, coaching, fading”. They differ from Case Managers or care coordinators in that the health navigator will ultimately step away from the participant once the modeling/coaching/fading process is successful.

Typically a full-time navigator will have 12 – 15 clients at any one time, and averages 30-40 clients annually, depending on how quickly the clients moves into full self-management. Many of the services are Medicaid billable under Targeted Case Management or Rehabilitation providing the documentation reflects justification for the services rendered. Participants are trained on billing codes and documentation. The program has developed its own curriculum and provides its own training and certification.

2nd Story, Santa Cruz

2nd Story is a SAMHSA-funded program that is an entirely Peer-Run Crisis Center in Santa Cruz. All staff are trained in “Intentional Peer Support” and all wellness class topics are determined by the guests. The program provides its own training. The length of stay is no longer than two weeks, and guests are encouraged to maintain their “normal” life (school, work) during their stay. Outreach is conducted by staff posted at County mental health departments telling potential guests about the program. Referrals are also made by psychiatrists, care managers, and Telecare, a county mental health services provider/contractor, sometimes diverts people to 2nd Story rather than enrolling them in a longer term, more structured social rehabilitation facility. The program is proving to be a key preventative service in Santa Cruz that forestalls or reduces the need for crisis residential and sub-acute stabilization programs.

In-Home Outreach Team (IHOT), San Diego

As Assisted Outpatient Treatment steadily gains ground in more California counties, a small program in San Diego is providing an effective and legitimate alternative at promoting and facilitating voluntary access to services. IHOT teams consist of a Peer Specialist, family member, personal service coordinator and team lead. They provide in-home outreach to adults with serious mental illness (SMI) who are reluctant or resistant to receiving mental health services. IHOT also provides support and education to family members and/or caretakers of IHOT participants. They work with individuals living with severe mental illness and who may also be dually diagnosed with a substance use disorder or drug dependency. Teams serve a combined 240-300 consumers per year (80-100 per team).

A 2013 San Diego Health and Human Services report notes that the average cost per IHOT participant amounts to \$8,100, compared to an annual cost per individual in a Full Service Partnership (\$20,000 including housing) and Assisted Outpatient Treatment (\$34,000). Staff ratios are similarly proportionate: IHOT = 1:25 staff to client ratio; FSP and AOT each have a 1:10 staff to client ratio.

What Other States Employ and Certify Peer Specialists?

As of 2013, Certified Peer Specialists were certified and employed in 31 states and the federal Department of Veteran's Affairs. The extent of engagement and responsibility varies from state to state, but all services are Medicaid billable. These 31 states are consistent in their belief and trust in Peer Specialists – when will California join them?

What is Stopping California?

Despite all of the merits, fiscal and clinical, of Certified Peer Specialists, California has not been able to match its actions to its talk in this area. California embraces the concept of recovery, wellness, and resilience – and recognizes the essential components of both employment and inclusion as part of those processes – but it has failed to turn those concepts to tangible actions.

No State Department feels that it is in their purview to establish, implement or oversee a state certification process. Education may approve a curriculum, but it is not empowered to grant certification. Department of Health Care Services may be able to approve billable services, but is not empowered to establish curriculum or gage mastery of the subject matter. The Office of Statewide Health Planning and Development (OSHPD) has a Workforce Development Division, and is specifically charged with mental health workforce development issues, but without specific language or policy permitting OSHPD to include or pursue the specific classification of Peer Specialist, OSHPD does not felt comfortable facilitating it. In short, the single, largest barrier has been the identification of a lead agency or organization that can be charged with facilitation, implementation, and identification of a certification and oversight

body. There may be philosophical or conceptual agreement on the importance of Peer Specialists, but no policy or political direction to move it forward.

How Can California Catch Up?

Peer Specialist Certification is a cross-cutting, inclusive, and cost-saving classification that has applications across all vulnerable and at-risk populations in the state – veterans, homeless, Transition Age Youth, elderly, and criminal justice populations to name a few - and has particular utility in integrated services for the dually diagnosed and co-morbid conditions in health care.

The California Mental Health Planning Council (CMHPC) recommends that the Legislature continue and solidify its mission to create a seamless, comprehensive, continuum of mental health services and care by:

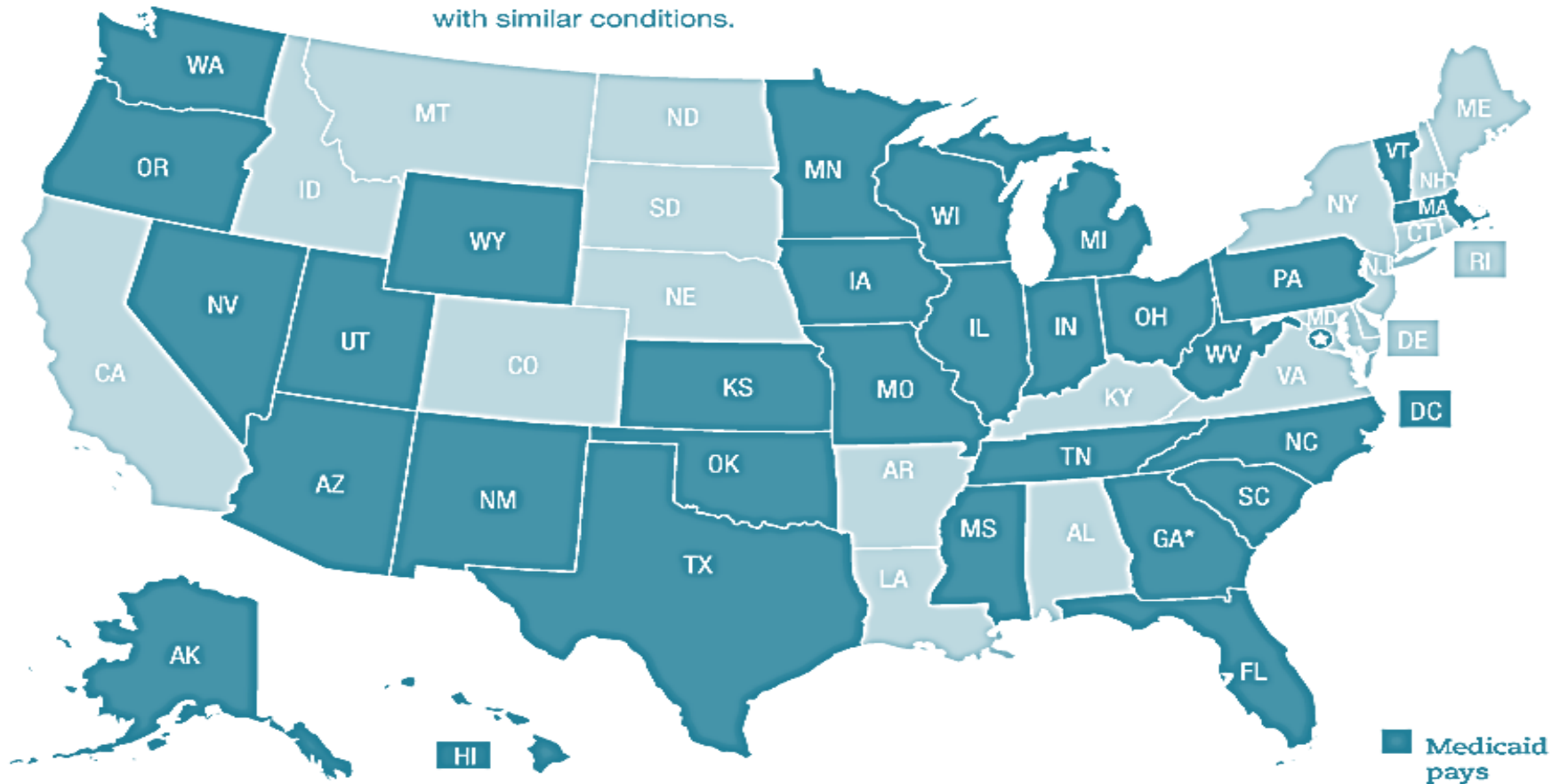
- developing clarifying legislative language that MHSAs and/or other funding may be used to establish an implementation and oversight body for statewide Peer Specialist Certification; and/or
- making Peer Certification a priority of the 2015-16 Legislative Session as a stand-alone issue ; and/or
- requiring the Certification of Peer Specialists in legislation pertaining to workforce expansion or expanded services for vulnerable populations: and/or
- identifying and including funding for the establishment of a Peer Specialist certifying and oversight body through the annual Budget Act.

The CMHPC has been following and supporting the efforts of Inspired at Work, California Association of Mental Health Peer Run Organizations (CAMHPRO), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) and the former Working Well Together Group to bring this issue to the forefront of mental health policy. These groups dedicated countless hours to investigating best practices, training models, potential curriculums, and workforce applications for Certified Peer Specialists and have generously shared their time and information to bring the CMHPC and others up to speed. Their work deserves attention and close consideration by anybody that might be in a position to support the implementation process. For detailed information on the background, issues, application, and potential processes, please visit: <http://workingwelltogether.org/resources/recruiting-hiring-and-workforce-retention/wwt-toolkit-employing-individuals-lived> or <http://www.inspiredatwork.net/Resources.html>,

Mental Health Peer Specialists

States where Medicaid pays for them

In 31 states, Medicaid pays for licensed peer specialists, counselors recovering from severe mental illness or substance addiction who are trained to help others with similar conditions.



Source: OptumHealth and Appalachian Consulting Group
 NOTE: In Georgia, Medicaid pays peer specialists to provide "whole health" counseling.

Stateline infographic by Adam Rotmil and Christine Vestal
 September 11, 2013

2013

Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers



Working Well Together

Training and Technical Assistance Center



Report prepared for CAMHRO PEERS
under Working Well Together
by Inspired at Work
Lucinda Dei Rossi, MPA, CPRP and
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We'd like to specially recognize Karin Lettau for her diligence, hard work and grace in ensuring that all stakeholders felt heard and understood throughout the process.

DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the Office of Statewide Health Planning and Development.

Executive Summary

Working Well Together is the only statewide organization dedicated to transforming systems to be client and family-driven by supporting the sustained development of client, family member and parent/caregiver employment within every level of the public mental health workforce. As part of this effort Working Well Together has, for the last three years, engaged in researching and evaluating the feasibility of inclusion of Peer Support into a State Plan Amendment for Specialty Mental Health services. This three year effort has included thorough state-wide and national research and extensive stakeholder involvement and has yielded seventeen recommendations for the development of Peer Support as an integral service within the public mental health system.

The statewide survey conducted to evaluate the current practice of hiring consumers and family members into the mental health workforce revealed that most counties have indeed hired people with lived experience of a mental health challenge or parents/family members of individuals with a mental health issue into the mental health workforce. However the survey also revealed that there remain significant workforce issues that must be addressed. Of the thirty responding counties that hire people with lived experience, none required previous training or education beyond a high school diploma as a qualification for hire. This was found to be true even in counties that have developed excellent training programs for Peer Support. Additional findings revealed that a variety of generalist job titles are used to hire Peer Support Specialists, job duties and descriptions vary widely and may or may not include peer support as a job duty.

The stakeholder process exposed a number of workforce issues that must be addressed to further the professional development of Peer Support as a discipline and Peer Support Specialists as practitioners. Perhaps the most pressing issue is the lack of a definition and/or understanding of Peer Support. While most counties have hired individuals with lived experience as well as parents and family members to provide services, many of these practitioners are providing services that are traditionally considered “case management” and include collateral, targeted case management and rehabilitation services. Another identified trend was the use of peer employees as clerical support, transportation providers and social or recreational activities support. Interestingly, while many of these practitioners are providing billable services within the scope of practice of “Other Qualified Provider”, very few

counties (approximately nine) are billing Medi-Cal for these services. Going forward it is vital that Peer Support is identified as a separate and distinct service from other services provided under the current definitions of Specialty Mental Health services. Additional workforce issues identified by stakeholders necessary to advance the development for and respect of Peer Support include the;

1. Creation of welcoming environments that embrace these practitioners.
2. Development of multi-disciplinary teams that respect this new discipline.
3. Education and training of County Directors and Administration as well as the existing workforce on the value, role and legitimacy of peer support.
4. Training and acceptance of Medi-Caid approved use of recovery/resilience/wellness language in documentation.

While stakeholders strongly support the inclusion of peer support into a State Plan Amendment, they also support flexibility in what services individuals with lived experience can provide within the mental health system. Stakeholders strongly support career ladders that include non-certified peer providers as well as people with lived experience continuing their education and advancing into existing positions traditionally used in mental health settings, including supervision and management as well as the development of career ladders that include advancement opportunities within the practice of peer support. In short, stakeholders support maximum flexibility in what people with lived experience can provide and bill for within the existing State Plan as well as the inclusion of peer support as a new service category.

Stakeholders also emphasize the importance of recognizing that there are a number of services that enhance wellness and recovery/resiliency that peers may provide but that may not be reimbursed by Medi-Caid. It will be vital, when considering adding peer support as a new service, that reimbursement for peer support services not become the primary driving focus when offering/providing these services to clients and their families.

Working Well Together has engaged stakeholders in on-going teleconferences, webinars, work-groups, and five regional stakeholder meetings to provide feedback and recommendations that will support the requirements as laid out by the CMS letter regarding inclusion of peer support as a part of services provided under Specialty Mental Health. This resulted in several recommendations in support of the development of a statewide

Certification for Peer Support Specialists. In May of 2013 a final Statewide Stakeholder Summit was convened to provide further vetting with the goal of finalizing recommendations for the inclusion of peer support into the State Plan Amendment as well as the development of a statewide Certification for Peer Support Specialists. By and large the vast majority of stakeholders support the original recommendations, however, where appropriate, adjustments have been made in alignment with stakeholder feedback. Also where appropriate, additional edits to specific recommendations have been made to provide clarity. The seventeen recommendations are listed below.

DRAFT

Final Stakeholder Recommendations regarding Certification of Peer Support Specialists

Recommendation 1

Develop a statewide certification for Peer Support Specialists, to include:

- Adult Peer Support Specialists
- Young Adult Peer Support Specialists
- Older Adult Peer Support Specialists
- Family Peer Support Specialists (Adult Services)
- Parent Peer Support Specialists (Child/Family Services)

- 1.1 Require Peer Support Specialists to practice within the adopted Peer Support Specialist Code of Ethics.
 - 1.1.1 Seek final approval of Peer Support Code of Ethics by the Governing Board of Working Well Together.
- 1.2 Develop or adopt standardized content for a state-wide curriculum for training Peer Support Specialists.
- 1.3 Require a total of 80 hours of training for Peer Support Specialist Certification.
 - 1.3.1 55-hour core curriculum of general peer support education that all peer support specialists will receive as part of the required hours towards certification.
 - 1.3.2 25-hours of specialized curriculum specific to each Peer Support Specialist category.
- 1.4 Require an additional 25 hours of training to become certified in a specialty area such as forensics, co-occurring services, whole health and youth in foster care.
- 1.5 Require six months full-time equivalent experience in providing peer support services.
 - 1.5.1 This experience can be acquired through employment, volunteer work or as part of an internship experience.
- 1.6 Require 15 hours of CEU's per year in subject matter relevant to peer support services to maintain certification.
- 1.7 Require re-certification every three years.
- 1.8 Allow a grandfathering-in process in lieu of training.

- 1.8.1 Require one year of full-time equivalent employment in peer support services.
- 1.8.2 Require three letters of recommendation. One letter must be from a supervisor.
The other letters may come from co-workers or people served.
- 1.9 Require an exam to demonstrate competency.
 - 1.9.1 Provide test-taking accommodations as needed.
 - 1.9.2 Provide the exam in multiple languages and assure cultural competency of exam.

Recommendation 2

Identify or create a single certifying body that is peer-operated and/or partner with an existing peer-operated entity with capacity for granting certification.

Recommendation 3

Include Peer Support as a service and Peer Support Specialist as a provider type within a new State Plan Amendment.

- 3.1 Seek adoption of the definitions of Peer Support Specialist providers and Peer Support services by the Governing Board of Working Well Together for use within the State Plan Amendment.
- 3.2 Maintain the ability for people with lived experience to provide services as “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.
- 3.2 Acknowledge that there are important and non-billable services that Peer Support Specialists can and do provide.

Recommendation 4

Include in the State Plan the ability to grant site certification for peer-operated agencies to provide billable peer support services.

- 4.1 Allow for peer-operated agencies to provide other services billable under “other qualified provider” within their scope of practice, including but not limited to rehabilitation services, collateral and targeted case management.

Recommendation 5

Address the concern that current practice of documentation for billing may not be aligned with the values and principles of peer support and a wellness, recovery and resiliency orientation.

- 5.1 Engage with partners such as Department of Health Care Services and the California Mental Health Director’s Association in order to develop an action plan to advocate for the use of CMS-approved recovery/resiliency-oriented language in documentation.

Recommendation 6

Investigate the options for broadening the definition of “service recipient” to include parents and family members of minors receiving services so that peer support services can be accessed more easily.

Recommendation 7

Convene a working group consisting of Working Well Together, the Mental Health Directors, the Office of Statewide Healthcare Planning and Development (OSHPD) and the Department of Health Care Services to develop buy-in and policies that will create consistency of practice regarding peer support services across the state.

Recommendation 8

Develop standards and oversight for the provider/entity that provides training of Peer Support Specialists.

- 8.1 Allow for multiple qualified training entities.
- 8.2 Training organizations must demonstrate infrastructure capacity that will allow for peer trainers.
- 8.3 Training must be provided by either individuals with lived experience or by a team that includes individuals with lived experience.

Recommendation 9

Establish qualifications for who may supervise Peer Support Specialists.

- 9.1 Engage with the Mental Health Directors to develop a policy that outlines key qualifications necessary for the supervision of Peer Support Specialists.
- 9.2 Preferred supervisors are those individuals with lived experience and expertise in peer support.
- 9.3 Due to capacity issues, supervisors may include qualified people who receive specific training on the role, values and philosophy of peer support.
- 9.4 Recognize and define the specific qualities and skills within supervision that are required for the supervision of Peer Support Specialists. These skills should align with the values and philosophy of peer support.

Recommendation 10

Develop a plan to provide extensive and expansive training on the values, philosophy and efficacy of peer support to mental health administration and staff.

Recommendation 11

Develop a plan to ensure that welcoming environments are created that embrace the use of multi-disciplinary teams that can incorporate Peer Support Specialists fully onto mental health teams.

Recommendation 12

Develop a policy statement that recognizes and defines the unique service components of peer support as separate and distinct from other disciplines and services in order to maintain the integrity of peer support services.

Recommendation 13

Develop a policy statement and plan that supports the professional development of Peer Support Specialists that allows the practitioner to maintain and hone his/her professional values, ethics and principles.

Recommendation 14

Develop a plan for funding the development of certification.

- 14.1 Work with the Office of Statewide Healthcare Planning and Development to utilize

state-wide monies from the MHSA Workforce, Education and Training fund.

14.2 Investigate other potential funding sources.

14.3 Develop recommendations for funding of components of certification such as financial assistance with training, exam and certification fees.

Recommendation 15

Seek representation on committees and workgroups that are addressing civil service barriers to the employment of Peer Support Specialists.

Recommendation 16

Work with Mental Health Directors to seek agreement on a desired workforce minimum of Peer Support Specialists within each county to more fully actualize the intent of the MHSA.

Recommendation 17

Develop state-wide models that can inform county leadership on the development of career ladders for Peer Support Specialists that begin with non-certified Peer Support Specialists and creates pathways into management and leadership positions.

AMENDED IN SENATE JANUARY 23, 2019

SENATE BILL

No. 10

Introduced by Senator Beall (*Principal
coauthor: Assembly Member Waldron*)
(*Coauthor: Senator Nielsen*)
(*Coauthor: Assembly Member Carrillo*)

December 3, 2018

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to mental health.

legislative counsel's digest

SB 10, as amended, Beall. Mental health services: peer, parent, transition-age, and family support specialist certification.

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~~ *healthcare* benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid *program* provisions. Existing law ~~provides for~~ *establishes* a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act also requires funds to be reserved for the costs of the State Department of Health Care Services, the California ~~Mental~~ *Behavioral* Health Planning Council, the Office of Statewide Health

Planning and Development (OSHPD), the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to certain programs provided for by the act, subject to appropriation in the annual Budget Act. The act provides that it may be amended by the Legislature by a $\frac{2}{3}$ vote of each house as long as the amendment is consistent with, and furthers the intent of, the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include 4 certification categories: adult peer support specialist, transition-age youth peer support specialist, family peer support specialist, and parent peer support specialist. The certification program's components would include, among others, defining responsibilities and practice guidelines, determining curriculum and core competencies, specifying training and continuing education requirements, establishing a code of ethics, and determining a certification revocation process. The bill would require an applicant for the certification as a peer, parent, transition-age, or family support specialist to meet specified requirements, including successful completion of the curriculum and training requirements.

This bill would require the department to consult with OSHPD and other stakeholders in implementing the certification program, including requiring quarterly stakeholder meetings. The bill would authorize the department to use funding provided through the MHSA, upon appropriation, to develop and administer the certification program, and would authorize the use of these MHSA funds to serve as the state's share of funding to claim federal financial participation under the ~~Medicaid Program~~ program.

This bill would authorize the department to establish a certification fee schedule and to require remittance of fees as contained in the schedule, for the purpose of supporting the department's activities associated with the ongoing administration of the certification program.

This

This bill would require the department to amend the Medicaid state plan to include a certified peer, parent, transition-age, and family peer

support specialist as a provider type for purposes of the Medi-Cal program and to include peer support specialist services as a distinct service type for purposes of the Medi-Cal program. The bill would require Medi-Cal reimbursement for peer support specialist services to be implemented only if, and to the extent that, federal financial participation is available and the department obtains all necessary federal approvals. The bill also would authorize the department to implement, interpret, or make specific its provisions by means of ~~informational~~ informal notices, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2022, and, commencing July 1, 2020, would require the department to provide semiannual status reports to the Legislature until regulations have been adopted.

This bill would declare that it clarifies terms and procedures under the Mental Health Services Act.

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

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

1 SECTION 1. Article 1.4 (commencing with Section 14045.10)
 2 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
 3 Institutions Code, to read:

4
 5 Article 1.4. Peer, Parent, Transition-Age, and Family Support
 6 Specialist Certification Program
 7

8 14045.10. This article shall be known, and may be cited, as
 9 the Peer, Parent, Transition-Age, and Family Support Specialist
 10 Certification Act of 2019.

11 14045.11. The Legislature finds and declares all of the
 12 following:

13 (a) With the enactment of the Mental Health Services Act in
 14 2004, support to include peer providers identified as consumers,
 15 parents, and family members for the provision of services has been
 16 on the rise.

17 (b) There are over 6,000 peer providers in California who
 18 provide individualized support, coaching, facilitation, and
 19 education to clients with mental ~~health care~~ *healthcare* needs and

1 substance use ~~disorder~~, *disorders*, in a variety of settings, yet no
2 statewide scope of practice, standardized curriculum, training
3 standards, supervision standards, or certification protocol is
4 available.

5 (c) The United States Department of Veterans Affairs and over
6 30 states utilize standardized curricula and certification protocols
7 for peer support services.

8 (d) The federal Centers for Medicare and Medicaid Services
9 (CMS) recognizes that the experiences of peer support specialists,
10 as part of an evidence-based model of care, can be an important
11 component in a state's delivery of effective mental health and
12 substance use disorder treatment. The CMS encourages states to
13 offer comprehensive programs.

14 (e) A substantial number of research studies demonstrate that
15 peer supports improve client functioning, increase client
16 satisfaction, reduce family burden, alleviate depression and other
17 symptoms, reduce hospitalizations and hospital days, increase
18 client activation, and enhance client self-advocacy.

19 (f) Certification can encourage an increase in the number,
20 diversity, and availability of peer support specialists.

21 14045.12. It is the intent of the Legislature that the peer, parent,
22 transition-age, and family support specialist certification program,
23 established under this article, achieve all of the following:

24 (a) Support the ongoing provision of services for beneficiaries
25 experiencing mental ~~health care~~ *healthcare* needs, substance use
26 disorder needs, or both by certified peer support specialists.

27 (b) Support coaching, linkage, and skill building of beneficiaries
28 with mental health needs, substance use disorder needs, or both,
29 and to families or significant support persons.

30 (c) Increase family support by building on the strengths of
31 families and helping them achieve a better understanding of mental
32 illness in order to help beneficiaries achieve desired outcomes.

33 (d) Provide part of a continuum of services, in conjunction with
34 other community mental health services and other substance use
35 disorder treatment.

36 (e) Collaborate with others providing care or support to the
37 beneficiary or family.

38 (f) Assist parents, families, and beneficiaries in developing
39 coping mechanisms and problem-solving skills in order to help
40 beneficiaries achieve desired outcomes.

1 (g) Promote skill building for beneficiaries in the areas of
2 socialization, recovery, self-sufficiency, self-advocacy,
3 development of natural supports, and maintenance of skills learned
4 in other support services.

5 (h) Encourage employment under the peer, parent, transition-age,
6 and family support specialist certification to reflect the culture,
7 ethnicity, sexual orientation, gender identity, mental health service
8 experiences, and substance use disorder experiences of the people
9 whom they serve.

10 14045.13. For purposes of this article, the following definitions
11 shall apply:

12 (a) “Adult peer support specialist” means a person who is 18
13 years of age or older and who has self-identified as having lived
14 experience of recovery from mental illness, substance use disorder,
15 or both, and the skills learned in formal training to deliver peer
16 support services in a behavioral setting to promote mind-body
17 recovery and resiliency for adults.

18 (b) “Certification” means the activities of the certifying body
19 related to the verification that an individual has met all of the
20 requirements under this article and that the individual may provide
21 mental health services and substance use disorder treatment
22 pursuant to this article.

23 (c) “Certified” means all federal and state requirements have
24 been satisfied by an individual who is seeking designation under
25 this article, including completion of curriculum and training
26 requirements, testing, and agreement to uphold and abide by the
27 code of ethics.

28 (d) “Code of ethics” means the standards to which a peer support
29 specialist is required to adhere.

30 (e) “Core competencies” are the foundational and essential
31 knowledge, skills, and abilities required for peer specialists.

32 (f) “Cultural competence” means a set of congruent behaviors,
33 attitudes, and policies that come together in a system or agency
34 that enables that system or agency to work effectively in
35 cross-cultural situations. A culturally competent system of care
36 acknowledges and incorporates, at all levels, the importance of
37 language and culture, intersecting identities, assessment of
38 cross-cultural relations, knowledge and acceptance of dynamics
39 of cultural differences, expansion of cultural knowledge, and

1 adaptation of services to meet culturally unique needs to provide
2 services in a culturally competent manner.

3 (g) “Department” means the State Department of Health Care
4 Services.

5 (h) “Family peer support specialist” means a person with lived
6 experience as a self-identified family member of an individual
7 experiencing mental illness, substance use disorder, or both, and
8 the skills learned in formal training to assist and empower families
9 of individuals experiencing mental illness, substance use disorder,
10 or both. For the purpose of this subdivision, “family member”
11 includes a sibling or kinship caregiver, and a partner of that family
12 member.

13 (i) “Parent” means a person who is parenting or has parented a
14 child or individual experiencing mental illness, substance use
15 disorder, or both, and who can articulate ~~his or her~~ *the parent’s*
16 understanding of ~~his or her~~ *their* experience with another parent
17 or caregiver. This person may be a birth parent, adoptive parent,
18 or family member standing in for an absent parent.

19 (j) “Parent peer support specialist” means a parent with formal
20 training to assist and empower families parenting a child or
21 individual experiencing mental illness, substance use disorder, or
22 both.

23 (k) “Peer support specialist services” means culturally competent
24 services that promote engagement, socialization, recovery,
25 self-sufficiency, self-advocacy, development of natural supports,
26 identification of strengths, and maintenance of skills learned in
27 other support services. Peer support specialist services shall
28 include, but are not limited to, support, coaching, facilitation, or
29 education to Medi-Cal beneficiaries that is individualized to the
30 beneficiary and is conducted by a certified adult peer support
31 specialist, a certified transition-age youth peer support specialist,
32 a certified family peer support specialist, or a certified parent peer
33 support specialist.

34 (l) “Recovery” means a process of change through which an
35 individual improves ~~his or her~~ *their* health and wellness, lives a
36 self-directed life, and strives to reach ~~his or her~~ *their* full potential.
37 This process of change recognizes cultural diversity and inclusion,
38 and honors the different routes to resilience and recovery based
39 on the individual and ~~his or her~~ *their* cultural community.

1 (m) “Transition-age youth peer support specialist” means a
2 person who is 18 years of age or older and who has self-identified
3 as having lived experience of recovery from mental illness,
4 substance use disorder, or both, and the skills learned in formal
5 training to deliver peer support services in a behavioral setting to
6 promote mind-body recovery and resiliency for transition-age
7 youth, including adolescents and young adults.

8 14045.14. No later than July 1, 2020, the department shall do
9 all of the following:

10 (a) Establish a certifying body, either through contract or through
11 an interagency agreement, to provide for the certification activities
12 described in this article.

13 (b) Provide for a statewide certification for each of the following
14 categories of peer support specialists, as contained in federal
15 guidance issued by the Centers for Medicare and Medicaid
16 Services, State Medicaid Director Letter (SMDL) #07-011:

17 (1) Adult peer support specialists, who may serve individuals
18 across the lifespan.

19 (2) Transition-age youth peer support specialists.

20 (3) Family peer support specialists.

21 (4) Parent peer support specialists.

22 (c) Define the range of responsibilities and practice guidelines
23 for the categories of peer support specialists listed in subdivision
24 (b), by utilizing best practice materials published by the federal
25 Substance Abuse and Mental Health Services Administration, the
26 federal Department of Veterans Affairs, and related notable experts
27 in the field as a basis for development.

28 (d) Determine curriculum and core competencies required for
29 certification of an individual as a peer support specialist, including
30 curriculum that may be offered in areas of specialization, including,
31 but not limited to, transition-age youth, veterans, gender identity,
32 sexual orientation, and any other areas of specialization identified
33 by the department. Core competencies-based curriculum shall
34 include, at a minimum, training related to all of the following
35 elements:

36 (1) The concepts of hope, recovery, and wellness.

37 (2) The role of advocacy.

38 (3) The role of consumers and family members.

39 (4) Psychiatric rehabilitation skills and service delivery, and
40 addiction recovery principles, including defined practices.

- 1 (5) Cultural competence training.
- 2 (6) Trauma-informed care.
- 3 (7) Group facilitation skills.
- 4 (8) Self-awareness and self-care.
- 5 (9) Cooccurring disorders of mental health and substance use.
- 6 (10) Conflict resolution.
- 7 (11) Professional boundaries and ethics.
- 8 (12) Safety and crisis planning.
- 9 (13) Navigation of, and referral to, other services.
- 10 (14) Documentation skills and standards.
- 11 (15) Study and test-taking skills.
- 12 (16) Confidentiality.
- 13 (e) Specify training requirements, including
- 14 core-competencies-based training and specialized training
- 15 necessary to become certified under this article, allowing for
- 16 multiple qualified training entities, and requiring training to include
- 17 people with lived experience as consumers and family members.
- 18 (f) Establish a code of ethics.
- 19 (g) Determine continuing education requirements for biennial
- 20 certification renewal.
- 21 (h) Determine the process for biennial certification renewal.
- 22 (i) Determine a process for investigation of complaints and
- 23 corrective action, which may include suspension and revocation
- 24 of certification.
- 25 (j) Determine a process for an individual employed as a peer
- 26 support specialist on January 1, 2020, to obtain certification under
- 27 this article.
- 28 14045.15. (a) In order to be certified as an adult peer support
- 29 specialist, an individual shall, at a minimum, satisfy all of the
- 30 following requirements:
- 31 (1) Be at least 18 years of age.
- 32 (2) Have or have had a primary diagnosis of mental illness,
- 33 substance use disorder, or both, that is self-disclosed.
- 34 (3) Have received, or be receiving, mental health services,
- 35 substance use disorder services, or both.
- 36 (4) Be willing to share ~~his or her~~ *the individual's* experience of
- 37 recovery.
- 38 (5) Demonstrate leadership and advocacy skills.
- 39 (6) Have a strong dedication to recovery.

- 1 (7) Agree, in writing, to abide by a code of ethics. A copy of
2 the code of ethics shall be signed by the applicant.
- 3 (8) Successfully complete the curriculum and training
4 requirements for an adult peer support specialist.
- 5 (9) Pass a certification examination approved by the department
6 for an adult peer support specialist.
- 7 (10) Successfully complete any required continuing education,
8 training, and recertification requirements.
- 9 (11) Meet all applicable federal requirements.
- 10 (b) To maintain certification pursuant to this section, an adult
11 peer support specialist shall do both of the following:
- 12 (1) Abide by the code of ethics and biennially sign an
13 affirmation.
- 14 (2) Complete any required continuing education, training, and
15 recertification requirements.
- 16 14045.16. (a) In order to be certified as a transition-age youth
17 peer support specialist, an individual shall, at a minimum, satisfy
18 all of the following requirements:
- 19 (1) Be at least 18 years of age.
- 20 (2) Have or have had a primary diagnosis of mental illness,
21 substance use disorder, or both, that is self-disclosed.
- 22 (3) Have received, or be receiving, mental health services,
23 substance use disorder addiction services, or both.
- 24 (4) Be willing to share ~~his or her~~ *the individual's* experience of
25 recovery.
- 26 (5) Demonstrate leadership and advocacy skills.
- 27 (6) Have a strong dedication to recovery.
- 28 (7) Agree, in writing, to abide by a code of ethics. A copy of
29 the code of ethics shall be signed by the applicant.
- 30 (8) Successfully complete the curriculum and training
31 requirements for a transition-age youth peer support specialist.
- 32 (9) Meet all applicable federal requirements.
- 33 (b) To maintain certification pursuant to this section, a
34 transition-age youth peer support specialist shall do both of the
35 following:
- 36 (1) Abide by the code of ethics and biennially sign an
37 affirmation.
- 38 (2) Complete any required continuing education, training, and
39 recertification requirements.

1 14045.17. (a) In order to be certified as a family peer support
2 specialist, an individual shall, at a minimum, satisfy all of the
3 following requirements:

- 4 (1) Be at least 18 years of age.
- 5 (2) Be self-identified as a family member of ~~an individual a~~
6 *person* experiencing mental illness, substance use disorder, or
7 both.
- 8 (3) Be willing to share ~~his or her~~ *the individual's* experience.
- 9 (4) Demonstrate leadership and advocacy skills.
- 10 (5) Have a strong dedication to recovery.
- 11 (6) Agree, in writing, to abide by a code of ethics. A copy of
12 the code of ethics shall be signed by the applicant.
- 13 (7) Successfully complete the curriculum and training
14 requirements for a family peer support specialist.
- 15 (8) Pass a certification examination approved by the department
16 for a family peer support specialist.
- 17 (9) Meet all applicable federal requirements.

18 (b) To maintain certification pursuant to this section, a family
19 peer support specialist shall do both of the following:

- 20 (1) Abide by the code of ethics and biennially sign an
21 affirmation.
- 22 (2) Complete any required continuing education, training, and
23 recertification requirements.

24 14045.18. (a) In order to be certified as a parent peer support
25 specialist, an individual shall, at a minimum, satisfy all of the
26 following requirements:

- 27 (1) Be at least 18 years of age.
- 28 (2) Be self-identified as a parent.
- 29 (3) Be willing to share ~~his or her~~ *the individual's* experience.
- 30 (4) Demonstrate leadership and advocacy skills.
- 31 (5) Have a strong dedication to recovery.
- 32 (6) Agree, in writing, to abide by a code of ethics. A copy of
33 the code of ethics shall be signed by the applicant.
- 34 (7) Successfully complete the curriculum and training
35 requirements for a parent peer support specialist.
- 36 (8) Meet all applicable federal requirements.

37 (b) To maintain certification pursuant to this section, a parent
38 peer support specialist shall do both of the following:

- 39 (1) Abide by the code of ethics and biennially sign an
40 affirmation.

1 (2) Complete any required continuing education, training, and
2 recertification requirements.

3 14045.19. (a) This article shall not be construed to imply that
4 an individual who is certified pursuant to this article is qualified
5 to, or authorized to, diagnose an illness, prescribe medication, or
6 provide clinical services.

7 (b) This article does not alter the scope of practice for a ~~health~~
8 ~~care~~ *healthcare* professional or authorize the delivery of ~~health~~
9 ~~care~~ *healthcare* services in a setting or manner that is not
10 authorized pursuant to the Business and Professions Code or the
11 Health and Safety Code.

12 14045.20. The department shall consult with the Office of
13 Statewide Health Planning and Development (OSHDP), peer
14 support and family organizations, mental health services and
15 substance use disorder treatment providers and organizations, the
16 County Behavioral Health Directors Association of California,
17 and the California Behavioral Health Planning Council in
18 implementing this article. Consultation shall initially include, at
19 a minimum, quarterly stakeholder meetings. The department may
20 additionally conduct technical workgroups upon the request of
21 stakeholders.

22 14045.21. To facilitate early intervention for mental health
23 services, community health workers may partner with peer, parent,
24 transition-age, and family support specialists to improve linkage
25 to services for the beneficiary.

26 ~~14045.22. The Legislature does not intend, in enacting this~~
27 ~~article, to modify the Medicaid state plan in any manner that would~~
28 ~~otherwise change or nullify the requirements, billing, or~~
29 ~~reimbursement of the “other qualified provider” provider type, as~~
30 ~~currently authorized by the Medicaid state plan.~~

31 14045.22. (a) *The department shall amend its Medicaid state*
32 *plan to do both of the following:*

33 (1) *Include each category of peer, parent, transition-age, and*
34 *family support specialist listed in subdivision (b) of Section*
35 *14045.14 and certified pursuant to this article as a provider type*
36 *for purposes of this chapter.*

37 (2) *Include peer support specialist services as a distinct service*
38 *type for purposes of this chapter, which may be provided to eligible*
39 *Medi-Cal beneficiaries who are enrolled in either a Medi-Cal*
40 *managed care plan or a mental health plan.*

1 **(b)** *The department may seek any federal waivers or other state*
2 *plan amendments as necessary to implement the certification*
3 *program provided for under this article.*

4 14045.23. The department may utilize Mental Health Services
5 Act moneys to fund state administrative costs related to developing
6 and administering this article, subject to an express appropriation
7 in the annual Budget Act for these purposes, and to the extent
8 authorized under the Mental Health Services Act. These funds
9 shall be available for purposes of claiming federal financial
10 participation under Title XIX of the federal Social Security Act
11 (42 U.S.C. Sec. ~~1396~~, *1396 et seq.*), contingent upon federal
12 approval.

13 14045.24. Medi-Cal reimbursement for peer support specialist
14 services shall be implemented only if, and to the extent that, federal
15 financial participation under Title XIX of the federal Social
16 Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all
17 necessary federal approvals have been obtained.

18 14045.25. The department may establish a certification fee
19 schedule and may require remittance as contained in the
20 certification fee schedule for the purpose of supporting the
21 activities associated with the ongoing administration of the peer,
22 parent, transition-age, and family support specialist certification
23 program. Certification fees charged by the department shall
24 reasonably reflect the expenditures directly applicable to the
25 ongoing administration of the peer, parent, transition-age, and
26 family support specialist certification program.

27 14045.26. For the purpose of implementing this article, the
28 department may enter into exclusive or nonexclusive contracts on
29 a bid or negotiated basis, including contracts for the purpose of
30 obtaining subject matter expertise or other technical assistance.

31 14045.27. Notwithstanding Chapter 3.5 (commencing with
32 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
33 Code, the department may implement, interpret, or make specific
34 this article by means of informal notices, plan letters, plan or
35 provider bulletins, or similar instructions, without taking regulatory
36 action, until the time regulations are adopted. The department shall
37 adopt regulations by July 1, 2022, in accordance with the
38 requirements of Chapter 3.5 (commencing with Section 11340) of
39 Part 1 of Division 3 of Title 2 of the Government Code.
40 Commencing July 1, 2020, the department shall provide semiannual

1 status reports to the Legislature, in compliance with Section 9795
2 of the Government Code, until regulations have been adopted.
3 SEC. 2. The Legislature finds and declares that this act clarifies
4 procedures and terms of the Mental Health Services Act within
5 the meaning of Section 18 of the Mental Health Services Act.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 163

VERSION: AMENDED APRIL 9, 2019

AUTHOR: PORTANTINO

SPONSOR: • DIR/ FLOORTIME COALITION OF CALIFORNIA

RECOMMENDED POSITION: SUPPORT

SUBJECT: HEALTH CARE COVERAGE: PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

Summary:

This bill seeks to close some of the loopholes that insurance companies use to deny treatment for behavioral health treatment for pervasive developmental disorder or autism. It also revises the definitions of a “qualified autism service professional” and a “qualified autism service paraprofessional.”

Existing Law:

- 1) Requires that every health care service plan or health insurance policy that provides hospital, medical or surgical coverage must also provide coverage for behavioral health treatment for pervasive developmental disorder or autism (PDD/A). (Health and Safety Code (HSC) §1374.73(a), Insurance Code (IC) §10144.51(a))
- 2) Requires these health care service plans and health insurers subject to this provision to maintain an adequate network of qualified autism service providers who provide behavioral health treatment. (HSC §1374.73(b), IC §10144.51(b))
- 3) Defines “behavioral health treatment” as professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, which develop or restore the functioning of an individual with pervasive developmental disorder or autism, and meets the following criteria (HSC §1374.73(c), IC §10144.51(c):
 - a) Is prescribed by a licensed physician and surgeon or is developed by a licensed psychologist;
 - b) Is provided under a treatment plan prescribed by a qualified autism service provider and administered by one of the following:
 - A qualified autism service provider;
 - A qualified autism service professional under supervision of a qualified autism service provider; or

- A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
 - c) The treatment plan has measurable goals over a specific timeline and the plan is reviewed by the provider at least once every six months; and
 - d) Is not used for purposes of providing or for the reimbursement of respite, day care, or educational services, or for reimbursement of parent participation.
- 4) Defines a “qualified autism service provider” as either (HSC §1374.73(c), IC §10144.51(c)):
- a) A person that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited and who designs, supervises, or provides treatment for pervasive developmental disorder or autism; or
 - b) A person who is licensed as a specified healing arts practitioner, including a psychologist, marriage and family therapist, educational psychologist, clinical social worker, or professional clinical counselor. The licensee must design, supervise, or provide treatment for pervasive developmental disorder or autism and be within his or her experience and competence.
- 5) Defines a “qualified autism service professional” as someone who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
- a) Provides behavioral health treatment;
 - b) Is supervised by a qualified autism service provider;
 - c) Provides treatment according to a treatment plan developed and approved by the qualified autism service provider.
 - d) Is a behavioral service provider who meets the educational and experience qualifications for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations (CCR); and
 - e) Has training and experience providing services for pervasive developmental disorder or autism pursuant to the Lanterman Developmental Disabilities Services Act or California Early Intervention Services Act.
 - f) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- 6) Defines a “qualified autism service paraprofessional” as an unlicensed and uncertified person who meets all of the following (HSC §1374.73(c), IC §10144.51(c)):
- a) Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice;

- b) Provides treatment and services according to a treatment plan developed and approved by the qualified autism service provider;
 - c) Meets education and training qualifications set forth in Title 17, §54342 of the CCR;
 - d) Has adequate education, training, and experience as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
 - e) Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.
- 7) Defines vendor service codes and sets requirements for regional centers to classify the following professions (17 CCR §54342):
- a) Associate Behavior Analysts;
 - b) Behavior Analysts;
 - c) Behavior Management Assistants;
 - d) Behavior Management Consultants; and
 - e) Behavior Management Programs.

This Bill:

- 1) Modifies the definition of “behavioral health treatment.” The new definition specifies that it means professional services and treatment programs based on behavioral, developmental, behavior-based, or other evidence-based models, including applied behavior analysis and other evidence-based behavior intervention programs, that develop or restore functioning. (HSC §1374.73(c)(1)), IC §10144.51(c)(1))
- 2) Specifies that the behavioral health treatment plan’s intervention plan includes parent participation, when clinically appropriate, that is individualized to the patient and takes into account the ability of the parent or caregiver to participate. (HSC §1374.73(c)(1)(C)(ii) and IC §10144.51(c)(1)(C)(ii))
- 3) Specifies that the behavioral health treatment’s intervention plan utilizes evidence-based practices with demonstrated clinical efficacy. (HSC §1374.73(c)(1)(C)(iii), IC §10144.51(c)(1)(C)(iii))
- 4) Makes the following changes to the definition of a “qualified autism service professional” (HSC §1374.73(c)(4) and IC §10144.51(c)(4)):
 - a) Specifies that they may provide behavioral health treatment, including clinical case management and case supervision, under the direction of a qualified autism service provider, provided that the services are consistent with their experience, training, or education.

- b) Requires them to meet one of the following criteria:
- i. Meet the education and experience requirements to be classified as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in regulation (17 CCR §54342), or
 - ii. Have a Bachelor of Arts or science degree and one of the following:
 - One year of experience in designing or implementing behavioral health treatment under supervision by a qualified autism service provider and 12 semester units from an accredited school in either applied behavior analysis or clinical coursework in behavioral health; or
 - Two years of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider; or
 - Be a registered psychological assistant or registered psychologist. However, these professionals may not supervise a qualified autism service paraprofessional until he or she has obtained at least 500 experience hours designing or implementing behavioral health treatment; or
 - Be an associate clinical social worker, associate marriage and family therapist, or associate professional clinical counselor. However, these professionals may not supervise a qualified autism service paraprofessional until they have obtained at least 500 hours of experience in designing or implementing behavioral health treatment; or
 - Be credentialed or certified by an accredited national entity, including but not limited to the Behavior Analyst Certification Board, to provide applied behavior analysis or behavioral health treatment.
- c) Have training and experience providing services for pervasive developmental disorder our autism.
- d) Has completed a background check with subsequent notifications.

5) Makes the following changes to the definition of a “qualified autism service paraprofessional” (HSC §1374.73(c)(5) and IC §10144.51(c)(5)):

- a) Requires them to meet one of the following:
- i. For applied behavioral analysis, the education and training qualifications described in 17 CCR §54342; or
 - ii. For other evidence-based behavioral health treatments, all of the following:

- Have an associate degree or have completed two years of study from an accredited college with coursework in a related field of study;
 - Have 40 hours of training in the specific form of behavioral health treatment developed by a qualified autism provider, and administered by a qualified autism service provider or autism services professional competent in the form of behavioral health treatment to be practiced by the paraprofessional;
 - Has adequate education, training, and experience, as certified by a qualified autism service provider;
- iii. They are credentialed or certified in applied behavior analysis or behavioral health treatment for paraprofessionals or technicians by a national entity that is accredited by the National Commission for Certifying Agencies or the American National Standards Institute. If the applicant has finished the required training and education necessary for this certification or credential and meets all other requirements, he or she may provide treatment and services for up to 180 days while in the process of obtaining the certification or credential.
- b) Requires them to complete a background check with subsequent notification to the employer.
- 6) Removes the clause exempting health care service plans and health insurance policies in the Medi-Cal program from the requirements to provide behavioral health treatment for PDD/A. (HSC §1374.73(d), IC §10144.51(d))
- 7) Specifies that the setting, location, or time of treatment recommended by the qualified autism service provider cannot be used as the only reason to deny or reduce coverage for medically necessary services. Also requires the setting to be consistent with the standard of care for behavioral health treatment. (HSC §1374.73(g)(1), IC §10144.51(g)(1))
- 8) Specifies that while parent or caregiver participation should be encouraged, lack of parent or caregiver participation shall not be used as a basis for denying or reducing coverage of medically necessary services. (HSC §1374.73(g)(2), IC §10144.51(g)(2))

Comments:

- 1) **Author's Intent.** The author's office states that currently, patients with pervasive development disorder or autism (PDD/A) are being denied treatment coverage for prescribed behavioral health treatment, due to loopholes in the law. Some of these loopholes include the requirement for parental participation and location of service requirements. In addition, in some cases, coverage is only being offered for one form of behavioral health treatment, leading to a shortage of network providers and a

6 to 12 month waiting list for services. This bill seeks to remove these loopholes, and to increase the requirements to qualify as an autism service paraprofessional.

- 2) Effect on Board Licensees.** This bill would broaden the requirements to qualify as an autism service professional. Currently, to qualify, one must meet the same education and experience requirements as a behavioral service provider approved by a regional center to provide services. This bill would leave that as one option to qualify but would also allow an individual with a registration as an associate marriage and family therapist, associate clinical social worker, or associate professional clinical counselor to qualify. Under the proposed language, a Board registrant would need to obtain at least 500 hours of experience designing and implementing behavioral health treatment before he or she could supervise a qualified autism service paraprofessional.
- 3) Prior Year Legislation.** Last year, the Board considered a substantially similar bill, SB 399 (Portantino). At its May meeting, the Board took a “support if amended” position on the bill and asked that Licensed Educational Psychologists (LEPs) also be included as someone who can be a “qualified autism service professional.”

However, upon discussion with the author’s office and sponsor, staff learned that making this change would likely be counter-productive for LEPs. LEPs are already included as qualified autism service providers, which is a higher category than qualified autism service professionals. As qualified autism service providers, LEPs can supervise qualified autism service professionals and paraprofessionals. The sponsor advised that including LEPs as professionals could be counter-productive, because it could allow insurance companies to require them to be supervised and to be paid at a reduced rate. Staff agrees with this assessment.

SB 399 was enrolled but was ultimately vetoed by Governor Brown. In his veto message, he stated that standards for providers of behavioral health treatment had already been updated in the prior year.

- 4) Other Previous Legislation.** AB 1074 (Chapter 385, Statutes of 2017) closed several loopholes in law being used to deny coverage for behavioral health treatment in an effort to increase access to care.

SB 1034 (Mitchell, 2016) would have made some adjustments to law to close some of the loopholes insurance companies use to deny behavioral health treatment. The Board took a “support” position on SB 1034 at its May 2016 meeting. However, the bill died in the Assembly Appropriations Committee.

AB 796 (Chapter 493, Statutes of 2016) deleted the sunset date on the law that requires health care service plans or insurance policies to provide coverage for behavioral health treatment for PDD/A.

SB 126 (Chapter 680, Statutes of 2013) extended the provisions of SB 946 until January 1, 2017.

SB 946 (Chapter 650, Statutes of 2011) requires every health care service plan contract and insurance policy that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for PDD/A.

5) Recommended Position. At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended that the Board consider taking a “support” position on this bill.

6) Support and Opposition.

Support

- Dir/Floortime Coalition of California (Sponsor)
- California Psychological Association
- Cherry Crisp Entertainment and Productions
- Golden Steps Pediatric Therapy
- Greenhouse Therapy Center
- Professional Child Development Associates
- The Interdisciplinary Council on Development and Learning
- The Newton Center for Affect Regulation
- (144 individuals)

Oppose

- America's Health Insurance Plans (AHIP); California Association for Behavior Analysis;
- Association of California Life & Health Insurance Companies
- California Association of Health Plans
- California Chamber of Commerce

7) History

2019

04/26/19 Set for hearing May 6.

04/23/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 6. Noes 0.) (April 22). Re-referred to Com. on APPR.

04/12/19 Set for hearing April 22.

04/09/19 Read second time and amended. Re-referred to Com. on HUMAN S.

04/08/19 From committee: Do pass as amended and re-refer to Com. on HUMAN S. (Ayes 8. Noes 0.) (April 3).

03/14/19 Set for hearing April 3.

03/14/19 April 10 hearing postponed by committee.

03/12/19 Set for hearing April 10.

02/06/19 Referred to Coms. on HEALTH and HUMAN S.

01/25/19 From printer. May be acted upon on or after February 24.

01/24/19 Introduced. Read first time. To Com. on RLS. for assignment. To print.

8) Attachments

Attachment A: Definitions in 17 CCR §54342 (*Partial: only includes pages with relevant definitions*)

ATTACHMENT A

THOMSON REUTERS

WESTLAW California Code of Regulations[Home Table of Contents](#)**§ 54342. Types of Services.**

17 CA ADC § 54342

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

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Title 17. Public Health

Division 2. Health and Welfare Agency - Department of Developmental Services Regulations

Chapter 3. Community Services

Subchapter 2. Vendorization

Article 3. Vendor Numbers and Service Codes

17 CCR § 54342

§ 54342. Types of Services.

(a) The following service codes shall be assigned to the following types of services:

(1) Activity Center - Service Code 505. Activity Centers shall meet the requirements in Sections 56710 through 56756 of these regulations for the specific service being vendored.

(2) Acute Care Hospitals - Service Code 700. A regional center shall classify a vendor as an acute care hospital if the vendor is either:

(A) An acute care hospital which is validly licensed as such by DHS, and which provides inpatient care 24-hours per day; or

(B) An acute psychiatric hospital which is validly licensed as such by DHS, and which provides care for the mentally disordered, incompetent persons referred to in Welfare and Institutions Code, Sections 5000 to 5550.

(3) Adaptive Skills Trainer - Service Code 605. A regional center shall classify a vendor as an adaptive skills trainer if the vendor possesses the skills, training and education necessary to enhance existing consumer skills. An adaptive skills trainer may also remedy consumer skill deficits in communication, social function or other related skill areas and shall meet the following requirements:

(A) Possess a Master's Degree in one of the following: education, psychology, counseling, nursing, social work, applied behavior analysis, behavioral medicine, speech and language, or rehabilitation; and

(B) Have at least one year of experience in the design and implementation of adaptive skills training plans.

(4) Adult Day Care - Service Code 855.

(A) A regional center shall classify a vendor as an adult day care facility if the vendor:

1. Possesses a valid day care license for adults issued by DSS or an agency authorized by DSS to assume specific licensing responsibilities; and

2. Provides nonmedical care and supervision to adults 18 years of age or older on less than a 24-hour per day basis.

(B) Adult day care does not include adult day programs as identified in (a)(1), (6), (12), (33), and (72).

(5) Adult Day Health Center - Service Code 702. A regional center shall classify a vendor as an adult day health center if the vendor has a signed adult day health care provider agreement with the Department of Health Services to provide the services described in Title 22, Chapter 5 to Medi-Cal beneficiaries who are eligible for and voluntarily elect to participate in an adult day health care program.

(6) Adult Development Center - Service Code 510. Adult Development Centers shall meet the requirements in Sections 56710 through 56756 of these regulations for the specific service being vendored.

(7) Art Therapist - Service Code 691. A regional center shall classify a vendor as an art therapist if the vendor possesses a current registration issued by the American Art Therapy Association and works with an individual using art media as a means of expression and communication to promote the individual's perceptive, intuitive, affective, and expressive experiences which lead to the individual's personal growth or personality reintegration.

(8) Associate Behavior Analyst - Service Code 613. A regional center shall classify a vendor as an Associate Behavior Analyst if the vendor assesses the function of a behavior of a consumer and designs, implements, and evaluates instructional and environmental modifications to produce socially significant improvements in the consumer's behavior through skill acquisition and the reduction of behavior, under direct supervision of a Behavior Analyst or Behavior Management Consultant. Associate Behavior Analysts engage in descriptive functional assessments to identify environmental factors of which behavior is a function. Associate Behavior Analysts shall not practice psychology, as defined in Business and Professions Code Section 2903. A regional center shall classify a vendor as an Associate Behavior Analyst if an individual is recognized by the National Behavior Analyst Certification Board as a Board Certified Associate Behavior Analyst.

(9) Attorney - Service Code 610. A regional center shall classify a vendor as an attorney if the vendor:

(A) Is an active member in good standing of the State Bar of California;

(B) Advises individuals of their legal rights; and

(C) Represents them in administrative and judicial proceedings, when necessary.

(10) Audiology - Service Code 706.

(A) A regional center shall classify a vendor as a provider of audiology services if the vendor is:

1. An audiologist who is validly licensed as an audiologist by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs; and
2. Uses techniques to identify and evaluate hearing disorders and to develop methods of improving hearing disorders involving speech, language, auditory behavior, and other aberrant behavior related to hearing loss.

(B) A vendored audiologist shall not dispense hearing aids to consumers, or be additionally vendored as an audiology center or hearing aid dispenser.

(11) Behavior Analyst - Service Code 612. Behavior Analyst means an individual who assesses the function of a behavior of a consumer and designs, implements, and evaluates instructional and environmental modifications to produce socially significant improvements in the consumer's behavior through skill acquisition and the reduction of behavior. Behavior Analysts engage in functional assessments or functional analyses to identify environmental factors of which behavior is a function. A Behavior Analyst shall not practice psychology, as defined in Business and Professions Code section 2903. A regional center shall classify a vendor as a Behavior Analyst if an individual is recognized by the national Behavior Analyst Certification Board as a Board Certified Behavior Analyst.

(12) Behavior Management Assistant - Service Code 615. A regional center shall classify a vendor as a behavior management assistant if the vendor designs and/or implements behavior modification intervention services under the direct supervision of a behavior management consultant; or if the vendor assesses the function of a behavior of a consumer and designs, implements, and evaluates instructional and environmental modifications to produce socially significant improvements in the consumer's behavior through skill acquisition and the reduction of behavior, under direct supervision of a Behavior Analyst or Behavior Management Consultant, and meets either of the following requirements:

(A) Possesses a Bachelor of Arts or Science Degree and has either:

1. Twelve semester units in applied behavior analysis and one year of experience in designing and/or implementing behavior modification intervention services; or
2. Two years of experience in designing and/or implementing behavior modification intervention services.

(B) Is registered as either:

1. A psychological assistant of a psychologist by the Medical Board of California or Psychology Examining Board; or
2. An Associate Licensed Clinical Social Worker pursuant to Business and Professions Code, Section 4996.18.

(13) Behavior Management Consultant - Service Code 620.

(A) A regional center shall classify a vendor as a behavior management consultant if the vendor designs and/or implements behavior modification intervention services and meets the following requirements:

1. Individuals vendored as a behavior management consultant prior to, or as of, December 31, 2006, that have not previously completed twelve semester units in applied behavior analysis, shall have until December 31, 2008 to complete twelve semester units in applied behavior analysis and possess a license and experience as specified in 3. through 7. below.
2. Individuals vendored as a behavior management consultant on, or after, January 1, 2007, shall, prior to being vendored, have completed twelve semester units in applied behavior analysis and possess a license and experience as specified in 3. through 7. below.
3. Possesses a valid license as a psychologist from the Medical Board of California or Psychology Examining Board; or
4. Is a Licensed Clinical Social Worker pursuant to Business and Professions Code, Sections 4996 through 4998.7; or
5. Is a Licensed Marriage and Family Therapist pursuant to Business and Professions Code, Sections 4980 through 4984.7; or
6. Is any other licensed professional whose California licensure permits the design and/or implementation of behavior modification intervention services.
7. Have two years experience designing and implementing behavior modification intervention services.

(B) Behavior management consultants shall follow the requirements of Title 17, Sections 50800 through 50823, when using planned behavior modification interventions that cause pain or trauma.

(14) Behavior Management Program - Service Code 515. Behavior Management Programs shall meet the requirements in Sections 56710 through 56756 of these regulations for the specific service being vendored.

(15) Camping Services - Service Code 850. A regional center shall classify a vendor as a provider of camping services if the vendor has staff that possesses demonstrated competence to supervise safety of camp activities and is:

(A) A day camp which:

1. Provides a creative experience in outdoor living for a limited period of hours per day and days per year; and
2. Contributes to the individual's mental, physical, and social growth by using the resources of the natural surroundings;

(B) A residential camp which:

1. Possesses a valid fire clearance issued by the California State Fire Marshal, city fire department, or local fire district;
2. Complies with the requirements of Title 17, Sections 30700 through 30753;
3. Has a registered nurse on staff at all hours of operation; or
4. Has received a waiver issued by the appropriate agency if any of the requirements specified in 1. through 3. above are not met; and
5. Provides:
 - a. A creative experience in outdoor living on a 24-hour per day basis for a limited period of time;
 - b. Services which use the resources of the natural surroundings to contribute to the individual's mental, physical, and social growth; and
 - c. Other consistent services; or

(C) A traveling camp which provides camping or vacation experiences by traveling to various campgrounds or other tourist areas.

(16) Child Day Care - Service Code 851. A regional center shall classify a vendor as child day care if the vendor:

(A) Possesses a valid family day care license issued by DSS or by an agency authorized by DSS to assume specified licensing responsibilities, and provides nonmedical care and supervision to children under 18 years of age on a less than 24-hour per day basis in the vendor's own home; or

(B) Possesses a valid day care license for children issued by DSS or by an agency authorized by DSS to assume specific licensing responsibilities, and provides personal care, protection, supervision and assistance to children under 18 years of age with special developmental needs in a nonresidential facility; or

(C) Possesses a preschool license issued by the Department of Education or a valid child care center license issued by DSS or an agency authorized by DSS to assume specified licensing responsibilities, and aids children in developing pre-academic skills, group training, and social skills in a nonresidential facility.

(17) Clinical Psychologist - Service Code 785. A regional center shall classify a vendor as a clinical psychologist if the vendor:

(A) Is validly licensed as a clinical psychologist by the Psychology Examining Committee of the Medical Board of California; and

(B) Provides:

1. Diagnosis and psychotherapy of mental and emotional disorders; or
2. Individual and group testing and counseling in order to assist individuals achieve more effective personal, social, educational, and vocational development and adjustment.

(18) Counseling Services - Service Code 625. The services included within this service code shall be provided by the following persons:

(A) Family Counselor - A regional center shall classify a vendor as a family counselor if the vendor possesses a valid Marriage and Family Therapist license issued by the California Board of Behavioral Science Examiners, and provides support and counseling to help the individual maintain and maximize the use of his or her current functioning patterns; and

(B) Social Worker - A regional center shall classify a vendor as a social worker if the vendor possesses a valid Clinical Social Worker's license issued by the California State Board of Behavioral Science Examiners, and provides the following services:

1. Social assessments;
2. Counseling; and
3. Other case work functions for the benefit of the individual.

(19) Dance Therapist - Service Code 692. A regional center shall classify a vendor as a dance therapist if the vendor is validly registered as a dance therapist by the American Dance Therapy Association, and provides the following services:

(A) Teaches the individual to use body movement and dance as the process in therapeutic intervention directed toward gaining insight into the consumer's problematic behavior, and expanding the consumer's freedom of movement, flexibility, and coordination;

(B) Provides opportunities for the individual to express and communicate feelings, needs, and conflicts; and

(C) Provides other services consistent with the duties specified in (A) and (B) above.

(20) Day Treatment Centers - Service Code 710. A regional center shall classify a vendor as a day treatment center if the vendor provides services to outpatients at an acute care hospital or acute psychiatric hospital.

(21) Dentistry - Service Code 715. A regional center shall classify a vendor as a dentist if the vendor is validly licensed by the California Board of Dental Examiners and practices the branch of medicine which specializes in the diagnosis, prevention, and treatment of diseases of the teeth and their associated structures.

(22) Developmental Specialist - Service Code 670. A regional center shall classify a vendor as a developmental specialist if the vendor possesses valid certification by an accredited hospital as having successfully completed a one-year developmental specialist training program, or if the vendor possesses a Master's Degree in Developmental Therapy from an accredited college or university.

(23) Diaper Service - Service Code 627. A regional center shall classify a vendor as a provider of diaper service if the vendor:

(A) Supplies cloth diapers for the consumer; and

(B) Provides pick-up, laundering, and delivery of the diapers to the consumer's home.

(24) Dietary Services - Service Code 720. A regional center shall classify a vendor as a provider of dietary services if the vendor is:

(A) A dietitian who is validly registered as a member of the American Dietetic Association and who prescribes or modifies a person's diet to meet the person's nutritional needs; or

(B) a nutritionist who evaluates an individual's nutritional needs and meets one of the following requirements:

1. Possesses a Master's Degree in one of the following:

- a. Food and Nutrition;
- b. Dietetics; or
- c. Public Health Nutrition; or

2. Is employed as a nutritionist by a county health department.

(25) Driver Trainer - Service Code 630. A regional center shall classify a vendor as a driver trainer if the vendor possesses the skills and training necessary to teach other individuals to drive automobiles and meets the following requirements:

(A) Possesses a current certification by the California Department of Motor Vehicles as a driver instructor; and

(B) Possesses a current and valid California driver's license.

(26) Durable Medical Equipment Dealer - Service Code 725. A regional center shall classify a vendor as a durable medical equipment dealer if the vendor possesses a valid business license, and operates a business which manufactures, individually tailors, or sells durable medical equipment as defined in Title 22, California Code of Regulations, Section 51160.

(27) Educational Psychologist - Service Code 672. A regional center shall classify a vendor as an educational psychologist if the vendor possesses a valid educational psychologist's license issued by the California Board of Behavioral Science Examiners, and provides evaluation and counseling to assist individuals in achieving more effective educational development.

(28) Family Home Agency (FHA) - Service Code 904. A regional center shall classify a vendor as a family home agency (FHA) if the agency:

(A) Recruits, approves, trains, and monitors family home and family teaching home providers;

(B) Provides services and supports to family home and family teaching home providers; and

(C) Assists consumers in moving into, or relocating from, family homes and family teaching homes.

(29) Genetic Counselor - Service Code 800. A regional center shall classify a vendor as a genetic counselor if the vendor possesses a valid Genetic Counselor License issued by the State of California.

(30) Hearing and Audiology Facilities - Service Code 730. A regional center shall classify a vendor as a hearing or audiology facility if the vendor is:

(A) A hearing facility which provides the following services:

- 1. Diagnosis of the individual's hearing loss; and
- 2. Treatment for individuals whose hearing loss does not require multi-disciplined diagnostic services; or

(B) An audiology facility which:

- 1. Treats the individual whose hearing loss requires multi-disciplined diagnostic services;
- 2. Provides a diagnosis of the individual's hearing loss;
- 3. Provides services intended to help the individual compensate for the hearing loss;
- 4. Does not dispense hearing aids to the individual;
- 5. Employs at least one audiologist who is licensed by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs; and
- 6. Employs individuals, other than (B)5. above, who perform services, all of whom shall be:
 - a. Licensed audiologists; or
 - b. Obtaining required professional experience, and whose required professional experience application has been approved by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs.

(31) Home Health Agency - Service Code 854. A regional center shall classify a vendor as a home health agency if the vendor possesses a valid home health agency license issued by DHS, or meets the requirements established by DHS for providing home health services, and is primarily engaged in providing skilled nursing services and at least one of the following:

(A) Physical therapy;

(B) Occupational therapy;

(C) Speech therapy;

(D) Medical social work; or

(E) Home health aide services.

(32) Home Health Aide - Service Code 856. A regional center shall classify a vendor as a home health aide if the vendor possesses a valid home health aide license issued by DHS or meets the requirements established by DHS for providing home health services, and who:

(A) Provides services to the individual in order to maintain a safe and healthful home environment;

(B) Performs personal services directed toward adequate nutrition and personal cleanliness;

(C) Supports a continuing medical and social treatment plan for homebound individuals; and

(D) Other services consistent with the duties specified in (a)(31)(A) through (C) above.

(33) Homemaker - Service Code 858. A regional center shall classify a vendor as a homemaker if the vendor maintains, strengthens, or safeguards the care of individuals in their homes.

(34) Homemaker Service - Service Code 860. A regional center shall classify a vendor as a homemaker service if the vendor employs, trains, and assigns personnel who maintain, strengthen, or safeguard the care of individuals in their homes.

(35) Independent Living Program - Service Code 520. Independent Living Programs shall meet the requirements in Sections 56710 through 56756 of these regulations for the specific service being vendored.

(36) Independent Living Specialist - Service Code 635. A regional center shall classify a vendor as an independent living specialist if the vendor possesses the skill, training, or education necessary to teach consumers to live independently and/or provide the supports necessary for the consumer to maintain a self-sustaining, independent-living situation in the community.

(37) Infant Development Program - Service Code 805. Infant development programs shall meet the appropriate requirements in Sections 56710 through 56734 and 56760 through 56774 of these regulations.

(38) Infant Development Specialist - Service Code 810. A regional center shall classify a vendor as an infant development specialist if the vendor has at least one year of experience working with parents and children with disabilities and possesses either of the following:

(A) A valid license or certification in one of the following disciplines:

1. Occupational therapy;
2. Physical therapy;
3. Special education;
4. Psychology;
5. Nursing; or
6. Speech and language therapy; or

(B) A Masters degree in child development/early childhood education which includes a minimum of 15 units of formal instruction in at least one of the following areas:

1. Typical and atypical infant development;
2. Infant assessment;
3. Infant intervention techniques; or
4. Family involvement in infant treatment.

(39) In-home Respite Services Agency - Service Code 862. A regional center shall classify a vendor as an in-home respite services agency if the vendor meets the appropriate requirements in Sections 56780 through 56802 of these regulations. Separate vendorization may be waived at the vendor's request for existing in-home respite services agency vendors requesting to provide new in-home respite services at an additional business address.

(40) In-home Respite Worker - Service Code 864. A regional center shall classify a vendor as a provider of in-home respite worker services if the vendor is an individual who:

(A) Has received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross;

(B) Has the skill, training, or education necessary to perform the required services; and

(C) Provides in-home respite services.

(41) Intermediate Care Facility/Developmentally Disabled (ICF/DD) - Service Code 925. A regional center shall classify a vendor as an intermediate care facility/developmentally disabled if the vendor possesses a valid ICF/DD health facility license issued by the Department of Health Services.

(42) Intermediate Care Facility/Developmentally Disabled-Habilitative (ICF/DD-H) - Service Code 930. A regional center shall classify a vendor as an intermediate care facility/developmentally disabled-habilitative if the vendor possesses a valid ICF/DD-H health facility license issued by the Department of Health Services.

(43) Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N) - Service Code 935. A regional center shall classify a

vendor as an intermediate care facility/developmentally disabled-nursing if the vendor possesses a valid ICF/DD-N health facility license issued by the Department of Health Services.

(44) Interpreter - Service Code 642. A regional center shall classify a vendor as an interpreter if the vendor demonstrates:

(A) Fluency in both English and in sign language; and

(B) Proficiency in facilitating communication between hearing-impaired and hearing persons using American sign language and spoken language.

(45) Laboratory and Radiologic Services - Service Code 735. The following types of services are included within this service code:

(A) A regional center shall classify a vendor as a clinical laboratory if the vendor:

1. Is validly licensed by DHS as a clinical laboratory, and examines and tests specimens.

(B) A regional center shall classify a vendor as a provider of radiological services if the vendor:

1. Possesses a valid license as a technologist or radiologist issued by DHS;

2. Uses x-ray equipment which is validly registered with DHS; and

3. Provides services which involve the use of x-rays or radioactive materials for medical, diagnostic, or treatment procedures.

(46) Licensed Vocational Nurse - Service Code 742. A regional center shall classify a vendor as a licensed vocational nurse if the vendor:

(A) Is validly licensed as a licensed vocational nurse by the California State Board of Vocational Nurse and Psychiatric Technician Examiners; or

(B) Is a nurse registry from whom the services of a licensed vocational nurse are obtained; and

(C) Provides services under the direction of a validly licensed registered nurse or physician.

(47) Mobility Training Services Agency - Service Code 645. A regional center shall classify a vendor as a provider of mobility training services if the vendor is an agency which employs staff who possess the skill, training, or education necessary to teach individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently.

(48) Mobility Training Services Specialist - Service Code 650. A regional center shall classify an individual as a vendor of mobility training services if the vendor possesses the skill, training, or education necessary to teach individuals how to use public transportation or other modes of transportation which will enable them to move about the community independently.

(49) Music Therapist - Service Code 693. A regional center shall classify a vendor as a music therapist if the vendor possesses a valid registration issued by the National Association for Music Therapy, and uses music media and activities to effect change or growth in the individual's:

(A) Self-awareness;

(B) Gross motor development;

(C) Fine motor development;

(D) Eye-hand coordination and visual tracking;

(E) Visual, auditory, and tactile awareness and perception;

(F) Language development and communication skills;

(G) Emotional expression;

(H) Self-esteem and body image;

(I) Socialization and community awareness; and

(J) Stereotypical behaviors.

(50) Nurse Anesthetist - Service Code 741. A regional center shall classify a vendor as a nurse anesthetist if the vendor:

(A) Is a nurse anesthetist who is validly licensed by the California State Board of Registered Nurses and certified by the American Association of Nurse Anesthetists; or

(B) Is a nurse registry from whom the services of a nurse anesthetist are obtained.

(51) Nurse's Aide or Assistant - Service Code 743. A regional center shall classify a vendor as a nurse's aide or assistant if the vendor:

(A) Is certified as a nurse's aide or a home health aide by DHS; or

(B) Is a nurse registry from whom the services of a nurse's aide or assistant are obtained; and

(C) Provides services under the direction of a validly licensed registered nurse or physician.

(52) Nursing Facility - Service Code 940. A regional center shall classify a vendor as a nursing facility if the vendor possesses a valid nursing facility license issued by the Department of Health Services.

(53) Occupational Therapy - Service Code 773. A regional center shall classify a vendor as a provider of occupational therapy if the

vendor is:

(A) An occupational therapist validly licensed by the California Board of Occupational Therapy and who, based on the written prescription of a physician, dentist or podiatrist, provides occupational therapy evaluation, treatment planning, treatment, instruction and consultative services; or

(B) An occupational therapist assistant validly certified by the California Board of Occupational Therapy and who provides occupational therapy evaluation, treatment planning, treatment, instruction and consultative services while under the direct supervision of a registered occupational therapist.

(54) Orthoptic Services - Service Code 745. A regional center shall classify a vendor as a provider of orthoptic services if the vendor is:

(A) An orthoptic technician who is validly certified by the American Orthoptic Council and provides the following services:

1. Treats an individual's defective visual habits.
2. Treats defects of binocular vision and muscle imbalance by exercise and visual training, and re-educating the individual's visual habits.

(B) An optometrist who is validly licensed as an optometrist by the California State Board of Optometry and provides the following services:

1. Examines the eye for defects and faults of refraction; and
2. Prescribes correctional lenses or exercises.

(55) Orthotic and Prosthetic Services - Service Code 750. A regional center shall classify a vendor as a provider of orthotic and prosthetic services if the vendor is:

(A) An orthotist who makes or fits orthopedic braces and who is either:

1. Validly certified by any of the following:
 - a. American Board for Certification in Orthotics and Prosthetics;
 - b. Academy of Orthotics and Prosthetics;
 - c. American Orthotics and Prosthetics Association;
 - d. California Children's Services Association; or
 - e. Veteran's Administration; or
2. A member of the California Orthotic and Prosthetic Association which employs only those orthotists who are eligible for certification.

(B) A prosthetist who makes or fits artificial limbs or other parts of the body, and who is either:

1. Validly certified by any of the following:
 - a. American Board for Certification in Orthotics and Prosthetics;
 - b. Academy of Orthotics and Prosthetics;
 - c. California Children's Services Association; or
 - d. Veteran's Administration; or
2. A member of the California Orthotic and Prosthetic Association which employs only those prosthetists who are eligible for certification.

(C) An individual who is validly licensed as a pharmacist by the California State Board of Pharmacy and who fits orthotic or prosthetic devices.

(56) Other Medical Equipment or Supplies - Service Code 755. A regional center shall classify a vendor as a provider of other medical equipment or supplies if the vendor is:

(A) A dispensing optician who is validly registered as a dispensing optician by the Division of Allied Health Professions of the Medical Board of California, and who:

1. Fills prescriptions of physicians or optometrists for prescription lenses and related products;
2. Fits and adjusts such lenses and spectacle frames; and
3. Fits contact lenses under the advice, direction, and responsibility of a physician or optometrist;

(B) A hearing aid dispenser who is validly licensed as a hearing aid dispenser by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs, and who:

1. Performs audiometric pure tone and speech testing;
2. Tests hearing in order to fit, dispense, or repair hearing aids; and
3. Is not vendored separately as an audiology center or individually as an audiologist; or

(C) A prosthetic and orthotic appliance factory which fits and sells orthotic and prosthetic appliances necessary for the restoration of function or replacement of body parts.

(57) Other Medical Services - Service Code 760. A regional center shall classify a vendor as a provider of other medical services if the vendor provides any medical services not included otherwise in this section, and services provided by clinics or other medical facilities which are not included in another service code.

(58) Out-of-home Respite Services - Service Code 868. A regional center shall classify a vendor as a provider of out-of-home respite services if the vendor:

(A) Is licensed by DSS or by an agency authorized by DSS or is licensed by DHS to provide out-of-home care to persons with developmental disabilities; and

(B) Is vendored by the regional center and provides services under the following service codes:

1. Service Code 855 - Adult Day Care; or
2. Service Code 851 - Child Day Care; or
3. Service Code 905 or 915 - Residential Facility Serving Adults; or
4. Service Code 910 or 920 - Residential Facility Serving Children; or
5. Service Code 930 - Intermediate Care Facility/Developmentally Disabled - Habilitative (ICF/DD-H); or
6. Service Code 935 - Intermediate Care Facility/Developmentally Disabled - Nursing (ICF/DD-N).

(C) Has staff who have received Cardiopulmonary Resuscitation (CPR) and First Aid training from agencies offering such training, including, but not limited to, the American Red Cross;

(D) Has the training, education, and skill to perform the required services; and

(E) Provides out-of-home respite services which consist of intermittent or regularly scheduled temporary care to individuals in a licensed facility and which:

1. Are designed to relieve families of the constant responsibility of caring for a member of that family who is a consumer;
2. Meet planned or emergency needs;
3. Are used to allow parents or the individual the opportunity for vacations and other necessities or activities of family life; and
4. Are provided to individuals away from their residence.

(59) Out-of-state Manufacturer or Distributor - Service Code 655. A regional center shall classify a vendor as an out-of-state manufacturer or distributor of merchandise if the vendor provides a specific item that is not available in California, or it is more economical to purchase the item outside of California.

(60) Pharmaceutical Services - Service Code 765. A regional center shall classify a vendor as a provider of pharmaceutical services if the vendor is:

(A) A person who is validly licensed as a pharmacist by the California State Board of Pharmacy, and who identifies, prepares, or preserves compounds and dispenses drugs; or

(B) A pharmacy which is validly licensed as a pharmacy by the California State Board of Pharmacy, and which is a facility where medicines are compounded or dispensed.

(61) Physical Therapy - Service Code 772. A regional center shall classify a vendor as a provider of physical therapy services if the vendor is:

(A) A physical therapist who is validly licensed by the Physical Therapy Examining Committee of the Medical Board of California and who, under medical supervision, treats individuals to relieve pain, develop or restore motor function, and maintain performance by using a variety of physical means; or

(B) A physical therapist assistant who is registered as a physical therapist assistant by the Physical Therapy Examining Committee of the Medical Board of California and who provides physical therapy while under the direct supervision of the licensed physical therapist.

(62) Physicians or Surgeons - Service Code 775. A regional center shall classify a vendor as a physician or surgeon if the vendor provides professional services to individuals and is validly licensed by the Medical Board of California as a physician or surgeon.

(63) Psychiatric Technician - Service Code 790. A regional center shall classify a vendor as a psychiatric technician if the vendor:

(A) Under medical direction, provides psychotherapeutical services; and

(B) Possesses a valid psychiatric technician's license issued by the California State Board of Vocational Nurse and Psychiatric Technician Examiners.

(64) Psychiatrist - Service Code 780. A regional center shall classify a vendor as a psychiatrist if the vendor:

(A) Is validly licensed as a physician and surgeon by the Medical Board of California;

(B) Is validly certified by the American Board of Psychiatry and Neurology; and

(C) Specializes in the diagnosis, treatment, and prevention of mental disorders.

(65) Recreational Therapist - Service Code 694. A regional center shall classify a vendor as a recreational therapist if the vendor possesses a valid registration issued by either the National Council for Therapeutic Recreation Certification or the California Board of Recreation and Park Certification and provides the following services:

- (A) Uses self-motivating recreational activities to develop the individual's motor skills, social skills, sensory functioning, or acceptable behavior;
- (B) Counsels the individual in recreation and leisure pursuits; and
- (C) Provides other services consistent with the duties specified in (A) and (B) above.

(66) Registered Nurse - Service Code 744. A regional center shall classify a vendor as a registered nurse if the vendor:

- (A) Is an individual who is validly licensed as a registered nurse by the California State Board of Registered Nurses; or
- (B) Is a nurse registry from whom the services of a registered nurse are obtained.

(67) Residential Facility Serving Adults - Owner Operated - Service Code 905. A regional center shall classify a vendor as an owner-operated residential facility serving adults if:

- (A) The facility serves adults;
- (B) The vendor possesses a valid community care facility license as required by Health and Safety Code, Sections 1500 through 1569.87; and
- (C) The facility is the residence of the licensee or a member of the corporate board (board of directors). The licensee may perform all of the activities necessary to operate the facility, or he/she may employ staff, which may include members of his/her family, to assist.

(68) Residential Facility Serving Children - Owner Operated - Service Code 910. A regional center shall classify a vendor as an owner-operated residential facility serving children if:

- (A) The facility serves children;
- (B) The vendor possesses a valid community care facility license as required by Health and Safety Code, Sections 1500 through 1569.87; and
- (C) The facility is the residence of the licensee or a member of the corporate board (board of directors). The licensee may perform all of the activities necessary to operate the facility, or he/she may employ staff which may include members of his/her family, to assist.

(69) Residential Facility Serving Adults - Staff Operated - Service Code 915. A regional center shall classify a vendor as a staff-operated residential facility serving adults if:

- (A) The facility serves adults;
- (B) The vendor possesses a valid community care facility license as required by Health and Safety Code, Sections 1500 through 1569.87; and
- (C) The facility is not the residence of the licensee or a member of the corporate board (board of directors) and the licensee employs personnel to provide direct care and training to individuals.

(70) Residential Facility Serving Children - Staff Operated - Service Code 920. A regional center shall classify a vendor as a staff-operated residential facility serving children if:

- (A) The facility serves children;
- (B) The vendor possesses a valid community care facility license as required in the Health and Safety Code, Section 1500 through 1569.87; and
- (C) The facility is not the residence of the licensee or a member of the corporate board (board of directors) and the licensee employs personnel to provide direct care and training to individuals.

(71) Respiratory Therapist - Service Code 793. A regional center shall classify a vendor as a respiratory therapist if the vendor:

- (A) Provides respiratory therapy services; and
- (B) Possesses a valid respiratory care practitioner certificate issued by the Respiratory Care Board of California of the Department of Consumer Affairs.

(72) Respite Facility - Service Code 869. A regional center shall classify a vendor as a respite facility if the vendor:

- (A) Is licensed as a residential facility by DSS or by an agency authorized by DSS;
- (B) Provides only out-of-home respite services in accordance with (a)(58)(E)1. through 4. above.
- (C) Meets the criteria specified in (a)(58)(C) and (D); and
- (D) Is not vendored by the regional center to provide services under the following service codes:

1. Service Code 905 or 915 - Residential Facility Serving Adults; or
2. Service Code 910 or 920 - Residential Facility Serving Children.

(73) Retail/Wholesale Stores - Service Code 660. A regional center shall classify a vendor as a retail/wholesale store if the facility provides goods for purchase and possesses a valid business license to operate that facility.

(74) Social Recreation Program - Service Code 525. Social Recreation Programs shall meet the requirements in Sections 56710 through 56756 of these regulations for the specific service being vendored.

(75) Speech Pathology - Service Code 707. A regional center shall classify a vendor as a provider of speech pathology services if the vendor is:

(A) A speech pathologist who is validly licensed as a speech pathologist by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board of the California Department of Consumer Affairs; and provides:

1. Diagnostic screening; and
2. Preventative and corrective therapy for persons with speech or language disorders.

(76) Teacher - Service Code 674. A regional center shall classify a vendor as a teacher if the vendor possesses a valid California teaching credential issued by the California Commission on Teacher Credentialing or an instruction credential such as a "Life Diploma" or "California Community Colleges Certificate" issued by the California Commission on Teacher Credentialing. A teacher provides the following services:

- (A) Conducts lessons;
- (B) Prepares instructional materials;
- (C) Instructs and supervises individuals in specific areas; and
- (D) Provides other services consistent with the duties specified in (A) through (C) above.

(77) Teacher's Aide - Service Code 676. A regional center shall classify a vendor as a teacher's aide if the vendor works under the supervision of a teacher and possesses the training, education, and/or skill to perform the services specified in (a)(76)(A) through (D) above.

(78) Teacher of Special Education - Service Code 678. A regional center shall classify a vendor as a teacher of special education if the vendor possesses a valid California teaching credential in Special Education issued by the California Commission on Teacher Credentialing and provides the services specified in (a)(76)(A) through (D) above.

(79) Translator - Service Code 643. A regional center shall classify a vendor as a translator if the vendor demonstrates:

- (A) Fluency in both English and a language other than English; and
- (B) The ability to read and write accurately in both English and a language other than English.

(80) Transportation - Additional Component - Service Code 880. A regional center shall classify a vendor as a provider of transportation services - additional component if the vendor:

- (A) Is vendored separately from the primary service. The vendoring regional center may waive separate vendorization as a transportation services -additional component if the vendor is a community-based day program vendor, who conducts its curriculum solely in natural environments, and the regional center determines that it would be more cost effective to include the cost of transporting consumers, which occurs between the first and last training site as specified in Section 57434(a)(3)(N). The cost of transporting consumers shall be considered more cost effective if the cost of including the transportation service in determining the rate of reimbursement for the community-based day program is less than the cost of providing the transportation service pursuant to separate vendorization as a provider of transportation services - additional component;
- (B) Provides services by employees of the primary service agency; and
- (C) Provides the regional center with proof of adequate insurance as designated by the vendoring regional center in accordance with the Welfare and Institutions Code, Section 4648.3.

(81) Transportation Assistant - Service Code 882. A regional center shall classify a vendor as a provider of transportation assistant services if the vendor:

- (A) Is vendored separately from the transportation service vendor;
- (B) Assists and monitors regional center consumers while the consumers are being transported; and
- (C) Meets the qualifications for transportation aides specified in Title 17, Section 58520(b).

(82) Transportation Auto Driver - Service Code 890. A regional center shall classify a vendor as transportation auto driver if the vendor provides the transportation to authorized services identified in the consumer's IPP and the vendor:

- (A) Is an individual who is actually providing the transportation service;
- (B) Possesses a valid California driver's license; and
- (C) Has evidence of maintenance of adequate insurance coverage.

(83) Transportation Broker - Service Code 883. A regional center shall classify a vendor as a transportation broker if the vendor:

- (A) Is not the transportation service provider; and
- (B) Develops routing and time schedules for the transport of consumers to and from their day program;
- (C) In addition to performing the duties specified in (A) and (B) above, a transportation broker may:
 1. Conduct monitoring and quality assurance activities; and/or

2. Perform safety reviews; and/or
3. Assist the regional center in implementing contracted transportation services.

(84) Transportation Companies - Service Code 875. A regional center shall classify a vendor as a transportation company if the vendor possesses a current business license as a transportation company and:

(A) Provides the regional center with proof of adequate insurance as designated by the vendoring regional center in accordance with the Welfare and Institutions Code, Section 4648.3; and

(B) Will be employed to transport individuals to and from their community-based day programs or other vendored services for the regional center.

(85) Transportation - Medical - Service Code 885. A regional center shall classify a vendor as a provider of medical transportation if the vendor:

(A) Provides medical transportation services; and

(B) Meets the standards specified in Title 22, California Code of Regulations, Sections 51231, 51231.1 or 51231.2, for Litter Vans, Wheelchair Vans, or Medical Transportation Services.

(86) Transportation - Public Transit Authority, Dial-A-Ride, Rental Car Agency or Taxi - Service Code 895. A regional center shall classify a vendor as a public transit authority, dial-a-ride rental car agency or taxi provider if the vendor is licensed to perform such services, and if the rate charged in the use of these services to consumers is the same as that charged to the general public for the same service.

(87) Tutor - Service Code 680. A regional center shall classify a vendor as a tutor if the vendor possesses the training, education, and/or skill necessary to provide the in-home individualized instruction to the individual which is supplementary to, or independent of, instruction provided by the classroom teacher.

(b) The following service code shall be assigned to the following type of service: Behavior Management Technician (Paraprofessional) - Service Code 616. A regional center may vendor a group practice, vendored pursuant to Section 54319(d), for the above service. The Behavior Management Technician (Paraprofessional) shall practice under the direct supervision of a certified Behavior Analyst or a Behavior Management Consultant who is within the same vendored group practice. The Behavior Management Technician (Paraprofessional) implements instructional and environmental modifications to produce socially significant improvements in the consumer's behavior through skill acquisition and the reduction of behavior. The Behavior Management Technician (Paraprofessional) shall meet the following requirements:

(1) Has a High School Diploma or the equivalent, has completed 30 hours of competency-based training designed by a certified behavior analyst, and has six months experience working with persons with developmental disabilities; or

(2) Possesses an Associate's Degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and has six months experience working with persons with developmental disabilities.

Note: Authority cited: Sections 4405, 4648(a) and 4686.3, Welfare and Institutions Code; and Section 11152, Government Code. Reference: Sections 4631, 4648(a) and 4691, Welfare and Institutions Code.

HISTORY

1. New section filed 6-26-90 as an emergency; operative 7-1-90 (Register 90, No. 36). A Certificate of Compliance must be transmitted to OAL by 10-29-90 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 6-26-90 order transmitted to OAL 9-28-90 and filed 10-29-90 (Register 90, No. 46).
3. Amendment of section filed as an emergency 6-17-93; operative 6-17-93. Submitted to OAL for printing only pursuant to SB485 (Chapter 722, Statutes of 1992) Section 147(a) (Register 93, No. 26).
4. Certificate of Compliance as to 6-17-93 order transmitted to OAL 6-20-94 and filed 8-2-94 (Register 94, No. 31).
5. Change without regulatory effect amending section, including incorporation and amendment of former section 54344, filed 1-17-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 3).
6. Amendment of subsection (a)(37), (a)(52)(B)2., (a)(54)(A)1., (a)(54)(B), (a)(58)(A), (a)(72), (a)(75) and (a)(81)(B), new subsections (a)(81)(C)1.-3. and amendment of (a)(83)(B) filed 4-25-2000; operative 5-25-2000 (Register 2000, No. 17).
7. New subsection (a)(10) and subsection renumbering filed 5-3-2001; operative 6-2-2001 (Register 2001, No. 18).
8. Change without regulatory effect amending subsections (a)(52)(A)-(B) filed 6-12-2003 pursuant to section 100, title 1, California Code of Regulations (Register 2003, No. 24).
9. New subsection (a)(8), subsection renumbering, amendment of newly designated subsections (a)(12) and (a)(13)(A), new subsection (a)(13)(A)1. and amendment of newly designated subsections (a)(13)2.-4., (a)(18)(A), (a)(32)(D), (a)(72)(B)-(C), (a)(76) and (a)(77) filed 4-29-2004; operative 5-29-2004 (Register 2004, No. 18).
10. Amendment of subsections (a)(28)(A)-(C) filed 11-7-2006; operative 12-7-2006 (Register 2006, No. 45).
11. Repealer and new subsection (a)(13)(A)1., new subsection (a)(13)(A)2., subsection renumbering and new subsection (a)(13)(A)7. filed 6-27-2007; operative 7-27-2007 (Register 2007, No. 26).
12. New subsections (b)-(b)(2) and amendment of Note filed 9-19-2011 as an emergency; operative 9-19-2011 (Register 2011, No. 38). A Certificate of Compliance must be transmitted to OAL by 9-19-2013 pursuant to Welfare and Institutions Code section 4686.3 or emergency language will be repealed by operation of law on the following day.

13. Change without regulatory effect amending subsection (a)(29) and repealing subsections (a)(29)(A)-(C) filed 10-2-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 40).

14. Certificate of Compliance as to 9-19-2011 order transmitted to OAL 9-16-2013 and filed 10-28-2013 (Register 2013, No. 44).

15. Change without regulatory effect amending subsections (a)(10)(A)1., (a)(30)(B)5., (a)(30)(B)6.b., (a)(56)(B) and (a)(75)(A) filed 4-16-2014 pursuant to section 100, title 1, California Code of Regulations (Register 2014, No. 16).

This database is current through 3/15/19 Register 2019, No. 11

17 CCR § 54342, 17 CA ADC § 54342

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AMENDED IN SENATE APRIL 9, 2019

SENATE BILL

No. 163

Introduced by Senator Portantino

January 24, 2019

An act to amend Section 1374.73 of the Health and Safety Code, and to amend Section 10144.51 of the Insurance Code, relating to healthcare coverage.

legislative counsel's digest

SB 163, as amended, Portantino. Healthcare coverage: pervasive developmental disorder or autism.

Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities and their families. Existing law defines developmental disability for these purposes to include, among other things, autism.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines "behavioral health treatment" to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism

service paraprofessional who is supervised as specified. Existing law defines a “qualified autism service provider” to refer to a person who is certified or licensed and a “qualified autism service professional” to refer to a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. Existing law defines a “qualified autism service paraprofessional” to mean an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider. Existing law also requires a qualified autism service provider to design, in connection with the treatment plan, an intervention plan that describes, among other information, the parent participation needed to achieve the plan’s goals and objectives, as specified. Under existing law, these coverage requirements provide an exception for specialized health care service plans or health insurance policies that do not cover mental health or behavioral health services, accident only, specified disease, hospital indemnity, or Medicare supplement health insurance policies, and health care service plans and health insurance policies in the Medi-Cal program.

Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), requires group health plans and health insurance issuers that provide both medical and surgical benefits and mental health or substance use disorder benefits to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. Existing state law subjects nongrandfathered individual and small group health care service plan contracts and health insurance policies that provide coverage for essential health benefits to those provisions of the MHPAEA.

This bill would revise the definition of behavioral health treatment to require the services and treatment programs provided to be based on behavioral, developmental, behavior-based, or other evidence-based models. The bill would remove the exception for health care service plans and health insurance policies in the Medi-Cal program, consistent with the MHPAEA.

This bill also would expand the definition of a “qualified autism service professional” to include behavioral service providers who meet

specified educational and professional or work experience qualifications. The bill would revise the definition of a “qualified autism service paraprofessional” by deleting the reference to an unlicensed and uncertified individual and by requiring the individual to comply with revised educational and training, or professional, requirements. The bill would also revise the definitions of both a qualified autism service professional and a qualified autism service paraprofessional to include the requirement that these individuals complete a background check.

This bill would require the intervention plan designed by the qualified autism service provider, when clinically appropriate, to include parent or caregiver participation that is individualized to the patient and takes into account the ability of the parent or caregiver to participate in therapy sessions and other recommended activities. The bill would specify that the lack of parent or caregiver participation shall not be used to deny or reduce medically necessary services and that the setting, location, or time of treatment not be used as the only reason to deny medically necessary services. Because a willful violation of the bill’s provisions by a health care service plan would be a crime, it would impose a state-mandated local program.

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

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

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

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

- 1 SECTION 1. Section 1374.73 of the Health and Safety Code,
2 as amended by Chapter 385 of the Statutes of 2017, is amended
3 to read:
4 1374.73. (a) (1) Every health care service plan contract that
5 provides hospital, medical, or surgical coverage shall also provide
6 coverage for behavioral health treatment for pervasive
7 developmental disorder or autism no later than July 1, 2012. The
8 coverage shall be provided in the same manner and shall be subject
9 to the same requirements as provided in Section 1374.72.
10 (2) Notwithstanding paragraph (1), as of the date that proposed
11 final rulemaking for essential health benefits is issued, this section

1 does not require any benefits to be provided that exceed the
2 essential health benefits that all health plans will be required by
3 federal regulations to provide under Section 1302(b) of the federal
4 Patient Protection and Affordable Care Act (Public Law 111-148),
5 as amended by the federal Health Care and Education
6 Reconciliation Act of 2010 (Public Law 111-152).

7 (3) This section shall not affect services for which an individual
8 is eligible pursuant to Division 4.5 (commencing with Section
9 4500) of the Welfare and Institutions Code or Title 14
10 (commencing with Section 95000) of the Government Code.

11 (4) This section shall not affect or reduce any obligation to
12 provide services under an individualized education program, as
13 defined in Section 56032 of the Education Code, or an individual
14 service plan, as described in Section 5600.4 of the Welfare and
15 Institutions Code, or under the federal Individuals with Disabilities
16 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
17 regulations.

18 (b) Every health care service plan subject to this section shall
19 maintain an adequate network that includes qualified autism service
20 providers who supervise or employ qualified autism service
21 professionals or paraprofessionals who provide and administer
22 behavioral health treatment. A health care service plan is not
23 prevented from selectively contracting with providers within these
24 requirements.

25 (c) For the purposes of this section, the following definitions
26 shall apply:

27 (1) “Behavioral health treatment” means professional services
28 and treatment programs based on behavioral, developmental,
29 behavior-based, or other evidence-based models, including applied
30 behavior analysis and other evidence-based behavior intervention
31 programs, that develop or restore, to the maximum extent
32 practicable, the functioning of an individual with pervasive
33 developmental disorder or autism and that meet all of the following
34 criteria:

35 (A) The treatment is prescribed by a physician and surgeon
36 licensed pursuant to Chapter 5 (commencing with Section 2000)
37 of, or is developed by a psychologist licensed pursuant to Chapter
38 6.6 (commencing with Section 2900) of, Division 2 of the Business
39 and Professions Code.

1 (B) The treatment is provided under a treatment plan prescribed
2 by a qualified autism service provider and is administered by one
3 of the following:

- 4 (i) A qualified autism service provider.
- 5 (ii) A qualified autism service professional supervised by the
6 qualified autism service provider.
- 7 (iii) A qualified autism service paraprofessional supervised by
8 a qualified autism service provider or qualified autism service
9 professional.

10 (C) The treatment plan has measurable goals over a specific
11 timeline that is developed and approved by the qualified autism
12 service provider for the specific patient being treated. The treatment
13 plan shall be reviewed no less than once every six months by the
14 qualified autism service provider and modified whenever
15 appropriate, and shall be consistent with Section 4686.2 of the
16 Welfare and Institutions Code pursuant to which the qualified
17 autism service provider does all of the following:

18 (i) Describes the patient’s behavioral health impairments or
19 developmental challenges that are to be treated.

20 (ii) Designs an intervention plan that includes the service type,
21 number of hours, and parent participation, when clinically
22 appropriate, needed to achieve the plan’s goal and objectives, and
23 the frequency at which the patient’s progress is evaluated and
24 reported. When clinically appropriate, the plan shall include parent
25 or caregiver participation that is individualized to the patient and
26 that takes into account the ability of the parent or caregiver to
27 participate in therapy sessions and other recommended activities.

28 (iii) Provides intervention plans that utilize evidence-based
29 practices, with demonstrated clinical efficacy in treating pervasive
30 developmental disorder or autism. ~~“Evidence-based practice” means~~
31 ~~a decisionmaking process that integrates the best available~~
32 ~~scientifically rigorous research, clinical expertise, and individuals’~~
33 ~~characteristics. Evidence-based practice is an approach to treatment~~
34 ~~rather than a specific treatment. Evidence-based practice promotes~~
35 ~~the collection, interpretation, integration, and continuous evaluation~~
36 ~~of valued, important, and applicable individual or family reported,~~
37 ~~clinically observed, and research supported evidence. The best~~
38 ~~available evidence, matched to consumer circumstances and~~
39 ~~preferences, is applied to ensure the quality of clinical judgment~~
40 ~~and facilitate the most cost-effective care.~~

1 (iv) Discontinues intensive behavioral intervention services
2 when the treatment goals and objectives are achieved or no longer
3 appropriate.

4 (D) The treatment plan is not used for purposes of providing or
5 for the reimbursement of respite, daycare, or educational services
6 and is not used to reimburse a parent for participating in the
7 treatment program. The treatment plan shall be made available to
8 the health care service plan upon request.

9 (2) “Pervasive developmental disorder or autism” shall have
10 the same meaning and interpretation as used in Section 1374.72.

11 (3) “Qualified autism service provider” means either of the
12 following:

13 (A) A person who is certified by a national entity, such as the
14 Behavior Analyst Certification Board, with a certification that is
15 accredited by the National Commission for Certifying Agencies
16 or the American National Standards Institute, and who designs,
17 supervises, or provides treatment for pervasive developmental
18 disorder or autism, provided the services are within the experience
19 and competence of the person who is nationally certified.

20 (B) A person licensed as a physician and surgeon, physical
21 therapist, occupational therapist, psychologist, marriage and family
22 therapist, educational psychologist, clinical social worker,
23 professional clinical counselor, speech-language pathologist, or
24 audiologist pursuant to Division 2 (commencing with Section 500)
25 of the Business and Professions Code, who designs, supervises,
26 or provides treatment for pervasive developmental disorder or
27 autism, provided the services are within the experience and
28 competence of the licensee.

29 (4) “Qualified autism service professional” means an individual
30 who meets all of the following criteria:

31 (A) Provides behavioral health treatment, which may include
32 clinical case management and case supervision under the direction
33 and supervision of a qualified autism service provider. However,
34 the services shall be consistent with the experience, training, or
35 education of the professional.

36 (B) Is supervised by a qualified autism service provider.

37 (C) Provides treatment pursuant to a treatment plan developed
38 and approved by the qualified autism service provider.

39 (D) Is a behavioral service provider who meets one of the
40 following criteria:

1 (i) Meets the education and experience qualifications described
2 in Section 54342 of Title 17 of the California Code of Regulations
3 for an associate behavior analyst, behavior analyst, behavior
4 management assistant, behavior management consultant, or
5 behavior management program.

6 (ii) Possesses a bachelor of arts or science degree and meets
7 one of the following qualifications:

8 (I) One year of experience in designing or implementing
9 behavioral health treatment supervised by a qualified autism service
10 provider and 12 semester units from an accredited institution of
11 higher learning in either applied behavioral analysis or clinical
12 coursework in behavioral health.

13 (II) Two years of experience in designing or implementing
14 behavioral health treatment supervised by a qualified autism service
15 provider.

16 (III) The person is a registered psychological assistant or
17 registered psychologist pursuant to Chapter 6.6 (commencing with
18 Section 2900) of Division 2 of the Business and Professions Code.
19 A registered psychological assistant or registered psychologist
20 may not supervise a qualified autism service paraprofessional until
21 the registered psychological assistant or registered psychologist
22 has obtained at least 500 hours of experience in designing or
23 implementing behavioral health treatment.

24 (IV) The person is an associate clinical social worker registered
25 with the Board of Behavioral Sciences pursuant to Section 4996.18
26 of the Business and Professions Code. An associate clinical social
27 worker may not supervise a qualified autism service
28 paraprofessional until the associate clinical social worker has
29 obtained at least 500 hours of experience in designing or
30 implementing behavioral health treatment.

31 (V) The person is a registered associate marriage and family
32 therapist with the Board of Behavioral Sciences pursuant to Section
33 4980.44 of the Business and Professions Code. A registered
34 associate marriage and family therapist may not supervise a
35 qualified autism service paraprofessional until the registered
36 associate marriage and family therapist has obtained at least 500
37 hours of experience in designing or implementing behavioral health
38 treatment.

39 (VI) The person is a registered associate professional clinical
40 counselor with the Board of Behavioral Sciences pursuant to

1 Section 4999.42 of the Business and Professions Code. A registered
2 associate professional clinical counselor may not supervise a
3 qualified autism service paraprofessional until the registered
4 associate professional clinical counselor has obtained at least 500
5 hours of experience in designing or implementing behavioral health
6 treatment.

7 (VII) The person is credentialed or certified by a national entity,
8 including, but not limited to, the Behavior Analyst Certification
9 Board, which is accredited by the National Commission for
10 Certifying Agencies or the American National Standards Institute
11 to provide applied behavior analysis or behavioral health treatment,
12 which may include case management and case supervision under
13 the direction and supervision of a qualified autism service provider.

14 (E) Has training and experience in providing services for
15 pervasive developmental disorder or autism.

16 (F) Is employed by the qualified autism service provider or an
17 entity or group that employs qualified autism service providers
18 responsible for the autism treatment plan.

19 (G) Has completed a background check performed by a
20 Department of Justice approved agency, with subsequent
21 notification to the person's employer pursuant to Section 11105.2
22 of the Penal Code.

23 (5) "Qualified autism service paraprofessional" means an
24 individual who meets all of the following criteria:

25 (A) Is supervised by a qualified autism service provider or
26 qualified autism service professional at a level of clinical
27 supervision that meets professionally recognized standards of
28 practice.

29 (B) Provides treatment and implements services pursuant to a
30 treatment plan developed and approved by the qualified autism
31 service provider.

32 (C) Meets one of the following:

33 (i) For applied behavioral analysis, the education and training
34 qualifications described in Section 54342 of Title 17 of the
35 California Code of Regulations.

36 (ii) For other evidence-based behavioral health treatments, all
37 of the following qualifications:

38 (I) Possesses an associate's degree or has completed two years
39 of study from an accredited college or university with coursework
40 in a related field of study.

1 (II) Has 40 hours of training in the specific form of behavioral
2 health treatment developed by a qualified autism service provider
3 and administered by a qualified autism service provider or qualified
4 autism service professional competent in the form of behavioral
5 health treatment to be practiced by the paraprofessional.

6 (III) Has adequate education, training, and experience, as
7 certified by a qualified autism service provider.

8 (iii) Is credentialed or certified in applied behavior analysis or
9 behavioral health treatment for paraprofessionals or technicians
10 by a national entity that is accredited by the National Commission
11 for Certifying Agencies or the American National Standards
12 Institute.

13 However, upon successful completion of the training and
14 education necessary for certification or a credential described in
15 this clause, if the applicant is otherwise qualified under this section,
16 the applicant may provide treatment and implement services for
17 up to 180 days while in the process of obtaining the certification
18 or credential.

19 (D) Has adequate education, training, and experience, as
20 certified by a qualified autism service provider or an entity or
21 group that employs qualified autism service providers.

22 (E) Is employed by the qualified autism service provider or an
23 entity or group that employs qualified autism service providers
24 responsible for the autism treatment plan.

25 (F) Has completed a background check performed by a
26 Department of Justice approved agency, with subsequent
27 notification to the person's employer pursuant to Section 11105.2
28 of the Penal Code.

29 (d) This section shall not apply to a specialized health care
30 service plan that does not deliver mental health or behavioral health
31 services to enrollees.

32 (e) This section does not limit the obligation to provide services
33 under Section 1374.72.

34 (f) As provided in Section 1374.72 and in paragraph (1) of
35 subdivision (a), in the provision of benefits required by this section,
36 a health care service plan may utilize case management, network
37 providers, utilization review techniques, prior authorization,
38 copayments, or other cost sharing.

39 (g) (1) The setting, location, or time of treatment recommended
40 by the qualified autism service provider shall not be used as the

1 only reason to deny or reduce coverage for medically necessary
2 services. The setting shall be consistent with the standard of care
3 for behavioral health treatment. This subdivision does not require
4 a health care service plan to provide reimbursement for services
5 delivered by school personnel pursuant to an enrollee's
6 individualized educational program for the purpose of accessing
7 educational services, unless otherwise required or permitted by
8 federal and state law. This subdivision does not require a health
9 care service plan to cover services rendered outside of the plan's
10 service area unless the services are urgently needed services, as
11 described in subdivision (h) of Section 1345, or emergency
12 services, as defined in Section 1317.1, or unless the benefit plan
13 expressly covers out-of-area services.

14 (2) Parent or caregiver participation may be associated with
15 greater improvements in functioning and should be encouraged.
16 However, the lack of parent or caregiver participation shall not be
17 used as a basis for denying or reducing coverage of medically
18 necessary services.

19 SEC. 2. Section 10144.51 of the Insurance Code, as amended
20 by Chapter 385 of the Statutes of 2017, is amended to read:

21 10144.51. (a) (1) Every health insurance policy shall also
22 provide coverage for behavioral health treatment for pervasive
23 developmental disorder or autism no later than July 1, 2012. The
24 coverage shall be provided in the same manner and shall be subject
25 to the same requirements as provided in Section 10144.5.

26 (2) Notwithstanding paragraph (1), as of the date that proposed
27 final rulemaking for essential health benefits is issued, this section
28 does not require any benefits to be provided that exceed the
29 essential health benefits that all health insurers will be required by
30 federal regulations to provide under Section 1302(b) of the federal
31 Patient Protection and Affordable Care Act (Public Law 111-148),
32 as amended by the federal Health Care and Education
33 Reconciliation Act of 2010 (Public Law 111-152).

34 (3) This section shall not affect services for which an individual
35 is eligible pursuant to Division 4.5 (commencing with Section
36 4500) of the Welfare and Institutions Code or Title 14
37 (commencing with Section 95000) of the Government Code.

38 (4) This section shall not affect or reduce any obligation to
39 provide services under an individualized education program, as
40 defined in Section 56032 of the Education Code, or an individual

1 service plan, as described in Section 5600.4 of the Welfare and
2 Institutions Code, or under the federal Individuals with Disabilities
3 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
4 regulations.

5 (b) Pursuant to Article 6 (commencing with Section 2240) of
6 Subchapter 2 of Chapter 5 of Title 10 of the California Code of
7 Regulations, every health insurer subject to this section shall
8 maintain an adequate network that includes qualified autism service
9 providers who supervise or employ qualified autism service
10 professionals or paraprofessionals who provide and administer
11 behavioral health treatment. A health insurer is not prevented from
12 selectively contracting with providers within these requirements.

13 (c) For the purposes of this section, the following definitions
14 shall apply:

15 (1) “Behavioral health treatment” means professional services
16 and treatment programs based on behavioral, developmental,
17 behavior-based, or other evidence-based-practice models, including
18 applied behavior analysis and other evidence-based behavior
19 intervention programs, that develop or restore, to the maximum
20 extent practicable, the functioning of an individual with pervasive
21 developmental disorder or autism, and that meet all of the following
22 criteria:

23 (A) The treatment is prescribed by a physician and surgeon
24 licensed pursuant to Chapter 5 (commencing with Section 2000)
25 of, or is developed by a psychologist licensed pursuant to Chapter
26 6.6 (commencing with Section 2900) of, Division 2 of the Business
27 and Professions Code.

28 (B) The treatment is provided under a treatment plan prescribed
29 by a qualified autism service provider and is administered by one
30 of the following:

31 (i) A qualified autism service provider.

32 (ii) A qualified autism service professional supervised by the
33 qualified autism service provider.

34 (iii) A qualified autism service paraprofessional supervised by
35 a qualified autism service provider or qualified autism service
36 professional.

37 (C) The treatment plan has measurable goals over a specific
38 timeline that is developed and approved by the qualified autism
39 service provider for the specific patient being treated. The treatment
40 plan shall be reviewed no less than once every six months by the

1 qualified autism service provider and modified whenever
2 appropriate, and shall be consistent with Section 4686.2 of the
3 Welfare and Institutions Code pursuant to which the qualified
4 autism service provider does all of the following:

5 (i) Describes the patient’s behavioral health impairments or
6 developmental challenges that are to be treated.

7 (ii) Designs an intervention plan that includes the service type,
8 number of hours, and parent participation, when clinically
9 appropriate, needed to achieve the plan’s goal and objectives, and
10 the frequency at which the patient’s progress is evaluated and
11 reported. When clinically appropriate, the plan shall include parent
12 or caregiver participation that is individualized to the patient and
13 that takes into account the ability of the parent or caregiver to
14 participate in therapy sessions and other recommended activities.

15 (iii) Provides intervention plans that utilize evidence-based
16 practices, with demonstrated clinical efficacy in treating pervasive
17 developmental disorder or autism. ~~“Evidence-based practice”~~
18 ~~means a decisionmaking process that integrates the best available~~
19 ~~scientifically rigorous research, clinical expertise, and individuals’~~
20 ~~characteristics. Evidence-based practice is an approach to treatment~~
21 ~~rather than a specific treatment. Evidence-based practice promotes~~
22 ~~the collection, interpretation, integration, and continuous evaluation~~
23 ~~of valued, important, and applicable individual or family reported,~~
24 ~~clinically observed, and research supported evidence. The best~~
25 ~~available evidence, matched to consumer circumstances and~~
26 ~~preferences, is applied to ensure the quality of clinical judgment~~
27 ~~and facilitate the most cost-effective care.~~

28 (iv) Discontinues intensive behavioral intervention services
29 when the treatment goals and objectives are achieved or no longer
30 appropriate.

31 (D) The treatment plan is not used for purposes of providing or
32 for the reimbursement of respite, daycare, or educational services
33 and is not used to reimburse a parent for participating in the
34 treatment program. The treatment plan shall be made available to
35 the insurer upon request.

36 (2) “Pervasive developmental disorder or autism” shall have
37 the same meaning and interpretation as used in Section 10144.5.

38 (3) “Qualified autism service provider” means either of the
39 following:

1 (A) A person who is certified by a national entity, such as the
2 Behavior Analyst Certification Board, with a certification that is
3 accredited by the National Commission for Certifying Agencies
4 or the American National Standards Institute, and who designs,
5 supervises, or provides treatment for pervasive developmental
6 disorder or autism, provided the services are within the experience
7 and competence of the person who is nationally certified.

8 (B) A person licensed as a physician and surgeon, physical
9 therapist, occupational therapist, psychologist, marriage and family
10 therapist, educational psychologist, clinical social worker,
11 professional clinical counselor, speech-language pathologist, or
12 audiologist pursuant to Division 2 (commencing with Section 500)
13 of the Business and Professions Code, who designs, supervises,
14 or provides treatment for pervasive developmental disorder or
15 autism, provided the services are within the experience and
16 competence of the licensee.

17 (4) “Qualified autism service professional” means an individual
18 who meets all of the following criteria:

19 (A) Provides behavioral health treatment, which may include
20 clinical case management and case supervision under the direction
21 and supervision of a qualified autism service provider. However,
22 the services shall be consistent with the experience, training, or
23 education of the professional.

24 (B) Is supervised by a qualified autism service provider.

25 (C) Provides treatment pursuant to a treatment plan developed
26 and approved by the qualified autism service provider.

27 (D) Is a behavioral service provider who meets one of the
28 following criteria:

29 (i) Meets the education and experience qualifications described
30 in Section 54342 of Title 17 of the California Code of Regulations
31 for an associate behavior analyst, behavior analyst, behavior
32 management assistant, behavior management consultant, or
33 behavior management program.

34 (ii) Possesses a bachelor of arts or science degree and meets
35 one of the following qualifications:

36 (I) One year of experience in designing or implementing
37 behavioral health treatment supervised by a qualified autism service
38 provider and 12 semester units from an accredited institution of
39 higher learning in either applied behavioral analysis or clinical
40 coursework in behavioral health.

1 (II) Two years of experience in designing or implementing
2 behavioral health treatment supervised by a qualified autism service
3 provider.

4 (III) The person is a registered psychological assistant or
5 registered psychologist pursuant to Chapter 6.6 (commencing with
6 Section 2900) of Division 2 of the Business and Professions Code.
7 A registered psychological assistant or registered psychologist
8 may not supervise a qualified autism service paraprofessional until
9 the registered psychological assistant or registered psychologist
10 has obtained at least 500 hours of experience in designing or
11 implementing behavioral health treatment.

12 (IV) The person is an associate clinical social worker registered
13 with the Board of Behavioral Sciences pursuant to Section 4996.18
14 of the Business and Professions Code. An associate clinical social
15 worker may not supervise a qualified autism service
16 paraprofessional until the associate clinical social worker has
17 obtained at least 500 hours of experience in designing or
18 implementing behavioral health treatment.

19 (V) The person is a registered associate marriage and family
20 therapist with the Board of Behavioral Sciences pursuant to Section
21 4980.44 of the Business and Professions Code. A registered
22 associate marriage and family therapist may not supervise a
23 qualified autism service paraprofessional until the registered
24 associate marriage and family therapist has obtained at least 500
25 hours of experience in designing or implementing behavioral health
26 treatment.

27 (VI) The person is a registered associate professional clinical
28 counselor with the Board of Behavioral Sciences pursuant to
29 Section 4999.42 of the Business and Professions Code. A registered
30 associate professional clinical counselor may not supervise a
31 qualified autism service paraprofessional until the registered
32 associate professional clinical counselor has obtained at least 500
33 hours of experience in designing or implementing behavioral health
34 treatment.

35 (VII) The person is credentialed or certified by a national entity,
36 including, but not limited to, the Behavior Analyst Certification
37 Board, which is accredited by the National Commission for
38 Certifying Agencies or the American National Standards Institute
39 to provide applied behavior analysis or behavioral health treatment,

1 which may include case management and case supervision under
2 the direction and supervision of a qualified autism service provider.

3 (E) Has training and experience in providing services for
4 pervasive developmental disorder or autism.

5 (F) Is employed by the qualified autism service provider or an
6 entity or group that employs qualified autism service providers
7 responsible for the autism treatment plan.

8 (G) Has completed a background check performed by a
9 Department of Justice approved agency, with subsequent
10 notification to the person’s employer pursuant to Section 11105.2
11 of the Penal Code.

12 (5) “Qualified autism service paraprofessional” means an
13 individual who meets all of the following criteria:

14 (A) Is supervised by a qualified autism service provider or
15 qualified autism service professional at a level of clinical
16 supervision that meets professionally recognized standards of
17 practice.

18 (B) Provides treatment and implements services pursuant to a
19 treatment plan developed and approved by the qualified autism
20 service provider.

21 (C) Meets one of the following:

22 (i) For applied behavioral analysis, the education and training
23 qualifications described in Section 54342 of Title 17 of the
24 California Code of Regulations.

25 (ii) For other evidence-based behavioral health treatments, all
26 of the following qualifications:

27 (I) Possesses an associate’s degree or has completed two years
28 of study from an accredited college or university with coursework
29 in a related field of study.

30 (II) Has 40 hours of training in the specific form of behavioral
31 health treatment developed by a qualified autism service provider
32 and administered by a qualified autism service provider or qualified
33 autism service professional competent in the form of behavioral
34 health treatment to be practiced by the paraprofessional.

35 (III) Has adequate education, training, and experience, as
36 certified by a qualified autism service provider.

37 (iii) Is credentialed or certified in applied behavior analysis or
38 behavioral health treatment for paraprofessionals or technicians
39 by a national entity that is accredited by the National Commission

1 for Certifying Agencies or the American National Standards
2 Institute.

3 However, upon successful completion of the training and
4 education necessary for certification or a credential described in
5 this clause, if the applicant is otherwise qualified under this section,
6 the applicant may provide treatment and implement services for
7 up to 180 days while in the process of obtaining the certification
8 or credential.

9 (D) Has adequate education, training, and experience, as
10 certified by a qualified autism service provider or an entity or
11 group that employs qualified autism service providers.

12 (E) Is employed by the qualified autism service provider or an
13 entity or group that employs qualified autism service providers
14 responsible for the autism treatment plan.

15 (F) Has completed a background check performed by a
16 Department of Justice approved agency, with subsequent
17 notification to the person's employer pursuant to Section 11105.2
18 of the Penal Code.

19 (d) This section shall not apply to a specialized health insurance
20 policy that does not cover mental health or behavioral health
21 services or an accident only, specified disease, hospital indemnity,
22 or Medicare supplement policy.

23 (e) This section does not limit the obligation to provide services
24 under Section 10144.5.

25 (f) As provided in Section 10144.5 and in paragraph (1) of
26 subdivision (a), in the provision of benefits required by this section,
27 a health insurer may utilize case management, network providers,
28 utilization review techniques, prior authorization, copayments, or
29 other cost sharing.

30 (g) (1) The setting, location, or time of treatment recommended
31 by the qualified autism service provider shall not be used as the
32 only reason to deny or reduce coverage for medically necessary
33 services. The setting shall be consistent with the standard of care
34 for behavioral health treatment. This subdivision does not require
35 a health insurer to provide reimbursement for services delivered
36 by school personnel pursuant to an enrollee's individualized
37 educational program for the purpose of accessing educational
38 services, unless otherwise required or permitted by federal and
39 state law. This subdivision does not require a health insurer to
40 cover services rendered outside of the health insurer's service area

1 unless the services are urgently needed services to prevent serious
2 deterioration of a covered person’s health resulting from unforeseen
3 illness or injury for which treatment cannot be delayed until the
4 covered person returns to the insurer’s service area, or emergency
5 services, as defined in Section 1317.1 of the Health and Safety
6 Code, or unless the benefit plan expressly covers out-of-area
7 services.

8 (2) Parent or caregiver participation may be associated with
9 greater improvements in functioning and should be encouraged.
10 However, the lack of parent or caregiver participation shall not be
11 used as a basis for denying or reducing coverage of medically
12 necessary services.

13 SEC. 3. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 601 **VERSION:** AMENDED MARCH 28, 2019

AUTHOR: MORRELL **SPONSOR:** R STREET INSTITUTE

RECOMMENDED POSITION: SUPPORT

SUBJECT: STATE AGENCIES: LICENSES: FEE WAIVER

Summary: This bill would allow the Board to reduce or waive fees for a license or registration, license or registration renewal, or replacement of a physical display license if the licensee or registrant can demonstrate being affected or displaced by a state or federal emergency.

Existing Law:

1. Defines three types of state emergencies (Government Code (GC) §8558):
 - a. “State of emergency,” which means proclaimed existence of disaster or extremely perilous conditions to safety of persons or property in the state. Examples of causes include fire, flood, storm, riot, drought, cyberterrorism, or earthquake, which are of such a great magnitude that they are beyond the control of services, personnel, equipment, and facilities of any single county and city and that instead require combined mutual aid.
 - b. “Local emergency,” which means proclaimed existence of disaster or extremely perilous conditions to safety of persons or property in a county and/or city. Examples of causes include fire, flood, storm, riot, drought, cyberterrorism, or earthquake, which are likely are beyond the control of services, personnel, equipment, and facilities of a political subdivision and that instead require combined mutual aid.
 - c. “State of war emergency,” which is a condition in which the state or nation is attacked by an enemy or warned by the federal government that an attack is probable or imminent.
2. Establishes the Board of Behavioral Sciences’ fees for initial license and registration, fees for renewal of a license and registration, and fees for a replacement certificate. (Business and Professions Code (BPC) §§4984.7, 4989.68, 4996.3, 4999.120, California Code of Regulation (CCR) Title 16 §§1816, 1816.1, and 1816.5)

3. Contains a clause that permits the Optometry Board to waive an application fee for an optometrist license if the applicant establishes displacement by a federally declared emergency and cannot relocate back to their state of practice within a reasonable amount of time without economic hardship. (BPC §3057)

This Bill:

1. Permits a state agency that issues any business license to reduce or waive any licensure fees, license renewal fees, or physical display license replacement fees for a person or business that has been displaced or affected by a proclaimed state emergency or a declared federal emergency. (GC §11009.5)
2. Requires this to be done within one year of the proclaimed or declared emergency and requires the requestor to demonstrate being displaced or affected to the satisfaction of the state agency. (GC §11009.5)
3. Defines a “license” for the purpose of the above waivers to include a certificate, registration, or other required document to engage in business. (GC §11009.5)

Comment:

1. **Author’s Intent.** The author notes that in recent years, California has experienced several costly natural disasters, including the Tubbs Fire, the Southern California mudslides, and the Camp Fire. They state that these disasters have affected an estimated 381,700 businesses, and many of these individuals must replace licensing documents. The goal of this bill is to help relieve pressure on these individuals and help them get back to work.
2. **Precedent with Other Boards.** The California Board of Optometry has a clause in its law that allows it to waive an application fee for an optometrist license if the applicant establishes displacement by a federally declared emergency and cannot relocate back to their state of practice within a reasonable amount of time. This Board does not currently have that type of explicit authority.
3. **Potential Fiscal Impact.** It is difficult to predict the potential fiscal impact to the Board of lost fee revenue due to declared emergencies. In most cases, any impact would be minor if a handful to several hundred licensees or registrants were affected. However, if a major disaster were to occur in an area with a high concentration of licensees, the fiscal impact could be significant.
4. **Need for Regulation.** If this bill were to pass, the Board may need to consider regulations to determine the process to request a fee waiver, and also to determine acceptable proof of being displaced or affected. Alternatively, the Board could choose to leave this decision to be made on a case-by-case basis.
5. **Recommended Position.** At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended the Board consider taking a “support” position on this bill.

6. Support and Opposition.

Support

- R Street Institute (Sponsor)
- California Board of Accountancy
- California Chamber of Commerce
- California Dental Association
- Rebuild Paradise Foundation
- Southwest California Legislative Council

Opposition

- None at this time.

7. History

2019

04/23/19 From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 9. Noes 0.) (April 22). Re-referred to Com. on APPR.

04/11/19 Set for hearing April 22.

04/09/19 From committee: Do pass and re-refer to Com. on B., P. & E.D. with recommendation: To consent calendar. (Ayes 16. Noes 0.) (April 9). Re-referred to Com. on B., P. & E.D.

03/28/19 From committee with author's amendments. Read second time and amended. Re-referred to Com. on G.O.

03/22/19 Set for hearing April 9.

03/14/19 Referred to Coms. on G.O. and B., P. & E.D.

02/25/19 Read first time.

02/25/19 From printer. May be acted upon on or after March 27.

02/22/19 Introduced. To Com. on RLS. for assignment. To print

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AMENDED IN SENATE MARCH 28, 2019

SENATE BILL

No. 601

**Introduced by Senator Morrell (Coauthors:
Senators Bates, Borgeas, and Nielsen) (Coauthors:
Assembly Members Dahle and Mathis)**

February 22, 2019

An act to add Section 11009.5 to the Government Code, relating to state government.

legislative counsel's digest

SB 601, as amended, Morrell. State agencies: licenses: fee waiver.

Existing law requires various licenses to be obtained by a person before engaging in certain professions or vocations or business activities, including licensure as a healing arts professional by various boards within the Department of Consumer Affairs.

This bill would authorize any state agency that issues any business license to reduce or waive any required fees for licensure, renewal of licensure, or the replacement of a physical license for display if a person or business establishes to the satisfaction of the state agency that the person or business has been displaced *or affected* by a declared ~~emergency~~, *federal emergency or proclaimed state emergency*, as defined.

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

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

- 1 SECTION 1. Section 11009.5 is added to the Government
- 2 Code, to read:

1 11009.5. (a) Notwithstanding any other law, a state agency
2 that issues any business license may, within one year of the
3 ~~declaration~~ *proclamation* of an emergency as defined in Section
4 ~~8558, 8558~~ *or a declared federal emergency*, reduce or waive any
5 required fees for licensure, renewal of licensure, or the replacement
6 of a physical license for display if a person or business establishes
7 to the satisfaction of the state agency that the person or business
8 has been displaced *or affected* by the *proclaimed or* declared
9 emergency.
10 (b) For purposes of this section, “license” includes, but is not
11 limited to, a certificate, registration, or other required document
12 to engage in business.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 660 **VERSION: INTRODUCED FEBRUARY 22, 2019**

AUTHOR: PAN **SPONSORS: CALIFORNIA FACULTY ASSOCIATION**

RECOMMENDED POSITION: SUPPORT IF AMENDED

SUBJECT: POSTSECONDARY EDUCATION: MENTAL HEALTH COUNSELORS

Summary:

This bill would require specified higher educational entities in California to hire one full-time equivalent mental health counselor per 1,500 students enrolled at each of their campuses.

Existing Law:

- 1) Establishes the Donahoe Higher Education Act, specifying that public higher education consists of the California Community Colleges, the California State University, and the University of California. (Education Code (EC) §66010)

This Bill:

- 1) Requires the following educational entities to have one full-time equivalent mental health counselor per 1,500 students enrolled at each respective campus during all academic terms, to the extent consistent with state and federal law (EC §66027.2(a)):
 - The Trustees of the California State University (CSU);
 - The governing board of each community college district.
- 2) Specifies that this requirement is a minimum requirement, and that additional mental health providers may be hired based on a campus's additional needs. (EC §66027.2(b))
- 3) Defines a "mental health counselor" as someone who meets both of the following (EC §66027.2(c)):
 - Provides individual and group counseling, crisis intervention, emergency services, referrals, program evaluation and research, or outreach and

- consultation interventions to the campus community, or any combination of these; and
- Is licensed in California by the applicable licensing entity.
- 4) Requires educational institutions subject to this requirement to report to the legislature every three years on how funding was spent and on the number of mental health counselors employed on each of its campuses. The report shall be conducted in accordance with state and federal privacy laws, and must include the following (EC §66027.2(d)):
- Results from a campus survey and focus groups regarding student needs and challenges regarding their mental health, emotional well-being, sense of belonging, and academic success; and
 - Campus data on attempted suicides.

Comment:

- 1) **Author's Intent.** The authors office states that the International Association of Counseling Services (IACS) recommends one full-time equivalent mental health counselor for every 1,000 to 1,500 students, and that exceeding this ratio could lead to longer wait lists for services, and more instances of students dropping out of school. They note that while the UC system reports that their ratio falls within this recommended range, it is estimated to be significantly higher for the CSU system. However, it is difficult to know exact ratios because of a lack of reporting and data.

The author believes this bill will address the mental health crisis facing California's public higher education system by requiring CSUs and community colleges to hire an appropriate number of mental health counselors and instituting consistent reporting requirements.

- 2) **Definition of a "Mental Health Counselor."** The Board may wish to discuss whether the bill's definition of a "mental health counselor" is adequate, including the following:
- Would it be preferable to specifically state which licensing boards are considered "applicable licensing entities?"
 - Should associates and trainees be included in the definition of "mental health counselor?"
- 3) **Previous Legislation.** Last year, the Board took a "support if amended" position on SB 968 (2018, Pan), which was very similar to this bill and required the same ratio of mental health counselors at CSU and community college campuses. The Board requested that in addition to its licensees, trainees and registered associates also be permitted to be hired to meet the ratio requirement.

Governor Jerry Brown vetoed SB 986 in September 2018. In his veto message, Governor Brown stated the following:

“...Investing greater resources in student mental health is an understandable goal. Such investments, however, should be actively considered and made within the budget process. Moreover, specific ratios should remain within the purview of the boards or with local campuses, rather than dictated by the state.”

4) Recommended Position. At its April 5, 2019 meeting, the Policy and Advocacy Committee recommended that the Board consider taking a “support if amended” position on the bill, and suggested the following amendments:

- The bill defines a “mental health counselor” (EC §66027.2(c)) as someone who provides specified services and who is licensed in the State of California by the applicable licensing entity. The Committee suggested that it would be clearer to specify the acceptable licensing boards or license types.
- The bill specifies that acceptable “mental health counselors” hold a license. However, the Committee suggested that the Board’s registrants be considered acceptable and count toward the ratio as well.

Staff relayed these suggestions to the author’s office. They indicated that they would discuss them with the sponsor. They noted the potential for some concern about including registrants, as it could encourage schools to hire more registrants for less pay.

5) Support and Opposition.

Support:

- California Faculty Association (Sponsor)
- American Academy Of Pediatrics, California
- Cal State Student Association
- California Psychological Association
- California State Council of Service Employees
- Disability Rights California
- San Jose-Evergreen Community College District

Opposition:

- None at this time.

6) History.

2019

04/29/19 April 29 hearing: Placed on APPR. suspense file.

04/18/19 Set for hearing April 29.

04/10/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (April 10). Re-referred to Com. on APPR.
03/15/19 Set for hearing April 10.
03/14/19 Referred to Com. on ED.
02/25/19 Read first time.
02/25/19 From printer. May be acted upon on or after March 27.
02/22/19 Introduced. To Com. on RLS. for assignment. To print.

**Introduced by Senator Pan (Principal
coauthor: Senator Portantino)
(Coauthor: Senator Galgiani)
(Coauthor: Assembly Member Bonta)**

February 22, 2019

An act to add Section 66027.2 to the Education Code, relating to postsecondary education.

legislative counsel's digest

SB 660, as introduced, Pan. Postsecondary education: mental health counselors.

Existing law establishes the California State University, administered by the Trustees of the California State University, and the California Community Colleges, administered by the Board of Governors of the California Community Colleges. Existing law provides for licensing and regulation of various professions in the healing arts, including physicians and surgeons, psychologists, marriage and family therapists, educational psychologists, clinical social workers, and licensed professional clinical counselors.

This bill would require the Trustees of the California State University and the governing board of each community college district to have one full-time equivalent mental health counselor with an applicable California license per 1,500 students enrolled at each of their respective campuses to the extent consistent with state and federal law. The bill would define mental health counselor for purposes of this provision. The bill would require those institutions, on or before January 1, 2021, and every 3 years thereafter, to report to the Legislature how funding was spent and the number of mental health counselors employed on each of its campuses, as specified. The bill would require each campus

of those institutions to, at least every 3 years, conduct a campus survey and focus groups to understand students' needs and challenges regarding, among other things, their mental health, would require each campus of those institutions to collect data on attempted suicides, as specified, and would require that data, without any personally identifiable information and collected in accordance with state and federal privacy law, to be included in the report to the Legislature. To the extent that this bill would impose new duties on community college districts, it would constitute a state-mandated local program.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

- 1 SECTION 1. The Legislature finds and declares all of the
2 following:
- 3 (a) Students face anxiety, depression, and stress as they confront
4 challenges of campus life.
- 5 (b) Suicide is the second leading cause of death among college
6 students claiming more than 1,100 lives every year nationally.
- 7 (c) One in four students has a diagnosable mental illness and
8 40 percent of students do not seek mental health services when
9 they need it.
- 10 (d) For students of color, these challenges may be even more
11 acute as they face additional stressors, such as discrimination,
12 immigration status, financial hardship, and being the first of their
13 families to attend college, and students of color are less likely to
14 access needed services.
- 15 (e) Among the many benefits of mental health counseling are
16 lower college dropout rates, improved academic performance, and
17 reduced legal liability for campuses.

1 (f) The California State University system in particular is
2 woefully understaffed with mental health counselors to address
3 the needs of their campuses.

4 SEC. 2. Section 66027.2 is added to the Education Code, to
5 read:

6 66027.2. (a) (1) The Trustees of the California State
7 University and the governing board of each community college
8 district shall have one full-time equivalent mental health counselor
9 per 1,500 students enrolled at each of their respective campuses
10 to the extent consistent with state and federal law.

11 (2) Where possible, mental health counselors hired under
12 paragraph (1) should be full-time staff, and efforts should be made
13 so that mental health counselors reflect the diversity of the student
14 body.

15 (3) The ratio specified in paragraph (1) shall apply during all
16 academic terms, including summer and winter sessions.

17 (b) The number of mental health counselors as computed
18 pursuant to subdivision (a) shall constitute the minimum number
19 of mental health counselors to be hired on a campus based on the
20 campus student population. Additional mental health counselors
21 may be hired in accordance with additional needs identified on a
22 campus.

23 (c) For purposes of this section, “mental health counselor” means
24 a person who provides individual counseling, group counseling,
25 crisis intervention, emergency services, referrals, program
26 evaluation and research, or outreach and consultation interventions
27 to the campus community, or any combination of these, and who
28 is licensed in the State of California by the applicable licensing
29 entity.

30 (d) (1) On or before January 1, 2021, and every three years
31 thereafter, a postsecondary educational institution subject to this
32 section shall report to the Legislature, consistent with Section 9795
33 of the Government Code, how funding was spent and the number
34 of mental health counselors employed on each of its campuses.

35 (2) Each campus of a postsecondary educational institution
36 subject to this section shall, at least every three years, conduct a
37 campus survey and focus groups, including focus groups with
38 students of color, to understand students’ needs and challenges
39 regarding their mental health and emotional well-being, sense of
40 belonging on campus, and academic success.

1 (A) The campus surveys and data collection required in
2 paragraph (2) shall be conducted in accordance with state and
3 federal privacy law, including, but not limited to, the
4 Confidentiality of Medical Information Act (Part 2.6 (commencing
5 with Section 56) of Division 1 of the Civil Code), the federal
6 Family Educational Rights and Privacy Act of 1974 (20 U.S.C.
7 Sec. 1232g), and the federal Health Insurance Portability and
8 Accountability Act of 1996 (Public Law 104-191).

9 (B) The data collected, without any personally identifiable
10 information, shall be included in the report required to be submitted
11 to the Legislature pursuant to paragraph (1).

12 (3) Each campus of a postsecondary educational institution
13 subject to this section shall collect data on attempted suicides
14 through self-reporting, mental health counselor records, and known
15 hospitalizations. This data, without any personally identifiable
16 information, shall be included in the report required to be submitted
17 to the Legislature pursuant to paragraph (1).

18 SEC. 3. If the Commission on State Mandates determines that
19 this act contains costs mandated by the state, reimbursement to
20 local agencies and school districts for those costs shall be made
21 pursuant to Part 7 (commencing with Section 17500) of Division
22 4 of Title 2 of the Government Code.

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 425 **VERSION:** AMENDED APRIL 30, 2019

AUTHOR: HILL **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: HEALTH CARE PRACTITIONERS: LICENSEE'S FILE: PROBATIONARY PHYSICIAN'S
AND SURGEON'S CERTIFICATE: UNPROFESSIONAL CONDUCT

Summary: This bill requires health facilities, clinics, or other entities that make arrangements for a healing arts licensee to practice or provide care for patients to report allegations of sexual abuse or sexual misconduct by a licensee to the applicable state licensing board within 15 days. The reporting requirements also extend to employees of these entities.

Existing Law:

1. Requires specified boards under the Department of Consumer Affairs (DCA), including the Board of Behavioral Sciences (Board) to create and maintain a central file of all license holders. The file is intended to be a historical record to provide an individual's history regarding the following (Business and Professions Code (BPC) §800(a)):
 - a. Convictions of crimes in this state or another state;
 - b. Judgements or settlements requiring a damages payment of over \$3,000 for injury or death caused by negligence, error, or unauthorized services;
 - c. Complaints made by the public; and
 - d. Disciplinary information required to be reported by a peer review body or licensed health care facility.
2. Requires the boards to provide forms for the public and other licensees to file written complaints. (BPC §800(b))
3. Requires the contents of the central file, except for public record items, to be confidential. However, a licensee may inspect and make copies of their file and may choose to submit an explanatory statement or other information for inclusion. (BPC §800(c))
4. Requires every insurer providing professional liability insurance to an LMFT, LCSW, or LPCC to report any settlement or arbitration award for death or personal injury

caused by negligence, error, or omission that is over \$10,000 to the Board within 30 days. (BPC §801(b))

5. Requires the court, within 10 days of a judgement that a Board licensee committed a crime or is liable for a death or personal injury resulting in a judgement over \$30,000, due to negligence, error, omission in practice, or unauthorized professional services, to report it to the Board. (BPC §803)
6. Requires the chief or director of a peer review body, licensed health care facility, or clinic to file a report with the applicable licensing agency within 15 days after the effective date of any of the following peer review body actions (BPC §805(b)):
 - a. A licensee's staff privileges or membership is denied or rejected for a medical disciplinary cause;
 - b. A licensee's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause; or
 - c. Restrictions are imposed or accepted on staff privileges, membership, or employment for 30 days or more in a 12-month period for a medical disciplinary cause.
7. Requires the chief or director of a peer review body, licensed health care facility, or clinic to file a report with the applicable licensing agency within 15 days after a final decision or recommendation of disciplinary action following formal investigation that determined any of the following may have occurred (BPC §805.01(b)):
 - a. Incompetence, gross, or repeated deviation from the standard of care involving death or serious bodily injury, to the extent of being dangerous or injurious to a person or to the public;
 - b. Using or prescribing controlled substances, dangerous drugs, or alcohol to the extent to be dangerous or injurious;
 - c. Repeated acts of excessive prescribing, furnishing, or administering controlled substances; or
 - d. Sexual misconduct with one or more patients during treatment or examination.
8. Does not require a peer review body to make a report described in Item 7 above, if it does not make a final decision or recommendation regarding disciplinary action. (BPC §805.01(f))

This Bill:

1. Requires a health facility, clinic, or other entity that makes arrangement allowing healing arts licensees to practice or provide care for patients, to report any allegation of licensee sexual abuse or sexual misconduct to the applicable licensing board

within 15 days of receiving the allegation. This includes, but is not limited to, arrangements where licensees have full staff privileges, or active, limited, auxiliary, provisional, temporary, or courtesy staff privileges, locum tenens arrangements, and contractual arrangements. (BPC §805.8(b))

2. Requires any employee or healing arts licensee that works in any health facility, clinic, or other entity as described in Item 1 above, who has knowledge of any allegation of sexual abuse or sexual misconduct by a healing arts licensee to file a report with the applicable licensing board and the administration of the health facility, clinic or other entity, within 15 days of knowing about it. (BPC §805.8(c))
3. Makes a willful failure to file a report punishable by a fine of up to \$100,000 per violation and may also constitute unprofessional conduct. The fine can be imposed in a civil or administrative action or brought by the applicable licensing board. (BPC §805.8(d))
4. Makes any failure (non-willful) to file a report punishable by a fine of up to \$50,000 per violation. The fine can be imposed in a civil or administrative action or brought by the applicable licensing board and shall be proportional to the severity of the failure to report. (BPC §805.8(e))
5. States that a person or entity shall not incur civil or criminal liability as a result of making the required report if made in good faith. (BPC §805.8(f))
6. Requires the applicable licensing board to investigate the circumstances underlying a required report it receives. (BPC §805.8(g))
7. Makes other changes to the Medical Board's licensing law that are related to its enforcement process. (BPC §§2221 and 2234)

Comment:

1. **Background and Author's Intent.** The author is seeking to close legal loopholes that can allow a practitioner with repeated sexual abuse and misconduct complaints to keep practicing at a health facility for years without their licensing board being notified.

The issue was brought to light by a May 2018 report by the L.A. Times, which disclosed multiple unresolved complaints by a USC gynecologist who had worked at the university for almost 30 years. None of the complaints had been reported to the Medical Board.

The author of this bill, Senator Jerry Hill, conducted a hearing on sexual misconduct reporting in the medical profession in response to the L.A. Times report. The hearing found that there are different reporting standards for different types of health facilities. For example, some facility types have no requirement to report sexual

abuse or misconduct allegations to a licensing board. Some have peer review groups that decide whether a report should be sent to the licensing board. (See **Attachment A** for the background information published for Senator Hill's hearing, including a discussion about the peer review process.)

- 2. Expansion of Setting Reporting Requirements.** Currently, Sections 805 and 805.01 require peer review bodies, licensed health care facilities, or clinics to make reports to the Board under certain circumstances. These circumstances include for sexual misconduct, if there has been a formal investigation and if a final decision or recommendation has been made. However, this does not guarantee a report will be made to the Board for sexual misconduct for a couple of reasons. First, as pointed out in **Attachment A**, different peer review bodies can have different standards. Second, a report is only required if a final decision or recommendation has been made.

This bill expands reporting by requiring a report to be filed for any allegation of sexual abuse or sexual misconduct. The individuals who must report are also greatly expanded: a health facility or clinic, or other entity that makes arrangements for a healing arts licensee to practice or provide care for patients. The reporting requirements also extend to employees of these entities.

Board licensees practice in a variety of settings. These include not only health facilities and clinics, but also private practices, schools, and corporations, to name a few. Staff asked the author's office to clarify whether "other entities" that arrange for a Board licensee to practice or provide care for patients would include all practice settings in the reporting requirements. The author's office indicated that their intent is to ensure that all instances or complaints of sexual misconduct be reported in any setting anytime a licensee is seeing a patient.

The Board may wish to discuss whether the reference to "other entities" in BPC §805.8(a)(4), (b), and (c) of the bill makes it sufficiently clear which settings/individuals must file a report, especially given the steep fines associated with a failure to report.

- 3. Potential Fiscal Impact on Board Operations.** This bill could result in an increase in complaints because it significantly changes the reporting requirements to the Board for licensee sexual misconduct. Currently, a report is required if a peer review body, licensed health care facility, or clinic has conducted a formal investigation and made a final decision or recommendation. This bill requires basically anyone, whether an employer or an employee, to make a report to the Board if there is a sexual misconduct complaint about a licensee.

It is unknown if the new reporting requirements will lead to a significant increase in complaints. Complaints by a 3rd party are more likely to close because the victim does not wish to participate and without their participation, there is often a lack of

evidence. For this reason, staff believes that the increased caseload would be minimal and could be absorbed within existing resources.

4. **Recommended Position.** At its April 5, 2019 meeting, the Policy and Advocacy Committee decided not to recommend a position on this bill but opted to continue to watch it to see if there were any new developments between then and the May Board meeting.

The author has made minor amendments to the bill since the Policy and Advocacy Committee meeting, but the requirements of the bill are still substantially the same.

5. **Support and Opposition.**

Support

- Consumer Attorneys of California
- Consumer Watchdog
- Medical Board of California

Opposition

- Association of California Life and Health Insurance Companies
- California Association of Health Plans
- California Chapter of the American College of Cardiology
- California Medical Association

6. **History.**

2019

- 04/30/19 Read second time and amended. Re-referred to Com. on APPR.
- 04/29/19 From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 7. Noes 2.) (April 23).
- 04/11/19 From committee with author's amendments. Read second time and amended. Re-referred to Com. on JUD.
- 04/10/19 Set for hearing April 23.
- 04/08/19 From committee: Do pass and re-refer to Com. on JUD. (Ayes 9. Noes 0.) (April 8). Re-referred to Com. on JUD.
- 03/26/19 Set for hearing April 8.
- 03/07/19 Referred to Coms. on B., P. & E.D. and JUD.
- 02/22/19 From printer. May be acted upon on or after March 24.
- 02/21/19 Introduced. Read first time. To Com. on RLS. for assignment. To print.

7. **Attachments.**

Attachment A: Background Information - Senate Committee on Business, Professions and Economic Development Oversight Hearing: *Sexual Misconduct Reporting in the Medical Profession: Missed Opportunities to Protect Patients* (June 18, 2018)

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ATTACHMENT A

Oversight Hearing of the
Senate Committee on Business, Professions and Economic Development

Sexual Misconduct Reporting in the Medical Profession: Missed Opportunities to Protect Patients

Monday, June 18, 2018
10:00 am
State Capitol, Room 3191

BACKGROUND INFORMATION

1. Introduction

The Committee has a significant history of interest and focus on statutory reporting requirements designed to inform health practitioner licensing boards about possible matters for investigation. Given the indispensable nature of health care, high quality patient care is vital. Patients expect their treating physicians or other medical professionals to be competent and qualified, and the Committee has long held that health practitioners who fail to meet established professional standards must be discovered, reviewed and disciplined if necessary in a timely manner.

2. Mandatory Reporting of Health Practitioner Settlements, Indictments, Convictions, and Discipline

There are a number of reporting requirements outlined in the Business and Professions Code designed to inform licensing boards about possible matters for investigation, including:

- BPC 801.01 requires the Medical Board of California (MBC), Osteopathic Medical Board of California (OMBC), California Board of Podiatric Medicine (BPM) and Physician Assistant Board (PAB) to receive reports of settlements over \$30,000 or arbitration awards or civil judgments of any amount. The report must be filed within 30 days by either the insurer providing professional liability insurance to the licensee, the state or governmental agency that self-insures the licensee, the employer of the licensee if the award is against or paid for by the licensee or the licensee if not covered by professional liability insurance.
- BPC 802.1 requires a licensees of MBC, OMBC, BPM and PAB to report indictments charging a felony and/or any convictions of any felony or misdemeanor, including a guilty verdict or plea of no contest to their licensing board.
- BPC Section 802.5 requires a coroner who receives information, based on findings reached by a pathologist that indicates that a death may be the result of a physician and

surgeon, podiatrists or physician assistant's gross negligence or incompetence, to submit a report to MBC, OMBC, BPM and PAB, as appropriate. The coroner must provide relevant information, including the name of the decedent and attending licensee as well as the final report and autopsy.

- BPC Sections 803, 803.5 and 803.6 require the clerk of a court that renders a judgment that a licensee has committed a crime, or is liable for any death or personal injury resulting in a judgment of any amount caused by the licensee's negligence, error or omission in practice, or his or her rendering of unauthorized professional services, to report that judgment to the appropriate healing arts licensing agency within 10 days after the judgment is entered. In addition, the court clerk is responsible for reporting criminal convictions to some licensing agencies (MBC, OMBC, BPM, Board of Chiropractic Examiners (BCE), PAB or other appropriate allied health board) and transmitting any felony preliminary hearing transcripts concerning a licensee to those boards.

- BPC Section 805 is one of the most important reporting requirements that allows boards to learn key information about licensees. Section 805 requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report when a licensee's application for staff privileges or membership is denied, or the licensee's staff privileges or employment are terminated or revoked for a medical disciplinary cause. Licensees include physicians and surgeons, doctors of podiatric medicine, clinical psychologists, marriage and family therapists, clinical social workers, professional clinical counselors, dentists, licensed midwives or physician assistants. The reporting entities are also required to file a report when restrictions are imposed or voluntarily accepted on the licensee's staff privileges for a cumulative total of 30 days or more for any 12-month period. The report must be filed within 15 days after the effective date of the action taken by a health facility peer review body.

- BPC Section 805.01 is a similarly extremely important requirement. The law requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported pursuant to section 805. This reporting requirement became effective January 2011 and is only required if the recommended action is taken for the following reasons:
 - Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.

 - The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, or of alcoholic beverages, to the extend or in such a manner as to be dangerous or injurious to the licentiate, or any

other persons, or the public, or to the extent that such use impairs the ability of the licensee to practice safely.

- Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- Sexual misconduct with one or more patients during a course of treatment or an examination.

The purpose of 805 reports is to provide licensing boards with early information about these serious charges so that they may investigate and take appropriate action to further consumer protection at the earliest possible moment. Accordingly, for any allegations listed above, the Legislature determined that an 805.01 report must be filed once a formal investigation has been completed, and a final decision or recommendation regarding the disciplinary action to be taken against a licensee has been determined by the peer review body, even when the licensee has not yet been afforded a hearing to contest the findings.

3. Peer Review

In peer review, health care practitioners evaluate their colleagues' work to determine compliance with the standard of care. Peer reviews are intended to detect incompetent or unprofessional practitioners early and terminate, suspend, or limit their practice if necessary. Peer review is triggered by a wide variety of events including patient injury, disruptive conduct, substance abuse, or other medical staff complaints. A peer review committee investigates the allegation, comes to a decision regarding the licensee's conduct, and takes appropriate remedial actions. There has historically been some reluctance among licensees to serve on peer review committees due to the risk of involvement in related future litigation, including medical malpractice lawsuits against a licensee under review. There are also concerns about "sham peer review" which uses the peer review system to discredit, harass, discipline, or otherwise negatively affect a practitioner's ability to practice or exercise professional judgment for a non-medical or reason unrelated to patient safety. Other criticisms of peer review include over legalization of the process, lack of transparency in the system, and the burdensome human and financial toll peer review brings not only to the hospital but also to a licensee under review.

In 1989, several due process provisions for physicians subject to an 805 report were adopted and codified under Section 809 et. seq. of the Business and Professions Code. Any physician, for whom an 805 report may be required to be filed, is entitled to specified due process rights, including notice of the proposed action, an opportunity for a hearing with full procedural rights (including discovery, examination of witnesses, formal record of the proceedings and written findings). Furthermore, a physician may seek a judicial review in the Superior Court pursuant to Code of Civil Procedure Section 1094.5 (writ of mandate). The due process requirements do not apply to peer review proceedings conducted in state or county hospitals, to the University of California hospitals or to other teaching hospitals as defined.

Recognizing that peer review is necessary to maintain and improve quality medical care, Congress, in 1986, enacted the Health Care Quality Improvement Act (HCQIA). HCQIA established standards for hospital peer review committees, provided immunity for those who participate in peer review, and created the National Practitioner Databank (NPDB). The NPDB is a confidential repository of information related to the professional competence and conduct of health care practitioners. Credentialing bodies are required to check the NPDB database before granting privileges or reappointing privileges to licensees. Entities such as hospitals, professional societies, state boards, and plaintiffs' attorneys are given access to the NPDB. In enacting the NPDB, Congress intended to improve the quality of health care by encouraging state licensing boards, hospitals, and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior and to restrict the ability of incompetent health care practitioners who attempt to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. The NPDB is a central repository of information about: (1) malpractice payments made for the benefit of health care practitioners; (2) licensure actions taken by state licensing boards; (3) professional review actions taken against licensees by hospitals and other health care entities, including health maintenance organizations, group practices, and professional societies; (4) actions taken by the Drug Enforcement Administration (DEA), and (5) Medicare/Medicaid Exclusions.

4. Industry Standards and California Study Findings

Private standard setting is also common in peer review. Organizations like the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or JCAHO), which accredits hospitals, health care providers and other health care settings across the country have established peer review standards for the entities it accredits. In order to receive Joint Commission accreditation, hospitals must have peer review and other quality assurance measures. Eligibility for federal funds such as Medicare and Medicaid often depends on accreditation.

A 2008 California study on peer review found variation and inconsistency in entity peer review policies and standards, including on the definition, procedures, commencement, practice and subject of peer review. Peer review means different activities to different entities, and can be triggered by a number of ways but is mostly part of the quality/safety/risk process of an entity. In addition, risk management/peer review issues are combined with mundane issues related to the "business" of an entity. All medical entities set their own standards for peer review, some more rigorous than others, and some adhere to them more meticulously than others. Additionally, each entity creates its own peer review policies, which can vary substantially. If a licensee is found to have provided substandard care, that physician may leave or be forced to leave the entity but can practice elsewhere, potentially endangering other patients. The peer review process is often lengthy and can take months or even years. There are also variations on the name of the peer review body, the number of members and the length of time a member serves on a committee (usually could be years before a peer review action is taken).

The study also identified poor tracking of peer review events and highlighted confusion on 805 reporting. According to the study, few cases lead to actual 805 reporting because of (a) disagreement or legal interpretation on whether 809 due process is required before every 805 report is submitted, and, (b) 809 due process leads to a substantial delay in the process (often 2 to 5 years). In addition, although entities make a sincere effort to conduct peer review, it rarely

leads to actual 805 or 809 actions, perhaps due to the confusion over when to file a report. The study found that in addition, entities have devised other methods to correct a physician behavior before filing an 805 report. The most common cases referred to a high level peer review are: disruptive licensee behavior/impairment, substandard technical skills, substance abuse, and failure to document/record patient treatment. It is also possible that some licensees would never be subject to peer review because they have practices that are not subject to any peer review requirements. The study also demonstrated a lack of coordination among state agencies and licensing agencies, noting that there is no systematic communication or coordination among various boards and agencies that would coordinate patient quality and safety issues. There is much complexity on the complaint process, enforcement process, and public disclosure rules.

In 2009, the California Supreme Court issued an opinion relating to peer review in *Mileikowsky v. West Hills Hospital Medical Center* in which the Court discussed the importance of the peer review process and pointed out the following: “The primary purpose of the peer review process is to protect the health and welfare of the people of California by excluding through the peer review mechanism those healing arts practitioners who provide substandard care or who engage in professional misconduct. This purpose also serves the interest of California’s acute care facilities by providing a means of removing incompetent physicians from a hospital’s staff to reduce exposure to possible malpractice liability. Another purpose, if not equally important, is to protect competent practitioners from being barred from practice for arbitrary or discriminatory reasons.”

5. Purpose of This Hearing

This hearing is intended to further examine how health practitioner discipline is handled, as well as provide Committee members information about current requirements to report and how actions taken by health facility administration and medical staff are provided to licensing boards.

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AMENDED IN SENATE APRIL 30, 2019

AMENDED IN SENATE APRIL 11, 2019

SENATE BILL

No. 425

Introduced by Senator Hill

February 21, 2019

An act to amend Sections 800, 2221, and 2234 of, and to add Section 805.8 to, the Business and Profession Code, relating to healing arts.

legislative counsel's digest

SB 425, as amended, Hill. Health care practitioners: licensee's file: probationary physician's and surgeon's certificate: unprofessional conduct.

Existing law requires the Medical Board of California and specified other boards responsible for the licensure, regulation, and discipline of health care practitioners to separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board, including prescribed historical information for each licensee. Existing law makes the contents of any central file that are not public records confidential, except that the licensee or their counsel or a representative are authorized to inspect and have copies made of the licensee's complete file other than the disclosure of the identity of an information source. Existing law authorizes a board to protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material.

This bill would delete the specification that the summary be comprehensive.

Existing law establishes a peer review process for certain healing arts licentiates, as defined, and requires the chief of staff of a medical or

professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic to report specified information, including the denial or revocation of staff privileges, as defined, for a medical disciplinary cause or reason, within 15 days of the denial or revocation to the relevant state licensing agency. Existing law makes a violation of this reporting requirement punishable by a civil fine.

This bill would require any health facility or ~~clinic, administrator or chief executive officer of a health care service plan,~~ *clinic* or other entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients to report any allegation of sexual abuse or sexual misconduct made against a healing arts licensee to the relevant state licensing agency within 15 days of receiving the allegation and would require the relevant agency to investigate the circumstances underlying a received report. The bill would also require an employee or healing arts licensee that works in a health facility or ~~clinic, health care service plan,~~ *clinic* or other entity with knowledge of any allegation of sexual abuse or sexual misconduct by a healing arts licensee to report to the relevant state agency having jurisdiction over the healing arts licensee and the administration of the health facility or ~~clinic, health care service plan,~~ *clinic* or other entity within 15 days of knowing about the allegation of sexual abuse or sexual misconduct. The bill would make a willful failure to file the report by a health facility or ~~clinic, health care service plan,~~ *clinic* or other entity punishable by a civil fine not to exceed \$100,000 per violation and any other failure to make that report punishable by a civil fine not to exceed \$50,000 per violation, as specified. The bill would also prohibit a person, including an employee or individual contracted or subcontracted to provide health care services, a health facility or ~~clinic, a health care service plan,~~ *clinic* or other entity from incurring civil or criminal liability as a result of making a ~~report.~~ *report if made in good faith.*

The Medical Practice Act establishes the Medical Board of California for the licensure, regulation, and discipline of physicians and surgeons.

The act authorizes the board to deny a physician's and surgeon's certificate to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of their license. The act authorizes the board in its sole discretion to issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions.

This bill would require the board to disclose a probationary physician's and surgeon's certificate and the operative statement of issues to an inquiring member of the public and to post the certificate and statement on the board's internet website for 10 years from issuance.

The act requires the board to take action against any licensee who is charged with unprofessional conduct and provides that unprofessional conduct includes the repeated failure by a certificate holder who is the subject of an investigation by the board, in the absence of good cause, to attend and participate in an interview by the board.

This bill would delete the condition that the failure to attend and participate in an interview by the board be repeated. The bill would also delete an obsolete provision.

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

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

1 SECTION 1. Section 800 of the Business and Professions Code
2 is amended to read:

3 800. (a) The Medical Board of California, the Podiatric
4 Medical Board of California, the Board of Psychology, the Dental
5 Board of California, the Dental Hygiene Board of California, the
6 Osteopathic Medical Board of California, the State Board of
7 Chiropractic Examiners, the Board of Registered Nursing, the
8 Board of Vocational Nursing and Psychiatric Technicians of the
9 State of California, the State Board of Optometry, the Veterinary
10 Medical Board, the Board of Behavioral Sciences, the Physical
11 Therapy Board of California, the California State Board of
12 Pharmacy, the Speech-Language Pathology and Audiology and
13 Hearing Aid Dispensers Board, the California Board of
14 Occupational Therapy, the Acupuncture Board, and the Physician
15 Assistant Board shall each separately create and maintain a central
16 file of the names of all persons who hold a license, certificate, or
17 similar authority from that board. Each central file shall be created
18 and maintained to provide an individual historical record for each
19 licensee with respect to the following information:

20 (1) Any conviction of a crime in this or any other state that
21 constitutes unprofessional conduct pursuant to the reporting
22 requirements of Section 803.

1 (2) Any judgment or settlement requiring the licensee or the
2 licensee's insurer to pay any amount of damages in excess of three
3 thousand dollars (\$3,000) for any claim that injury or death was
4 proximately caused by the licensee's negligence, error or omission
5 in practice, or by rendering unauthorized professional services,
6 pursuant to the reporting requirements of Section 801 or 802.

7 (3) Any public complaints for which provision is made pursuant
8 to subdivision (b).

9 (4) Disciplinary information reported pursuant to Section 805,
10 including any additional exculpatory or explanatory statements
11 submitted by the licensee pursuant to subdivision (f) of Section
12 805. If a court finds, in a final judgment, that the peer review
13 resulting in the 805 report was conducted in bad faith and the
14 licensee who is the subject of the report notifies the board of that
15 finding, the board shall include that finding in the central file. For
16 purposes of this paragraph, "peer review" has the same meaning
17 as defined in Section 805.

18 (5) Information reported pursuant to Section 805.01, including
19 any explanatory or exculpatory information submitted by the
20 licensee pursuant to subdivision (b) of that section.

21 (b) (1) Each board shall prescribe and promulgate forms on
22 which members of the public and other licensees or certificate
23 holders may file written complaints to the board alleging any act
24 of misconduct in, or connected with, the performance of
25 professional services by the licensee.

26 (2) If a board, or division thereof, a committee, or a panel has
27 failed to act upon a complaint or report within five years, or has
28 found that the complaint or report is without merit, the central file
29 shall be purged of information relating to the complaint or report.

30 (3) Notwithstanding this subdivision, the Board of Psychology,
31 the Board of Behavioral Sciences, and the Respiratory Care Board
32 of California shall maintain complaints or reports as long as each
33 board deems necessary.

34 (c) (1) The contents of any central file that are not public
35 records under any other provision of law shall be confidential
36 except that the licensee involved, or the licensee's counsel or
37 representative, may inspect and have copies made of the licensee's
38 complete file except for the provision that may disclose the identity
39 of an information source. For the purposes of this section, a board
40 may protect an information source by providing a copy of the

1 material with only those deletions necessary to protect the identity
2 of the source or by providing a summary of the substance of the
3 material. Whichever method is used, the board shall ensure that
4 full disclosure is made to the subject of any personal information
5 that could reasonably in any way reflect or convey anything
6 detrimental, disparaging, or threatening to a licensee’s reputation,
7 rights, benefits, privileges, or qualifications, or be used by a board
8 to make a determination that would affect a licensee’s rights,
9 benefits, privileges, or qualifications. The information required to
10 be disclosed pursuant to Section 803.1 shall not be considered
11 among the contents of a central file for the purposes of this
12 subdivision.

13 (2) The licensee may, but is not required to, submit any
14 additional exculpatory or explanatory statement or other
15 information that the board shall include in the central file.

16 (3) Each board may permit any law enforcement or regulatory
17 agency when required for an investigation of unlawful activity or
18 for licensing, certification, or regulatory purposes to inspect and
19 have copies made of that licensee’s file, unless the disclosure is
20 otherwise prohibited by law.

21 (4) These disclosures shall effect no change in the confidential
22 status of these records.

23 SEC. 2. Section 805.8 is added to the Business and Professions
24 Code, to read:

25 805.8. (a) As used in this section, the following terms shall
26 have the following meanings:

27 (1) “Agency” means the relevant state licensing agency with
28 regulatory jurisdiction over a healing arts licensee listed in
29 paragraph ~~(3)~~. (2).

30 ~~(2) “Health care service plan” means a health care service plan~~
31 ~~licensed under Chapter 2.2 (commencing with Section 1340) of~~
32 ~~Division 2 of the Health and Safety Code.~~

33 ~~(3)~~

34 (2) “Healing arts licensee” or “licensee” means a licensee
35 licensed under Division 2 (commencing with Section 500) or any
36 initiative act referred to in that division. “Healing arts licensee”
37 or “licensee” also includes a person authorized to practice medicine
38 pursuant to Sections 2064.5, 2113, and 2168.

39 ~~(4)~~

1 (3) “Other entity” includes, but is not limited to, a postsecondary
2 educational institution as defined in Section 66261.5 of the
3 Education Code.

4 (b) A health facility or ~~clinic, the administrator or chief~~
5 ~~executive officer of a health care service plan, clinic~~ or other entity
6 that makes any arrangement under which a healing arts licensee
7 is allowed to practice or provide care for patients shall file a report
8 of any allegation of sexual abuse or sexual misconduct made
9 against a healing arts licensee to the agency within 15 days of
10 receiving the allegation of sexual abuse or sexual misconduct. An
11 arrangement under which a licensee is allowed to practice or
12 provide care for patients includes, but is not limited to, full staff
13 privileges, active staff privileges, limited staff privileges, auxiliary
14 staff privileges, provisional staff privileges, temporary staff
15 privileges, courtesy staff privileges, locum tenens arrangements,
16 and contractual arrangements to provide professional services,
17 including, but not limited to, arrangements to provide outpatient
18 services.

19 (c) An employee or a healing arts licensee that works in any
20 health facility or ~~clinic, health care service plan, clinic~~ or other
21 entity that subdivision (b) applies to who has knowledge of any
22 allegation of sexual abuse or sexual misconduct by a healing arts
23 licensee shall file a report with the agency that has regulatory
24 jurisdiction over the healing arts licensee and the administration
25 of the health facility or ~~clinic, health care service plan, clinic~~ or
26 other entity within 15 days of knowing about the allegation of
27 sexual abuse or sexual misconduct.

28 (d) A willful failure to file the report described in subdivision
29 (b) shall be punishable by a fine not to exceed one hundred
30 thousand dollars (\$100,000) per violation. The fine may be imposed
31 in any civil or administrative action or proceeding brought by or
32 on behalf of any agency having regulatory jurisdiction over the
33 licensee regarding whom the report was or should have been filed.
34 If the person who is designated or otherwise required to file the
35 report under this section is a licensed physician and surgeon, the
36 action or proceeding shall be brought by the Medical Board of
37 California. If the person who is designated or otherwise required
38 to file the report required under this section is a licensed doctor of
39 podiatric medicine, the action or proceeding shall be brought by
40 the Podiatric Medical Board of California. The fine shall be paid

1 to that agency, but not expended until appropriated by the
2 Legislature. A violation of this subdivision may constitute
3 unprofessional conduct by the licensee. A person who is alleged
4 to have violated this subdivision may assert any defense available
5 at law. As used in this subdivision, “willful” means a voluntary
6 and intentional violation of a known legal duty.

7 (e) Except as provided in subdivision (d), any failure to file the
8 report described in subdivision (b) shall be punishable by a fine
9 not to exceed fifty thousand dollars (\$50,000) per violation. The
10 fine may be imposed in any civil or administrative action or
11 proceeding brought by or on behalf of any agency having
12 regulatory jurisdiction over the person regarding whom the report
13 was or should have been filed. If the person who is designated or
14 otherwise required to file the report required under this section is
15 a licensed physician and surgeon, the action or proceeding shall
16 be brought by the Medical Board of California. If the person who
17 is designated or otherwise required to file the report required under
18 this section is a licensed doctor of podiatric medicine, the action
19 or proceeding shall be brought by the Podiatric Medical Board of
20 California. The fine shall be paid to that agency, but not expended
21 until appropriated by the Legislature. The amount of the fine
22 imposed, not exceeding fifty thousand dollars (\$50,000) per
23 violation, shall be proportional to the severity of the failure to
24 report and shall differ based upon written findings, including
25 whether the failure to file caused harm to a patient or created a
26 risk to patient safety; whether any person who is designated or
27 otherwise required by law to file the report required under this
28 section exercised due diligence despite the failure to file or whether
29 the person knew or should have known that a report required under
30 this section would not be filed; and whether there has been a prior
31 failure to file a report required under this section. The amount of
32 the fine imposed may also differ based on whether a health care
33 facility or clinic is a small or rural hospital as defined in Section
34 124840 of the Health and Safety Code.

35 (f) A person, including an employee or individual contracted
36 or subcontracted to provide health care services, a health facility
37 or clinic, ~~a health care service plan~~, or other entity shall not incur
38 any civil or criminal liability as a result of making a report required
39 by this ~~section~~. *section if made in good faith.*

1 (g) The agency shall investigate the circumstances underlying
2 a report received pursuant to this section.

3 SEC. 3. Section 2221 of the Business and Professions Code is
4 amended to read:

5 2221. (a) The board may deny a physician's and surgeon's
6 certificate to an applicant guilty of unprofessional conduct or of
7 any cause that would subject a licensee to revocation or suspension
8 of their license. The board, in its sole discretion, may issue a
9 probationary physician's and surgeon's certificate to an applicant
10 subject to terms and conditions, including, but not limited to, any
11 of the following conditions of probation:

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

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

17 (3) Continuing medical or psychiatric treatment.

18 (4) Ongoing participation in a specified rehabilitation program.

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

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

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

24 (8) Compliance with all provisions of this chapter.

25 (9) Payment of the cost of probation monitoring.

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

33 (c) The board shall deny a physician's and surgeon's certificate
34 to an applicant who is required to register pursuant to Section 290
35 of the Penal Code. This subdivision does not apply to an applicant
36 who is required to register as a sex offender pursuant to Section
37 290 of the Penal Code solely because of a misdemeanor conviction
38 under Section 314 of the Penal Code.

39 (d) An applicant shall not be eligible to reapply for a physician's
40 and surgeon's certificate for a minimum of three years from the

1 effective date of the denial of their application, except that the
2 board, in its discretion and for good cause demonstrated, may
3 permit reapplication after not less than one year has elapsed from
4 the effective date of the denial.

5 (e) The board shall disclose a probationary physician's and
6 surgeon's certificate issued pursuant to this section and the
7 operative statement of issues to an inquiring member of the public
8 and shall post the certificate and statement on the board's internet
9 website for 10 years from issuance.

10 SEC. 4. Section 2234 of the Business and Professions Code is
11 amended to read:

12 2234. The board shall take action against any licensee who is
13 charged with unprofessional conduct. In addition to other
14 provisions of this article, unprofessional conduct includes, but is
15 not limited to, the following:

16 (a) Violating or attempting to violate, directly or indirectly,
17 assisting in or abetting the violation of, or conspiring to violate
18 any provision of this chapter.

19 (b) Gross negligence.

20 (c) Repeated negligent acts. To be repeated, there must be two
21 or more negligent acts or omissions. An initial negligent act or
22 omission followed by a separate and distinct departure from the
23 applicable standard of care shall constitute repeated negligent acts.

24 (1) An initial negligent diagnosis followed by an act or omission
25 medically appropriate for that negligent diagnosis of the patient
26 shall constitute a single negligent act.

27 (2) When the standard of care requires a change in the diagnosis,
28 act, or omission that constitutes the negligent act described in
29 paragraph (1), including, but not limited to, a reevaluation of the
30 diagnosis or a change in treatment, and the licensee's conduct
31 departs from the applicable standard of care, each departure
32 constitutes a separate and distinct breach of the standard of care.

33 (d) Incompetence.

34 (e) The commission of any act involving dishonesty or
35 corruption that is substantially related to the qualifications,
36 functions, or duties of a physician and surgeon.

37 (f) Any action or conduct that would have warranted the denial
38 of a certificate.

39 (g) The failure by a certificate holder, in the absence of good
40 cause, to attend and participate in an interview by the board. This

- 1 subdivision shall only apply to a certificate holder who is the
- 2 subject of an investigation by the board.

O



CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 8

VERSION: AMENDED MARCH 19, 2019

AUTHOR: CHU

**SPONSOR: MENTAL HEALTH AMERICA
OF CALIFORNIA**

RECOMMENDED POSITION: NONE

SUBJECT: PUPIL HEALTH: MENTAL HEALTH PROFESSIONALS

Summary:

This bill would require schools to employ at least one mental health professional for every 400 pupils.

Existing Law:

- 1) Specifies minimum requirements for a services credential with a specialization in pupil personnel services are a bachelor's degree or higher, a fifth year of study, and any specialized professional preparation required by the Commission on Teacher Credentialing. (Education Code (EC) §44266)
- 2) Specifies that a services credential with a specialization in pupil personnel services authorizes that holder to perform the pupil personnel service designated on the credential, which may include, but not be limited to, school counseling, school psychology, child welfare and attendance services, and school social work. (EC §44266)
- 3) Specifies the various types of services credentials with a specialization in pupil personnel services (See **Attachment A**). Permits school districts to utilize other types of service providers, including state licensees, to assist in providing pupil personnel services if they are supervised by an individual with a pupil personnel services authorization. (California Code of Regulations (CCR) Title 5, §80049.1)

This Bill:

- 1) By December 31, 2022 requires schools (including charter schools) to have at least one mental health professional for every 400 pupils generally accessible to pupils on campus during school hours. (EC §49429.5(a))
- 2) Requires schools with less than 400 pupils do at least one of the following (EC §49429.5(a)):

- a) Have at least one mental health professional generally accessible to pupils on campus during school hours; or
 - b) Employ at least one mental health professional to provide services at multiple schools; or
 - c) Enter into an agreement with a county or community-based organization for at least one mental health professional to provide services at the school.
- 3) Outlines the role of the required mental health professional in the school, which includes providing individual and small group counseling. (EC §49429.5(b))
- 4) Requires a school mental health professional who does not hold a services credential with a specialization in either pupil personnel services or in health (for a school nurse) to be under the supervision of an individual with a service credential specialization in pupil personnel services or administrative services in order to work with pupils. (EC §49429.5(c))
- 5) Defines a “mental health professional” as including the following (EC §49429.5(g)(2)):
- a) An individual who holds a services credential with a specialization in pupil personnel services that authorizes the person to perform school counseling, school psychology, or school social work.
 - b) An individual who holds a services credential with a specialization in health for a school nurse.
 - c) A professional licensed in California to provide mental health services, including, but not limited to, psychologists, marriage and family therapists, and clinical counselors.
 - d) A marriage and family therapist intern or trainee.
 - e) A clinical counselor intern or trainee.
- 6) Permits schools to hire community mental health workers, cultural brokers, or peer providers to supplement the services of mental health providers, if they are supervised by someone with a services credential specializing in either pupil personnel services or administrative services. (EC §49429.5(d))

Comment:

- 1) **Author’s Intent.** According to the author, “We need to do more to provide mental health support for youth; the sooner the better. Schools provide the ideal place to reach all students, especially those who currently face barriers to access. The idea for this bill came from dynamic young people engaged on this very issue and they have advocated for schools to support their mental wellness. By placing mental

health professionals on campus, this bill will break down stigma while providing timely services for our children and young adults.”

The author also notes that he will be requesting funds through the budget process so that schools can implement the bill.

- 2) **Debate over Appropriate License/Credential.** This bill requires a mental health professional working in a school who does not hold a services credential with a specialization in pupil personnel services or a services credential in health (if a school nurse) to be supervised by an individual with a services credential in pupil personnel services or administrative services. This appears to already be a requirement, per 5 CCR §80049.1(c) (See **Attachment A**).

One group opposing the bill, the California Teachers Association (CTA), believes that only individuals holding a pupil personnel services credential should count toward the ratio. They note that these personnel are trained specifically to deal with children, as opposed to other mental health licensees trained to work in clinical, but not school, settings.

- 3) **Inclusion of Clinical Social Workers.** This bill does not include licensed clinical social workers, associate social workers, or social work interns in the definition of “mental health professionals.” The definition does not necessarily limit clinical social workers from this definition, but they are not listed specifically, while LMFTs, LPCCs, and their corresponding associates and trainees are.
- 4) **Reference to Marriage and Family Therapist and Professional Clinical Counselor “Interns”.** This bill refers to LMFT and LPCC registrants as “interns,” which is an outdated reference. The “intern” references should be changed to “associate” references.
- 5) **Related Legislation.** The Board is also considering SB 660 (Pan) today. SB 660 would require California Community Colleges and the California State University system to hire one full-time equivalent mental health counselor per 1,500 students enrolled at each of their campuses.

6) **Support and Opposition.**

Support

- Alliance for Children’s Rights
- American Federation of State, County and Municipal Employees, AFL-CIO
- Association of California Healthcare Districts, and Affiliated Entity Alpha Fund
- Brain XP
- Calexico Unified School District
- California Association for Health, Physical Education, Recreation & Dance
- California Association of Marriage and Family Therapists
- California Coalition for Mental Health

- California State PTA
- Desert Sands Unified School District
- Disability Rights California
- Heber Elementary School District
- Mental Health Association in California
- NAMI Amador
- Nextgen California
- Parents and Caregivers for Wellness
- Self
- Steinberg Institute
- The California Association of Local Behavioral Health Boards and Commissions
- United Parents
- University of Southern California

Opposition

- California Right to Life Committee, Inc.
- California School Boards Association
- California Teachers Association

7) **History.**

2019

- 04/24/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 1.) (April 23). Re-referred to Com. on APPR.
- 04/02/19 In committee: Set, first hearing. Hearing canceled at the request of author.
- 03/20/19 Re-referred to Com. on HEALTH.
- 03/19/19 Read second time and amended.
- 03/18/19 From committee: Amend, and do pass as amended and re-refer to Com. on HEALTH. (Ayes 5. Noes 0.) (March 13).
- 03/05/19 Re-referred to Com. on ED.
- 03/04/19 From committee chair, with author's amendments: Amend, and re-refer to Com. on ED. Read second time and amended.
- 01/17/19 Referred to Coms. on ED. and HEALTH.
- 12/04/18 From printer. May be heard in committee January 3.
- 12/03/18 Read first time. To print.

8) **Attachments.**

Attachment A: California Code of Regulations (CCR) Title 5, §80049.1: Types of Services Credentials with a specialization in Pupil Personnel Services

Attachment B: Strauss, Valerie (February 15, 2018) "If Americans really cared about students' mental health, these school ratios would be very different" *The Washington Post*.

ATTACHMENT A

§ 80049.1. Authorization for Service.

5 CA ADC § 80049.1

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations [Currentness](#)

Title 5. Education

Division 8. Commission on Teacher Credentialing

Chapter 1. Credentials Issued Under the Teacher Preparation and Licensing Law of 1970

Article 2. Credential Types, Authorizations, and Requirements

5 CCR § 80049.1

§ 80049.1. Authorization for Service.

(a) A Services Credential with a specialization in Pupil Personnel Services authorizes the holder to perform pupil personnel services in the specialization(s) named, as described below, in grades 12 and below, including preschool, and in programs organized primarily for adults:

(1) The Pupil Personnel Services: School Counseling Credential authorizes the holder to develop, plan, implement and evaluate a school counseling and guidance program that includes academic, career, personal and social development; advocate for the higher academic achievement and social development of all students; provide school-wide prevention and intervention strategies and counseling services; provide consultation, training and staff development to teachers and parents regarding students' needs; and supervise a district-approved advisory program as described in Education Code Section 49600.

(2) The Pupil Personnel Services: School Social Work Credential authorizes the holder to assess home, school, personal and community factors that may affect a student's learning; identify and provide intervention strategies for children and their families including counseling, case management, and crisis intervention; consult with teachers, administrators and other school staff regarding social and emotional needs of students; and coordinate family, school and community resources on behalf of students.

(3) The Pupil Personnel Services: School Psychology Credential authorizes the holder to provide services that enhance academic performance; design strategies and programs to address problems of adjustment; consult with other educators and parents on issues of social development, behavioral and academic difficulties; conduct psycho-educational assessments for purposes of identifying special needs; provide psychological counseling for individuals, groups and families; and coordinate intervention strategies for management of individual and school-wide crises.

(4) The Pupil Personnel Services: Child Welfare and Attendance Credential authorizes the holder to access appropriate services from both public and private providers, including law enforcement and social services; provide staff development to school personnel regarding state and federal laws pertaining to due process and child welfare and attendance laws; address school policies and procedures that inhibit academic success; implement strategies to improve student attendance; participate in school-wide reform efforts; and promote understanding and appreciation of those factors that affect the attendance of culturally-diverse student populations.

(b) An individual holding any of the authorizations described in this section may serve as an administrator of a pupil personnel services program per Education Code Section 44270.2.

(c) Nothing in this section shall be construed to preclude school districts from utilizing community-based service providers, including volunteers, individuals completing counseling-related internship programs, and state licensed individuals and agencies to assist in providing pupil personnel services, provided that such individuals and agencies are supervised in their school-based activities by an individual holding a pupil personnel services authorization.

Note: Authority cited: Sections 44225 and 44266, Education Code. Reference: Sections 44252 and 44266, Education Code.

HISTORY

1. New section filed 10-27-99; operative 11-26-99 (Register 99, No. 44).

This database is current through 4/5/19 Register 2019, No. 14

5 CCR § 80049.1, 5 CA ADC § 80049.1

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Answer Sheet Analysis

If Americans really cared about students' mental health, these school ratios would be very different

By Valerie Strauss

Grief counselors are always made available to help students when there is a traumatic event at a school, such as this week, when a gunman entered a Florida high school and fired a military-style assault weapon, killing 17 people. While health experts say counseling after a tragedy is vital, too many schools don't have anywhere near enough health professionals to help students before the catastrophes.

Consider:

In U.S. public schools today, it's estimated there is one school psychologist for every 1,381 students. The National Association of School Psychologists recommends one psychologist for every 500 to 700 students (which itself makes very busy work days for psychologists).

Let's turn to school counselors.

According to the latest available information from the American School Counselor Association, there was one counselor for every 482 students in 2014-2015. It's nearly twice what the association recommends: one counselor for every 250 students (which makes for very busy days for school counselors.)

And then there are school-based nurses. The National Association of School Nurses and the National Association of State School Nurse Consultants recommend that every student have direct access to a school nurse, though some states have recommended there be one school nurse for every 750 students in the healthy student population (which makes for a busy day for school nurses).

Yet a 2017 survey by the National Association of School Nurses found that only 39 percent of private and public schools in the United States have full-time nurses. In North Carolina, for example, a new legislative study found that the state would need to spend up to \$79 million a year in additional money to meet the 1 to 750 nurse-student ratio in public schools.

School-based psychologists, counselors and nurses do related but different things for students, but they are all professionals who are supposed to be part of the human scaffolding constructed around students to help them do their best in school.

According to the Association for Children's Mental Health, addressing mental health needs in schools is vital because "1 in 5 children and youth have a diagnosable emotional, behavioral or mental health disorder, and 1 in 10 young people have a mental health challenge that is severe enough to impair how they function at home,

school or in the community.” And it says that many estimates show that among kids aged 6 to 17, “at least one-half and many estimate as many as 80 percent” don’t receive the mental health care they require.

“It’s a huge issue,” said Amanda Nickerson, director of the Alberti Center for Bullying Abuse Prevention at the University at Buffalo Graduate School of Education, who is attending the annual convention in Chicago of the National Association of School Psychologists. “We do not have enough mental health professionals to meet the increasingly complex needs of the students that are walking through the door.”

Nickerson said the inevitable calls for immediate action after a shooting often miss the point.

“We are getting better providing, unfortunately in some ways, the crisis intervention, but that’s after something terrible happens,” she said. “As we look toward solutions after something like this happens, people automatically go to highly expensive hardware sorts of solutions. Why don’t we have metal detectors? Where are the cameras? Where are the guards?”

“I’m not saying those things aren’t important,” she said. “But to create a safe and secure environment, we have to address psychological safety and connectedness and how we are resolving conflicts that doesn’t involve more conflict. That is critically important, and our school-based mental health experts are trained to do that. But there aren’t enough people and not enough hours in the day currently with the way our staffing is.”

Though research and common sense say that schools should be properly staffed with health professionals, that has not been the focus of modern school reformers, who have focused not on the health of students but on testing metrics.

That was true in Democratic and Republican presidential administrations, including the current one. President Trump’s statement about the shooting in South Florida, which left 17 people dead, said in part:

Our administration is working closely with local authorities to investigate the shooting and learn everything we can. We are committed to working with state and local leaders to help secure our schools, and tackle the difficult issue of mental health.

Yet on Monday, his administration released a 2019 budget proposal that mental health professionals said does not show a commitment to tackling the many issues affecting mental health.


The National Association of School Psychologists, for example, expressed “deep concern” with specific proposed items, including gutting significant programs in the federal K-12 law. The American Psychological Association said while the budget includes additional resources to address the nation’s opioid epidemic, improve veterans’ health care and fund scientific research, it “would decimate critical education, justice and behavioral health workforce programs if enacted.”

There is something else missing in the United States that affects the mental health of students, as explained in this [Washington Post story](#) about mass shootings at U.S. schools compared with other countries:

There's also another crucial difference with the United States: extensive, mandatory health insurance, which allows schools to have direct and immediate access to psychologists and intervention teams.

If schools are calling in grief counselors, it's already too late to avoid disaster. And if Americans really cared about having the personnel in schools to address mental health needs, then schools would be adequately staffed with the professionals who students need to be healthy and do their best.

Valerie Strauss

Valerie Strauss is an education writer who authors The Answer Sheet blog. She came to The Washington Post as an assistant foreign editor for Asia in 1987 and weekend foreign desk editor after working for Reuters as national security editor and a military/foreign affairs reporter on Capitol Hill. She also previously worked at UPI and the LA Times. [Follow](#) 



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AMENDED IN ASSEMBLY MARCH 19, 2019
AMENDED IN ASSEMBLY MARCH 4, 2019
california legislature—2019–20 regular session

ASSEMBLY BILL

No. 8

**Introduced by Assembly Members Chu and Eduardo Garcia
(Coauthors: Assembly Members Carrillo, Cristina Garcia, and
Blanca Rubio)**

(Coauthors: Senators Beall, Portantino, and Wilk)

December 3, 2018

An act to add Section 49429.5 to the Education Code, relating to pupil health.

legislative counsel's digest

AB 8, as amended, Chu. Pupil health: mental health professionals.

Existing law requires the governing board of ~~any~~ a school district to give diligent care to the health and physical development of pupils and authorizes the governing board of a school district to employ properly certified persons for the work. Existing law requires a school of a school district or county office of education and a charter school to notify pupils and parents or guardians of pupils no less than twice during the school year on how to initiate access to available pupil mental health services on campus or in the community, or both, as provided. Existing law requires, subject to sufficient funds being provided, the State Department of Education, in consultation with the State Department of Health Care Services and appropriate stakeholders, to, on or before July 1, 2020, develop guidelines for the use of telehealth technology in public schools, including charter schools, to provide mental health and behavioral health services to pupils on school campuses.

This bill would require, on or before December 31, 2022, a school of a school district or county office of education and a charter school to have at least one mental health professional, as defined, for every 400 pupils generally accessible to pupils on campus during school hours. The bill would require, on or before December 31, 2022, a school of a school district or county office of education and a charter school with fewer than 400 pupils to have at least one mental health professional generally accessible to pupils on campus during school hours, to employ at least one mental health professional to serve multiple schools, or to enter into a memorandum of understanding with a county agency or community-based organization for at least one mental health professional employed by the agency or organization to provide services to pupils. The bill would ~~require~~ encourage a school subject to the bill's provisions with pupils who are eligible to receive Medi-Cal benefits to seek reimbursement for costs of implementing the bill's provisions through the Local Educational Agency Medi-Cal Billing Option and the School-Based Medi-Cal Administrative Activities program, as specified. By imposing additional requirements on local educational agencies, the bill would impose a state-mandated local program.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) In 2014, an estimated 22.5 million Americans 12 years of
- 4 age or older reported needing treatment for a substance use
- 5 disorder, and 11.8 million adults reported needing mental health
- 6 treatment.
- 7 (b) Mental health disorders and substance use disorders share
- 8 some underlying causes, including changes in brain composition,
- 9 genetic vulnerabilities, and early exposure to stress or trauma.

1 (c) Fifty-seven percent of Californian children have experienced
2 trauma.

3 (d) Research shows that people with mental health issues are at
4 a higher risk of a substance use disorder.

5 (e) Early intervention and prevention of mental health and
6 substance use disorders are critical to Californians' behavioral and
7 physical health.

8 (f) Three hundred thousand Californian children 4 to 11 years
9 of age, inclusive, have mental health needs, but over 70 percent
10 never receive treatment.

11 (g) For youth in poverty or with non-English-speaking parents,
12 over 80 percent never receive treatment for their mental health
13 needs.

14 (h) Both mental health issues and substance use disorders in
15 pupils can lead to absenteeism, suspensions, and dropping out of
16 school at an early age.

17 (i) Schools have been identified as the optimal place to provide
18 mental health services and improve access to mental health services
19 for pupils, especially pupils of color and pupils in historically
20 underserved communities.

21 (j) Reflecting on incidents of violence on school campuses,
22 national educator and school professional organizations recommend
23 in published best practices for creating safe and successful schools
24 improving access to school-based mental health supports by
25 ensuring adequate staffing levels of school-employed mental health
26 professionals.

27 (k) The State of California ranks last or near last in the country
28 for pupil access to mental health care at school. Currently,
29 California has one school nurse for every 2,240 pupils, ranking
30 39th in the country, and one school counselor for every 792 pupils,
31 ranking last in the country. Additionally, the state has only one
32 school psychologist for every 1,265 pupils and one school social
33 worker for every 12,870 pupils.

34 SEC. 2. Section 49429.5 is added to the Education Code, to
35 read:

36 49429.5. (a) On or before December 31, 2022, a school of a
37 school district or county office of education and a charter school
38 shall have at least one mental health professional for every 400
39 pupils generally accessible to pupils on campus during school
40 hours. On or before December 31, 2022, a school of a school

1 district or county office of education and a charter school with
2 fewer than 400 pupils shall do one of the following:

3 (1) Have at least one mental health professional generally
4 accessible to pupils on campus during school hours.

5 (2) Employ at least one mental health professional to provide
6 services to pupils at multiple schools.

7 (3) Enter into a memorandum of understanding with a county
8 agency or community-based organization for at least one mental
9 health professional employed by the agency or organization to
10 provide services to pupils.

11 (b) The role of a mental health professional required pursuant
12 to this section shall include, but is not limited to, all of the
13 following:

14 (1) Providing individual and small group counseling supports
15 to individual pupils ~~as well as~~ and pupil groups to address
16 social-emotional and mental health concerns.

17 (2) Facilitating collaboration and coordination between school
18 and community providers to support pupils and their families by
19 assisting families in identifying and accessing additional mental
20 health services within the community as needed.

21 (3) Promoting school climate and culture through
22 evidence-informed strategies and programs by collaborating with
23 school staff to develop best practices for behavioral health
24 management and classroom climate.

25 (4) Providing professional development to staff in diverse areas,
26 including, but not limited to, behavior management strategies,
27 mental health support training, trauma-informed practices, and
28 professional self-care.

29 (c) A mental health professional required pursuant to this section
30 who does not hold a services credential with a specialization in
31 pupil personnel services as described in Section 44266 or a services
32 credential with a specialization in health for a school nurse as
33 described in Section 44267.5 shall work with pupils only under
34 the supervision of an individual who holds a services credential
35 with a specialization in pupil personnel services as described in
36 Section 44266 or a services credential with a specialization in
37 administrative services as described in Section 44270.2.

38 (d) A school of a school district or county office of education
39 and a charter school may employ community mental health
40 workers, cultural brokers, or peer providers to supplement the

1 services provided by mental health professionals if they have a
2 current certificate of clearance from the Commission on Teacher
3 Credentialing and are supervised in their school-based activities
4 by an individual who holds a services credential with a
5 specialization in pupil personnel services as described in Section
6 44266 or a services credential with a specialization in
7 administrative services as described in Section 44270.2.

8 (e) A school of a school district or county office of education
9 and a charter school with pupils who are eligible to receive
10 Medi-Cal benefits ~~shall~~ *is encouraged to* do both of the following:

11 (1) Seek reimbursement, to the extent applicable, through the
12 Local Educational Agency Medi-Cal Billing Option for services
13 provided pursuant to this section.

14 (2) Seek reimbursement, to the extent applicable, through the
15 School-Based Medi-Cal Administrative Activities program for
16 administrative costs related to providing services pursuant to this
17 section.

18 (f) (1) This section does not alter the scope of practice for any
19 mental health professional in a manner that is not authorized
20 pursuant to existing law.

21 (2) This section does not authorize the delivery of mental health
22 services in a setting or in a manner that is not authorized pursuant
23 to existing law.

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

26 (1) “Community mental health worker” or “cultural broker”
27 means a frontline public health worker with behavioral health
28 training who works for pay or as a volunteer in association with
29 the local health care systems and usually shares ethnicity, language,
30 socioeconomic status, or life experiences with the pupils served.
31 A community mental health worker sometimes offers interpretation
32 and translation services and culturally appropriate health education
33 and information, assists pupils and family members in receiving
34 the care they need, and gives, to the extent permitted by law,
35 informal counseling and guidance.

36 (2) “Mental health professional” includes any of the following:

37 (A) An individual who holds a services credential with a
38 specialization in pupil personnel services as described in Section
39 44266 that authorizes the individual to perform school counseling,
40 school psychology, or school social work.

1 (B) An individual who holds a services credential with a
2 specialization in health for a school nurse as described in Section
3 44267.5.

4 (C) A professional licensed by the State of California to provide
5 mental health services, including, but not limited to, psychologists,
6 marriage and family therapists, and clinical counselors.

7 (D) A marriage and family therapist intern as described in
8 subdivision (b) of Section 4980.03 of the Business and Professions
9 Code.

10 (E) A marriage and family therapist trainee as described in
11 subdivision (c) of Section 4980.03 of the Business and Professions
12 Code.

13 (F) A clinical counselor intern as described in subdivision (f)
14 of Section 4999.12 of the Business and Professions Code.

15 (G) A clinical counselor trainee as described in subdivision (g)
16 of Section 4999.12 of the Business and Professions Code.

17 (3) “Peer provider” means a person who draws on lived
18 experience with mental illness or a substance use disorder and
19 recovery, bolstered by specialized training, to deliver valuable
20 support services in a mental health setting. Peer providers may
21 include people who have lived experience as clients, family
22 members, or caretakers of individuals living with mental illness.
23 Peer providers offer culturally competent services that promote
24 engagement, socialization, recovery, self-sufficiency,
25 self-advocacy, development of natural supports, identification of
26 strengths, and maintenance of skills learned in other support
27 services. Services provided by peer providers include, but are not
28 limited to, support, coaching, facilitation, or education that is
29 individualized to the pupil.

30 SEC. 3. If the Commission on State Mandates determines that
31 this act contains costs mandated by the state, reimbursement to
32 local agencies and school districts for those costs shall be made
33 pursuant to Part 7 (commencing with Section 17500) of Division
34 4 of Title 2 of the Government Code.

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CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 544 **VERSION: AMENDED MARCH 21, 2019**

AUTHOR: BROUGH **SPONSOR: AUTHOR**

RECOMMENDED POSITION: NONE

SUBJECT: PROFESSIONS AND VOCATIONS: INACTIVE LICENSE FEES AND ACCRUED AND UNPAID RENEWAL FEES

Summary:

This bill would prohibit boards under the Department of Consumer Affairs (DCA) from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration. It would also limit the maximum renewal fee for an inactive licensed to no more than 50 percent of the renewal fee for an active license.

Existing Law:

- 1) Specifies that the fee to renew an LMFT, LEP, LCSW, or LPCC license on inactive status shall be one-half of the standard renewal fee. (Business and Professions Code (BPC) §§4984.8, 4989.44, 4997, and 4999.112)
- 2) Specifies a process by which a Board of Behavioral Sciences (Board) licensee may renew an expired license within three years after its expiration date, which includes paying renewal fees, paying delinquency fees, certifying compliance with continuing education requirements, and notifying the Board of any convictions. (BPC §§4984, 4984.1, 4989.32, 4989.36, 4989.68, 4996.6, and 4999.104)

This Bill:

- 1) Prohibits boards under DCA, including this Board, from requiring a person to pay accrued and unpaid renewal fees as a condition of reinstating an expired license or registration. (BPC §121.5, 4989.36, and 4999.104)
- 2) Prohibits the fee to renew a license in an inactive status from being more than 50 percent of the active renewal fee. (BPC §§462, 703)

Comment:

1) Author's Intent. The author's office states the following:

"For someone who might have decided to let his/her license lapse for a period of time in order to focus on raising children, dealing with personal or family illness, etc., it does not seem fair to require them to pay several years of accrued renewal fees to reinstate the license and start working again."

2) Current Practice. The Board's inactive renewal fees are already one-half of the active renewal fees.

The Board does currently charge accrued unpaid renewal fees in order to renew any license that is within three years of its expiration date. (Licensees that have been expired more than three years must reapply for licensure.) The Board does not charge accrued unpaid renewal fees to renew a registration.

3) Number of Delinquent Licensees Renewing. For each of the past 4 years, the Board has seen fewer than 50 cases per year of licensees owing back renewal fees for its four license types combined. Therefore, any fiscal impact of this bill is estimated to be minor and absorbable.

4) Amendment Needed: BPC §4989.68. BPC §4989.68(a)(4), which is part of LEP licensing statute, states the following:

"The delinquency fee shall be a maximum amount of seventy-five dollars (\$75). A person who permits his or her license to become delinquent may have it restored only upon payment of all the fees that he or she would have paid if the license had not become delinquent, plus the payment of any and all delinquency fees."

This section is not being amended in this bill. If the bill moves forward, this section needs to be amended to be consistent with section 4989.36.

Staff has relayed this concern to the author's office, and they have indicated they are working to address the issue.

5) Amendment Needed: BPC §4999.104. The bill strikes section 4999.104(b), which states that to renew an expired license the licensee must "Pay all fees that would have been paid if the license had not become delinquent." Striking this sentence is consistent with the intent of the bill to not charge back fees, however, unlike the Board's other three license types, there is no specification in this section that the renewing licensee still has to pay the current renewal fee. This needs to be specified.

Staff has also relayed this concern to the author's office, and they have indicated they are working to address the issue.

6) Support and Opposition.

Support:

- Unknown at this time.

Opposition:

- Department of Consumer Affairs, Speech-Language Pathology and audiology and Hearing Aid Dispensers Board

7) History.

2019

- 04/24/19 From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 19. Noes 0.) (April 23).
Re-referred to Com. on APPR.
- 03/25/19 Re-referred to Com. on B. & P.
- 03/21/19 From committee chair, with author's amendments: Amend, and re-refer to Com. on B. & P. Read second time and amended.
- 03/21/19 Referred to Com. on B. & P.
- 02/14/19 From printer. May be heard in committee March 16.
- 02/13/19 Read first time. To print.

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ASSEMBLY BILL

No. 544

Introduced by Assembly Member Brough

February 13, 2019

~~An act to amend Section 4073 of the Business and Professions Code, relating to healing arts.~~ *An act to amend Sections 121.5, 462, 703, 1006.5, 1718, 1718.3, 1936, 2427, 2456.3, 2535.2, 2538.54, 2646, 2734, 2892.1, 2984, 3147, 3147.7, 3524, 3774, 3775.5, 4545, 4843.5, 4901, 4966, 4989.36, 4999.104, 5070.6, 5600.2, 5680.1, 6796, 6980.28, 7076.5, 7417, 7672.8, 7725.2, 7729.1, 7881, 7883, 8024.7, 8802, 9832, 9832.5, 9884.5, 19170.5, and 19290 of the Business and Professions Code, relating to professions and vocations.*

legislative counsel's digest

AB 544, as amended, Brough. ~~Prescriptions.~~ *Professions and vocations: inactive license fees and accrued and unpaid renewal fees.*

Existing law provides for the licensure and regulation of professions and vocations by various boards within the Department of Consumer Affairs. Existing law provides for the payment of a fee for the renewal of certain licenses, certificates, or permits in an inactive status, and, for certain licenses, certificates, and permits that have expired, requires the payment of all accrued fees as a condition of reinstatement of the license, certificate, or permit.

This bill would limit the maximum fee for the renewal of a license in an inactive status to no more than 50% of the renewal fee for an active license. The bill would also prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.

~~The Pharmacy Law provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy, which is within the Department of Consumer Affairs, and authorizes a pharmacist filling a prescription order for a drug product prescribed by its brand or trade name to select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name of those drug products having the same active chemical ingredients, as specified.~~

~~This bill would make a nonsubstantive change to that provision.~~

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

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

1 SECTION 1. Section 121.5 of the Business and Professions
 2 Code is amended to read:

3 121.5. (a) Except as otherwise provided in this code, the
 4 application of delinquency fees ~~or accrued and unpaid renewal~~
 5 ~~fees~~ for the renewal of expired licenses or registrations shall not
 6 apply to licenses or registrations that have lawfully been designated
 7 as inactive or retired.

8 (b) *Notwithstanding any other law, a board shall not require a*
 9 *person to pay accrued and unpaid renewal fees as a condition of*
 10 *reinstating an expired license or registration.*

11 SEC. 2. Section 462 of the Business and Professions Code is
 12 amended to read:

13 462. (a) Any of the boards, bureaus, commissions, or programs
 14 within the department may establish, by regulation, a system for
 15 an inactive category of licensure for persons who are not actively
 16 engaged in the practice of their profession or vocation.

17 (b) The regulation shall contain the following provisions:

18 (1) The holder of an inactive license issued pursuant to this
 19 section shall not engage in any activity for which a license is
 20 required.

21 (2) An inactive license issued pursuant to this section shall be
 22 renewed during the same time period in which an active license
 23 is renewed. The holder of an inactive license need not comply with
 24 any continuing education requirement for renewal of an active
 25 license.

1 (3) The renewal fee for a license in ~~an active status shall apply~~
2 ~~also for a renewal of a license in an inactive status, unless a lesser~~
3 ~~renewal fee is specified by the board.~~ *status shall be no more than*
4 *50 percent of the renewal fee for a license in an active status.*

5 (4) In order for the holder of an inactive license issued pursuant
6 to this section to restore ~~his or her~~ *the* license to an active status,
7 the holder of an inactive license shall comply with all the
8 following:

9 (A) Pay the renewal fee.

10 (B) If the board requires completion of continuing education
11 for renewal of an active license, complete continuing education
12 equivalent to that required for renewal of an active license, unless
13 a different requirement is specified by the board.

14 (c) This section shall not apply to any healing arts board as
15 specified in Section 701.

16 *SEC. 3. Section 703 of the Business and Professions Code is*
17 *amended to read:*

18 703. (a) An inactive healing arts license or certificate issued
19 pursuant to this article shall be renewed during the same time
20 period at which an active license or certificate is renewed. In order
21 to renew a license or certificate issued pursuant to this article, the
22 holder thereof need not comply with any continuing education
23 requirement for renewal of an active license or certificate.

24 (b) ~~The~~ *Notwithstanding any other law, the* renewal fee for a
25 license or certificate in an ~~active~~ *inactive* status shall ~~apply also~~
26 ~~for renewal of a license or certificate in an inactive status, unless~~
27 ~~a lower fee has been established by the issuing board.~~ *be no more*
28 *than 50 percent of the renewal fee for a license in an active status.*

29 *SEC. 4. Section 1006.5 of the Business and Professions Code*
30 *is amended to read:*

31 1006.5. Notwithstanding any other law, the amount of
32 regulatory fees necessary to carry out the responsibilities required
33 by the Chiropractic Initiative Act and this chapter are fixed in the
34 following schedule:

35 (a) Fee to apply for a license to practice chiropractic: three
36 hundred seventy-one dollars (\$371).

37 (b) Fee for initial license to practice chiropractic: one hundred
38 eighty-six dollars (\$186).

39 (c) Fee to renew an ~~active or inactive~~ license to practice
40 chiropractic: three hundred thirteen dollars (\$313).

- 1 (d) Fee to renew an inactive license to practice chiropractic:
- 2 no more than 50 percent of the renewal fee for an active license.
- 3 ~~(d)~~
- 4 (e) Fee to apply for approval as a continuing education provider:
- 5 eighty-four dollars (\$84).
- 6 ~~(e)~~
- 7 (f) Biennial continuing education provider renewal fee: fifty-six
- 8 dollars (\$56).
- 9 ~~(f)~~
- 10 (g) Fee to apply for approval of a continuing education course:
- 11 fifty-six dollars (\$56) per course.
- 12 ~~(g)~~
- 13 (h) Fee to apply for a satellite office certificate: sixty-two dollars
- 14 (\$62).
- 15 ~~(h)~~
- 16 (i) Fee to renew a satellite office certificate: thirty-one dollars
- 17 (\$31).
- 18 ~~(i)~~
- 19 (j) Fee to apply for a license to practice chiropractic pursuant
- 20 to Section 9 of the Chiropractic Initiative Act: three hundred
- 21 seventy-one dollars (\$371).
- 22 ~~(j)~~
- 23 (k) Fee to apply for a certificate of registration of a chiropractic
- 24 corporation: one hundred eighty-six dollars (\$186).
- 25 ~~(k)~~
- 26 (l) Fee to renew a certificate of registration of a chiropractic
- 27 corporation: thirty-one dollars (\$31).
- 28 ~~(l)~~
- 29 (m) Fee to file a chiropractic corporation special report:
- 30 thirty-one dollars (\$31).
- 31 ~~(m)~~
- 32 (n) Fee to apply for approval as a referral service: five hundred
- 33 fifty-seven dollars (\$557).
- 34 ~~(n)~~
- 35 (o) Fee for an endorsed verification of licensure: one hundred
- 36 twenty-four dollars (\$124).
- 37 ~~(o)~~
- 38 (p) Fee for replacement of a lost or destroyed license: fifty
- 39 dollars (\$50).
- 40 ~~(p)~~

1 (q) Fee for replacement of a satellite office certificate: fifty
2 dollars (\$50).

3 ~~(q)~~

4 (r) Fee for replacement of a certificate of registration of a
5 chiropractic corporation: fifty dollars (\$50).

6 ~~(r)~~

7 (s) Fee to restore a forfeited or canceled license to practice
8 chiropractic: double the annual renewal fee specified in subdivision
9 (c).

10 ~~(s)~~

11 (t) Fee to apply for approval to serve as a preceptor: thirty-one
12 dollars (\$31).

13 ~~(t)~~

14 (u) Fee to petition for reinstatement of a revoked license: three
15 hundred seventy-one dollars (\$371).

16 ~~(u)~~

17 (v) Fee to petition for early termination of probation: three
18 hundred seventy-one dollars (\$371).

19 ~~(v)~~

20 (w) Fee to petition for reduction of penalty: three hundred
21 seventy-one dollars (\$371).

22 *SEC. 5. Section 1718 of the Business and Professions Code is*
23 *amended to read:*

24 1718. Except as otherwise provided in this chapter, an expired
25 license may be renewed at any time within five years after its
26 expiration on filing of application for renewal on a form prescribed
27 by the board, and payment of ~~all accrued~~ *the* renewal and
28 delinquency fees. If the license is renewed more than 30 days after
29 its expiration, the licensee, as a condition precedent to renewal,
30 shall also pay the delinquency fee prescribed by this chapter.
31 Renewal under this section shall be effective on the date on which
32 the application is filed, on the date on which the renewal fee is
33 paid, or on the date on which the delinquency fee, if any, is paid,
34 whichever last occurs. If so renewed, the license shall continue in
35 effect through the expiration date provided in Section 1715 which
36 next occurs after the effective date of the renewal, when it shall
37 expire if it is not again renewed.

38 *SEC. 6. Section 1718.3 of the Business and Professions Code*
39 *is amended to read:*

1 1718.3. (a) A license which is not renewed within five years
 2 after its expiration may not be renewed, restored, reinstated, or
 3 reissued thereafter, but the holder of the license may apply for and
 4 obtain a new license if the following requirements are satisfied:

5 (1) No fact, circumstance, or condition exists which would
 6 justify denial of licensure under Section 480.

7 (2) ~~He or she~~ *The person* pays all of the fees which would be
 8 required of ~~him or her if he or she~~ *if the person were then* applying
 9 for the license for the first time and ~~all the~~ renewal and delinquency
 10 fees which have accrued since the date on which ~~he or she last~~
 11 ~~renewed his or her license.~~ *fees.*

12 (3) ~~He or she~~ *The person* takes and passes the examination, if
 13 any, which would be required of ~~him or her if he or she~~ *if the*
 14 *person were then* applying for the license for the first time, or
 15 otherwise establishes to the satisfaction of the board that with due
 16 regard for the public interest, ~~he or she~~ *the person* is qualified to
 17 practice the profession or activity in which ~~he or she again~~ *the*
 18 *person* seeks to be licensed.

19 (b) The board may impose conditions on any license issued
 20 pursuant to this section, as it deems necessary.

21 (c) The board may by regulation provide for the waiver or refund
 22 of all or any part of the examination fee in those cases in which a
 23 license is issued without an examination under this section.

24 *SEC. 7. Section 1936 of the Business and Professions Code is*
 25 *amended to read:*

26 1936. Except as otherwise provided in this article, an expired
 27 license may be renewed at any time within five years after its
 28 expiration by filing an application for renewal on a form prescribed
 29 by the hygiene board and payment of ~~all accrued~~ *the* renewal and
 30 delinquency fees. If the license is renewed after its expiration, the
 31 licensee, as a condition precedent of renewal, shall also pay the
 32 delinquency fee prescribed by this article. Renewal under this
 33 section shall be effective on the date on which the application is
 34 filed, on the date on which the renewal fee is paid, or on the date
 35 on which the delinquency fee, if any, is paid, whichever last occurs.
 36 If so renewed, the license shall continue in effect until the
 37 expiration date provided in Section 1935 that next occurs after the
 38 effective date of the renewal.

39 *SEC. 8. Section 2427 of the Business and Professions Code is*
 40 *amended to read:*

1 2427. (a) Except as provided in Section 2429, a license which
2 has expired may be renewed at any time within five years after its
3 expiration on filing an application for renewal on a form prescribed
4 by the licensing authority and payment of ~~all accrued~~ *the* renewal
5 ~~fees~~ *fee* and any other fees required by Section 2424. If the license
6 is not renewed within 30 days after its expiration, the licensee, as
7 a condition precedent to renewal, shall also pay the prescribed
8 delinquency fee, if any. Except as provided in Section 2424,
9 renewal under this section shall be effective on the date on which
10 the renewal application is filed, on the date on which the renewal
11 ~~fee or accrued renewal fees are~~ *is* paid, or on the date on which
12 the delinquency fee or the delinquency fee and penalty fee, if any,
13 are paid, whichever last occurs. If so renewed, the license shall
14 continue in effect through the expiration date set forth in Section
15 2422 or 2423 which next occurs after the effective date of the
16 renewal, when it shall expire and become invalid if it is not again
17 renewed.

18 (b) Notwithstanding subdivision (a), the license of a doctor of
19 podiatric medicine which has expired may be renewed at any time
20 within three years after its expiration on filing an application for
21 renewal on a form prescribed by the licensing authority and
22 payment of ~~all accrued~~ *the* renewal ~~fees~~ *fee* and any other fees
23 required by Section 2424. If the license is not renewed within 30
24 days after its expiration, the licensee, as a condition precedent to
25 renewal, shall also pay the prescribed delinquency fee, if any.
26 Except as provided in Section 2424, renewal under this section
27 shall be effective on the date on which the renewal application is
28 filed, on the date on which the renewal ~~fee or accrued renewal fees~~
29 ~~are~~ *is* paid, or on the date on which the delinquency fee or the
30 delinquency fee and penalty fee, if any, are paid, whichever last
31 occurs. If so renewed, the license shall continue in effect through
32 the expiration date set forth in Section 2422 or 2423 which next
33 occurs after the effective date of the renewal, when it shall expire
34 and become invalid if it is not again renewed.

35 *SEC. 9. Section 2456.3 of the Business and Professions Code*
36 *is amended to read:*

37 2456.3. Except as provided in Section 2429, a license which
38 has expired may be renewed at any time within five years after its
39 expiration by filing an application for renewal on a form prescribed
40 by the board and payment of ~~all accrued~~ *the* renewal ~~fees~~ *fee* and

1 any other fees required by Section 2455. Except as provided in
2 Section 2456.2, renewal under this section shall be effective on
3 the date on which the renewal application is filed, on the date on
4 which the renewal fee ~~or accrued renewal fees are~~ *is* paid, or on
5 the date on which the delinquency fee or the delinquency fee and
6 penalty fee, if any, are paid, whichever last occurs. If so renewed,
7 the license shall continue in effect through the expiration date set
8 forth in Section 2456.1 which next occurs after the effective date
9 of the renewal.

10 *SEC. 10. Section 2535.2 of the Business and Professions Code*
11 *is amended to read:*

12 2535.2. Except as provided in Section 2535.3, a license that
13 has expired may be renewed at any time within five years after its
14 expiration upon filing of an application for renewal on a form
15 prescribed by the board and payment of ~~all accrued and unpaid~~
16 ~~renewal fees.~~ *the renewal fee.* If the license is not renewed on or
17 before its expiration, the licensee, as a condition precedent to
18 renewal, shall also pay the prescribed delinquency fee. Renewal
19 under this section shall be effective on the date on which the
20 application is filed, on the date on which ~~all the renewal fees are~~
21 *fee is* paid, or on the date on which the delinquency fee is paid,
22 whichever last occurs. If so renewed, the license shall continue in
23 effect through the expiration date provided in Section 2535, after
24 the effective date of the renewal, when it shall expire and become
25 invalid if it is not again renewed.

26 *SEC. 11. Section 2538.54 of the Business and Professions Code*
27 *is amended to read:*

28 2538.54. Except as otherwise provided in this article, an expired
29 license may be renewed at any time within three years after its
30 expiration on filing of an application for renewal on a form
31 prescribed by the board, and payment of ~~all accrued and unpaid~~
32 ~~renewal fees.~~ *the renewal fee.* If the license is renewed after its
33 expiration the licensee, as a condition precedent to renewal, shall
34 also pay the delinquency fee prescribed by this article. Renewal
35 under this section shall be effective on the date on which the
36 application is filed, on the date on which the renewal fee is paid,
37 or on the date on which the delinquency fee, if any, is paid,
38 whichever last occurs. If so renewed, the license shall continue in
39 effect through the date provided in Section 2538.53 which next

1 occurs after the effective date of the renewal, when it shall expire
2 if it is not again renewed.

3 *SEC. 12. Section 2646 of the Business and Professions Code*
4 *is amended to read:*

5 2646. A license that has expired may be renewed at any time
6 within five years after its expiration by applying for renewal as
7 set forth in Section 2644. Renewal under this section shall be
8 effective on the date on which the renewal application is filed, on
9 the date on which the renewal fee ~~or accrued renewal fees are~~ *is*
10 paid, or on the date on which the delinquency fee and penalty fee,
11 if any, are paid, whichever last occurs. A renewed license shall
12 continue in effect through the expiration date set forth in Section
13 2644 that next occurs after the effective date of the renewal, at
14 which time it shall expire and become invalid if it is not so
15 renewed.

16 *SEC. 13. Section 2734 of the Business and Professions Code*
17 *is amended to read:*

18 2734. Upon application in writing to the board and payment
19 of ~~the~~ *a fee not to exceed 50 percent of the* biennial renewal fee,
20 a licensee may have ~~his~~ *their* license placed in an inactive status
21 for an indefinite period of time. A licensee whose license is in an
22 inactive status may not practice nursing. However, such a licensee
23 does not have to comply with the continuing education standards
24 of Section 2811.5.

25 *SEC. 14. Section 2892.1 of the Business and Professions Code*
26 *is amended to read:*

27 2892.1. Except as provided in Sections 2892.3 and 2892.5, an
28 expired license may be renewed at any time within four years after
29 its expiration upon filing of an application for renewal on a form
30 prescribed by the board, payment of ~~all accrued and unpaid renewal~~
31 ~~fees,~~ *the renewal fee,* and payment of any fees due pursuant to
32 Section 2895.1.

33 If the license is renewed more than 30 days after its expiration,
34 the licensee, as a condition precedent to renewal, shall also pay
35 the delinquency fee prescribed by this chapter. Renewal under this
36 section shall be effective on the date on which the application is
37 filed, on the date on which ~~all the renewal fees are~~ *fee is* paid, or
38 on the date on which the delinquency fee is paid, whichever last
39 occurs. If so renewed, the license shall continue in effect through
40 the date provided in Section 2892 which next occurs after the

1 effective date of the renewal, when it shall expire if it is not again
2 renewed.

3 *SEC. 15. Section 2984 of the Business and Professions Code*
4 *is amended to read:*

5 2984. Except as provided in Section 2985, a license that has
6 expired may be renewed at any time within three years after its
7 expiration on filing of an application for renewal on a form
8 prescribed by the board and payment of ~~all accrued and unpaid~~
9 ~~the renewal fees.~~ *fee.* If the license is renewed after its expiration,
10 the licensee, as a condition precedent to renewal, shall also pay
11 the prescribed delinquency fee, if any. Renewal under this section
12 shall be effective on the date on which the application is filed, on
13 the date on which ~~all the renewal fees are~~ *fee is* paid, or on the date
14 on which the delinquency fee, if any, is paid, whichever last occurs.
15 If so renewed, the license shall continue in effect through the
16 expiration date provided in Section 2982 which next occurs after
17 the effective date of the renewal, when it shall expire and become
18 invalid if it is not again renewed.

19 *SEC. 16. Section 3147 of the Business and Professions Code*
20 *is amended to read:*

21 3147. (a) Except as otherwise provided by Section 114, an
22 expired optometrist license may be renewed at any time within
23 three years after its expiration, and a retired license issued for less
24 than three years may be reactivated to active status, by filing an
25 application for renewal or reactivation on a form prescribed by the
26 board, paying ~~all accrued and unpaid the renewal fees~~ *fee* or
27 ~~reactivation fees~~ *fee* determined by the board, paying any
28 delinquency fees prescribed by the board, and submitting proof of
29 completion of the required number of hours of continuing education
30 for the last two years, as prescribed by the board pursuant to
31 Section 3059. Renewal or reactivation to active status under this
32 section shall be effective on the date on which all of those
33 requirements are satisfied. If so renewed or reactivated to active
34 status, the license shall continue as provided in Sections 3146 and
35 3147.5.

36 (b) Expired statements of licensure, branch office licenses, and
37 fictitious name permits issued pursuant to Sections 3070, 3077,
38 and 3078, respectively, may be renewed at any time by filing an
39 application for renewal, paying ~~all accrued and unpaid renewal~~

1 ~~fees, the renewal fee~~, and paying any delinquency fees prescribed
2 by the board.

3 *SEC. 17. Section 3147.7 of the Business and Professions Code*
4 *is amended to read:*

5 3147.7. The provisions of Section 3147.6 shall not apply to a
6 person holding a license that has not been renewed within three
7 years of expiration, if the person provides satisfactory proof that
8 ~~he or she~~ *the person* holds an active license from another state and
9 meets all of the following conditions:

- 10 (a) Is not subject to denial of a license under Section 480.
- 11 (b) Applies in writing for restoration of the license on a form
12 prescribed by the board.
- 13 (c) Pays ~~all accrued and unpaid~~ *the renewal fee* and any
14 delinquency fees prescribed by the board.
- 15 (d) Submits proof of completion of the required number of hours
16 of continuing education for the last two years.
- 17 (e) Takes and satisfactorily passes the board's jurisprudence
18 examination.

19 *SEC. 18. Section 3524 of the Business and Professions Code*
20 *is amended to read:*

21 3524. A license or approval that has expired may be renewed
22 at any time within five years after its expiration by filing an
23 application for renewal on a form prescribed by the board or
24 Medical Board of California, as the case may be, and payment of
25 ~~all accrued and unpaid renewal fees.~~ *the renewal fee*. If the license
26 or approval is not renewed within 30 days after its expiration, the
27 licensed physician assistant and approved supervising physician,
28 as a condition precedent to renewal, shall also pay the prescribed
29 delinquency fee, if any. Renewal under this section shall be
30 effective on the date on which the application is filed, on the date
31 on which ~~all the renewal fees are~~ *fee is* paid, or on the date on
32 which the delinquency fee, if any, is paid, whichever occurs last.
33 If so renewed, the license shall continue in effect through the
34 expiration date provided in Section 3522 or 3523 which next occurs
35 after the effective date of the renewal, when it shall expire, if it is
36 not again renewed.

37 *SEC. 19. Section 3774 of the Business and Professions Code*
38 *is amended to read:*

39 3774. On or before the birthday of a licensed practitioner in
40 every other year, following the initial licensure, the board shall

1 mail to each practitioner licensed under this chapter, at the latest
2 address furnished by the licensed practitioner to the executive
3 officer of the board, a notice stating the amount of the renewal fee
4 and the date on which it is due. The notice shall state that failure
5 to pay the renewal fee on or before the due date and submit
6 evidence of compliance with Sections 3719 and 3773 shall result
7 in expiration of the license.

8 Each license not renewed in accordance with this section shall
9 expire but may within a period of three years thereafter be
10 reinstated upon payment of ~~all accrued and unpaid~~ *the* renewal
11 ~~fees~~ and penalty fees required by this chapter. The board may also
12 require submission of proof of the applicant's qualifications, except
13 that during the three-year period no examination shall be required
14 as a condition for the reinstatement of any expired license that has
15 lapsed solely by reason of nonpayment of the renewal fee.

16 *SEC. 20. Section 3775.5 of the Business and Professions Code*
17 *is amended to read:*

18 3775.5. The fee for an inactive license shall be ~~the same as~~ *no*
19 *more than 50 percent of the renewal fee for an active license* for
20 the practice of respiratory care as specified in Section 3775.

21 *SEC. 21. Section 4545 of the Business and Professions Code*
22 *is amended to read:*

23 4545. Except as provided in Section 4545.2, a license that has
24 expired may be renewed at any time within four years after its
25 expiration on filing an application for renewal on a form prescribed
26 by the board, payment of ~~all accrued and unpaid renewal fees,~~ *the*
27 *renewal fee,* and payment of all fees required by this chapter. If
28 the license is renewed more than 30 days after its expiration, the
29 holder, as a condition precedent to renewal, shall also pay the
30 delinquency fee prescribed by this chapter. Renewal under this
31 section shall be effective on the date on which the application is
32 filed, on the date on which the renewal fee is paid, or on the date
33 on which the delinquency fee, if any, is paid, whichever last occurs.
34 If so renewed, the license shall continue in effect through the date
35 provided in Section 4544 which next occurs after the effective date
36 of the renewal, when it shall expire if it is not again renewed.

37 A certificate which was forfeited for failure to renew under the
38 law in effect before October 1, 1961, shall, for the purposes of this
39 article, be considered to have expired on the date that it became
40 forfeited.

1 *SEC. 22. Section 4843.5 of the Business and Professions Code*
2 *is amended to read:*

3 4843.5. Except as otherwise provided in this article, an expired
4 certificate of registration may be renewed at any time within five
5 years after its expiration on filing of an application for renewal on
6 a form prescribed by the board, and payment of ~~all accrued and~~
7 ~~unpaid renewal fees.~~ *the renewal fee.* If the certificate of
8 registration is renewed more than 30 days after its expiration, the
9 registrant, as a condition precedent to renewal, shall also pay the
10 delinquency fee prescribed by this article. Renewal under this
11 section shall be effective on the date on which the application is
12 filed, on the date ~~all the renewal fees are~~ *fee is* paid, or on the date
13 on which the delinquency fee, if any, is paid, whichever occurs
14 last.

15 *SEC. 23. Section 4901 of the Business and Professions Code*
16 *is amended to read:*

17 4901. Except as otherwise provided in this chapter, an expired
18 license or registration may be renewed at any time within five
19 years after its expiration on filing of an application for renewal on
20 a form prescribed by the board, and payment of ~~all accrued and~~
21 ~~unpaid renewal fees.~~ *the renewal fee.* If the license or registration
22 is renewed more than 30 days after its expiration, the licensee or
23 registrant, as a condition precedent to renewal, shall also pay the
24 delinquency fee prescribed by this chapter. Renewal under this
25 section shall be effective on the date on which the application is
26 filed, on the date on which ~~all renewal fees are~~ *the renewal fee is*
27 paid, or on the date on which the delinquency fee, if any, is paid,
28 whichever last occurs. If so renewed, the license or registration
29 shall continue in effect through the expiration date provided in
30 Section 4900 that next occurs after the effective date of the renewal,
31 when it shall expire if it is not again renewed.

32 *SEC. 24. Section 4966 of the Business and Professions Code*
33 *is amended to read:*

34 4966. Except as provided in Section 4969, a license that has
35 expired may be renewed at any time within three years after its
36 expiration by filing of an application for renewal on a form
37 provided by the board, paying ~~all accrued and unpaid renewal fees,~~
38 *the renewal fee,* and providing proof of completing continuing
39 education requirements. If the license is not renewed prior to its
40 expiration, the acupuncturist, as a condition precedent to renewal,

1 shall also pay the prescribed delinquency fee. Renewal under this
 2 section shall be effective on the date on which the application is
 3 filed, on the date on which the renewal fee is paid, or on the date
 4 the delinquency fee is paid, whichever occurs last. If so renewed,
 5 the license shall continue in effect through the expiration date
 6 provided in Section 4965, after the effective date of the renewal,
 7 when it shall expire and become invalid if it is not again renewed.

8 *SEC. 25. Section 4989.36 of the Business and Professions Code*
 9 *is amended to read:*

10 4989.36. A licensee may renew a license that has expired at
 11 any time within three years after its expiration date by taking all
 12 of the actions described in Section 4989.32 and by paying ~~all~~
 13 ~~unpaid prior renewal fees and delinquency fees.~~ *the delinquency*
 14 *fee.*

15 *SEC. 26. Section 4999.104 of the Business and Professions*
 16 *Code is amended to read:*

17 4999.104. Licenses issued under this chapter that have expired
 18 may be renewed at any time within three years of expiration. To
 19 renew an expired license described in this section, the licensee
 20 shall do all of the following:

21 (a) File an application for renewal on a form prescribed by the
 22 board.

23 ~~(b) Pay all fees that would have been paid if the license had not~~
 24 ~~become delinquent.~~

25 ~~(c)~~

26 (b) Pay ~~all the delinquency fees.~~ *fee.*

27 ~~(d)~~

28 (c) Certify compliance with the continuing education
 29 requirements set forth in Section 4999.76.

30 ~~(e)~~

31 (d) Notify the board whether ~~he or she~~ *the licensee* has been
 32 convicted, as defined in Section 490, of a misdemeanor or felony,
 33 or whether any disciplinary action has been taken by any regulatory
 34 or licensing board in this or any other state, subsequent to the
 35 licensee's last renewal.

36 *SEC. 27. Section 5070.6 of the Business and Professions Code*
 37 *is amended to read:*

38 5070.6. Except as otherwise provided in this chapter, an expired
 39 permit may be renewed at any time within five years after its
 40 expiration upon the filing of an application for renewal on a form

1 prescribed by the board, payment of ~~all accrued and unpaid renewal~~
2 ~~fees~~ *the renewal fee*, and providing evidence satisfactory to the
3 board of compliance as required by Section 5070.5. If the permit
4 is renewed after its expiration, its holder, as a condition precedent
5 to renewal, shall also pay the delinquency fee prescribed by this
6 chapter. Renewal under this section shall be effective on the date
7 on which the application is filed, on the date on which the ~~accrued~~
8 ~~renewal fees are~~ *fee is* paid, or on the date on which the
9 delinquency fee, if any, is paid, whichever last occurs. If so
10 renewed, the permit shall continue in effect through the date
11 provided in Section 5070.5 that next occurs after the effective date
12 of the renewal, when it shall expire if it is not again renewed.

13 *SEC. 28. Section 5600.2 of the Business and Professions Code*
14 *is amended to read:*

15 5600.2. Except as otherwise provided in this chapter, a license
16 which has expired may be renewed at any time within five years
17 after its expiration on filing of application for renewal on a form
18 prescribed by the board, and payment of ~~all accrued and unpaid~~
19 ~~renewal fees.~~ *the renewal fee*. If a license is renewed more than
20 30 days after its expiration, the licenseholder, as a condition
21 precedent to renewal, shall also pay the delinquency fee prescribed
22 by this chapter. Renewal under this section shall be effective on
23 the date on which the application is filed, on the date on which the
24 renewal fee is paid, or on the date on which the delinquency fee,
25 if any, is paid, whichever last occurs. If so renewed, the license
26 shall continue in effect through the expiration date provided in this
27 chapter which next occurs after the effective date of the renewal,
28 when it shall expire if it is not again renewed.

29 *SEC. 29. Section 5680.1 of the Business and Professions Code*
30 *is amended to read:*

31 5680.1. Except as otherwise provided in this chapter, a license
32 that has expired may be renewed at any time within five years after
33 its expiration on filing of an application for renewal on a form
34 prescribed by the board, and payment of ~~all accrued and unpaid~~
35 ~~renewal fees.~~ *the renewal fee*. If the license is renewed more than
36 30 days after its expiration, the licenseholder, as a condition
37 precedent to renewal, shall also pay the delinquency fee prescribed
38 by this chapter. Renewal under this section shall be effective on
39 the date on which the application is filed, on the date on which ~~all~~
40 ~~the renewal fees are~~ *fee is* paid, or on the date on which the

1 delinquency fee, if any, is paid, whichever last occurs. If so
 2 renewed, the license shall continue in effect through the date
 3 provided in Section 5680 that next occurs after the effective date
 4 of the renewal, when it shall expire if it is not again renewed.

5 *SEC. 30. Section 6796 of the Business and Professions Code*
 6 *is amended to read:*

7 6796. Except as otherwise provided in this article, certificates
 8 of registration as a professional engineer and certificates of
 9 authority may be renewed at any time within five years after
 10 expiration on filing of application for renewal on a form prescribed
 11 by the board and payment of ~~all accrued and unpaid renewal fees.~~
 12 *the renewal fee.* If the certificate is renewed more than 60 days
 13 after its expiration, the certificate holder, as a condition precedent
 14 to renewal, shall also pay the delinquency fee prescribed by this
 15 chapter. Renewal under this section shall be effective on the date
 16 on which the application is filed, on the date on which the renewal
 17 fee is paid, or on the date on which the delinquency fee, if any, is
 18 paid, whichever last occurs.

19 The expiration date of a certificate renewed pursuant to this
 20 section shall be determined pursuant to Section 6795.

21 *SEC. 31. Section 6980.28 of the Business and Professions Code*
 22 *is amended to read:*

23 6980.28. A locksmith license not renewed within three years
 24 following its expiration may not be renewed thereafter. Renewal
 25 of the license within three years, or issuance of an original license
 26 thereafter, shall be subject to payment of any ~~and all fines~~ *fine*
 27 assessed by the chief or the director ~~which are~~ *that is* not pending
 28 appeal and all other applicable fees.

29 *SEC. 32. Section 7076.5 of the Business and Professions Code*
 30 *is amended to read:*

31 7076.5. (a) A contractor may inactivate ~~his or her~~ *their* license
 32 by submitting a form prescribed by the registrar accompanied by
 33 the current active license certificate. When the current license
 34 certificate has been lost, the licensee shall pay the fee prescribed
 35 by law to replace the license certificate. Upon receipt of an
 36 acceptable application to inactivate, the registrar shall issue an
 37 inactive license certificate to the contractor. The holder of an
 38 inactive license shall not be entitled to practice as a contractor until
 39 ~~his or her~~ *their* license is reactivated.

1 (b) Any licensed contractor who is not engaged in work or
2 activities which require a contractor's license may apply for an
3 inactive license.

4 (c) Inactive licenses shall be valid for a period of four years
5 from their due date.

6 (d) During the period that an existing license is inactive, no
7 bonding requirement pursuant to Section 7071.6, 7071.8 or 7071.9
8 or qualifier requirement pursuant to Section 7068 shall apply. An
9 applicant for license having met the qualifications for issuance
10 may request that the license be issued inactive unless the applicant
11 is subject to the provisions of Section 7071.8.

12 (e) The board shall not refund any of the renewal fee which a
13 licensee may have paid prior to the inactivation of ~~his or her~~ *the*
14 license.

15 (f) An inactive license shall be renewed on each established
16 renewal date by submitting the renewal application and paying the
17 inactive renewal fee.

18 (g) An inactive license may be reactivated by submitting an
19 application acceptable to the registrar, by paying ~~the full~~ *a fee no*
20 *more than 50 percent of the* renewal fee for an active ~~license~~
21 *license*, and by fulfilling all other requirements of this chapter. No
22 examination shall be required to reactivate an inactive license.

23 (h) The inactive status of a license shall not bar any disciplinary
24 action by the board against a licensee for any of the causes stated
25 in this chapter.

26 *SEC. 33. Section 7417 of the Business and Professions Code*
27 *is amended to read:*

28 7417. Except as otherwise provided in this article, a license
29 that has expired for failure of the licensee to renew within the time
30 fixed by this article may be renewed at any time within five years
31 following its expiration upon application and payment of ~~all~~
32 ~~accrued and unpaid~~ *the* renewal ~~fees~~ and delinquency fees. If the
33 license is renewed after its expiration, the licensee, as a condition
34 precedent to renewal, shall also pay the delinquency fee and meet
35 current continuing education requirements, if applicable, prescribed
36 by this chapter. Renewal under this section shall be effective on
37 the date on which the application is filed, or on the date on which
38 ~~the accrued renewal fees are~~ *fee is* paid, or on the date on which
39 the delinquency fee, if any, is paid, whichever occurs last. If so
40 renewed, the license shall continue in effect through the expiration

1 date provided in this article which next occurs following the
2 effective date of the renewal, when it shall expire if it is not again
3 renewed.

4 *SEC. 34. Section 7672.8 of the Business and Professions Code*
5 *is amended to read:*

6 7672.8. All cremated remains disposer registrations shall expire
7 at midnight on September 30 of each year. A person desiring to
8 renew ~~his or her~~ *their* registration shall file an application for
9 renewal on a form prescribed by the bureau accompanied by the
10 required fee. A registration that has expired may be renewed within
11 five years of its expiration upon payment of ~~all accrued and unpaid~~
12 ~~renewal fees.~~ *the renewal fee.* The bureau shall not renew the
13 registration of any person who has not filed the required annual
14 report until ~~he or she~~ *the person* has filed a complete annual report
15 with the department.

16 *SEC. 35. Section 7725.2 of the Business and Professions Code*
17 *is amended to read:*

18 7725.2. Except as otherwise provided in this chapter, a license
19 that has expired may be renewed at any time within five years after
20 its expiration on filing of an application for renewal on a form
21 prescribed by the bureau and payment of ~~all accrued and unpaid~~
22 ~~renewal fees.~~ *the renewal fee.* If the license is not renewed within
23 30 days after its expiration the licensee, as a condition precedent
24 to renewal, shall also pay the delinquency fee prescribed by this
25 chapter. Renewal under this section shall be effective on the date
26 on which the application is filed, on the date on which ~~all the~~
27 ~~renewal fees are~~ *fee is* paid, or on the date on which the
28 delinquency fee, if any, is paid, whichever last occurs. If so
29 renewed, the license shall continue in effect through the date
30 provided in Section 7725 that next occurs after the effective date
31 of the renewal, when it shall expire if it is not again renewed.

32 If a license is not renewed within one year following its
33 expiration, the bureau may require as a condition of renewal that
34 the holder of the license pass an examination on the appropriate
35 subjects provided by this chapter.

36 *SEC. 36. Section 7729.1 of the Business and Professions Code*
37 *is amended to read:*

38 7729.1. The amount of fees prescribed for a license or
39 certificate of authority under this act is that fixed by the following
40 provisions of this article. Any license or certificate of authority

1 provided under this act that has expired may be renewed within
2 five years of its expiration upon payment of ~~all accrued and unpaid~~
3 ~~renewal and regulatory fees.~~ *the renewal fee.*

4 *SEC. 37. Section 7881 of the Business and Professions Code*
5 *is amended to read:*

6 7881. Except as otherwise provided in this article, certificates
7 of registration as a geologist or as a geophysicist, or certified
8 specialty certificates, may be renewed at any time within five years
9 after expiration on filing an application for renewal on a form
10 prescribed by the board and payment of ~~all accrued and unpaid~~
11 ~~renewal fees.~~ *the renewal fee.* If the certificate is renewed more
12 than 30 days after its expiration, the certificate holder, as a
13 condition precedent to renewal, shall also pay the delinquency fee
14 prescribed by this chapter. Renewal under this section shall be
15 effective on the date on which the application is filed, on the date
16 on which ~~all the renewal fees are~~ *fee is* paid, or on the date on
17 which the delinquency fee, if any, is paid, whichever last occurs.
18 If so renewed, the certificate shall continue in effect through the
19 date provided in Section 7880 that next occurs after the effective
20 date of the renewal, when it shall expire if it is not again renewed.

21 *SEC. 38. Section 7883 of the Business and Professions Code*
22 *is amended to read:*

23 7883. A revoked certificate is subject to expiration as provided
24 in this article, but it may not be renewed. If it is reinstated after its
25 expiration, the holder of the certificate, as a condition precedent
26 to its reinstatement, shall pay a reinstatement fee in an amount
27 equal to the renewal fee in effect on the last regular date before
28 the date on which it is ~~reinstated, plus all accrued and unpaid~~
29 ~~renewal fees~~ *reinstated* and the delinquency fee, if any, accrued
30 at the time of its revocation.

31 *SEC. 39. Section 8024.7 of the Business and Professions Code*
32 *is amended to read:*

33 8024.7. The board shall establish an inactive category of
34 licensure for persons who are not actively engaged in the practice
35 of shorthand reporting.

36 (a) The holder of an inactive license issued pursuant to this
37 section shall not engage in any activity for which a license is
38 required.

39 (b) An inactive license issued pursuant to this section shall be
40 renewed during the same time period in which an active license

1 is renewed. The holder of an inactive license is exempt from any
2 continuing education requirement for renewal of an active license.

3 (c) The renewal fee for a license in an active status shall ~~apply~~
4 ~~also for a renewal of a license in an inactive status, unless a lesser~~
5 ~~renewal fee is specified by the board.~~ *be no more than 50 percent*
6 *of the renewal fee for a license in an active status.*

7 (d) In order for the holder of an inactive license issued pursuant
8 to this section to restore ~~his or her~~ *their* license to an active status,
9 the holder of an inactive license shall comply with both of the
10 following:

11 (1) Pay the renewal fee.

12 (2) If the board requires completion of continuing education for
13 renewal of an active license, complete continuing education
14 equivalent to that required for renewal of an active license, unless
15 a different requirement is specified by the board.

16 *SEC. 40. Section 8802 of the Business and Professions Code*
17 *is amended to read:*

18 8802. Except as otherwise provided in this article, licenses
19 issued under this chapter may be renewed at any time within five
20 years after expiration on filing of application for renewal on a form
21 prescribed by the board and payment of ~~all accrued and unpaid~~
22 ~~renewal fees.~~ *the renewal fee.* If the license is renewed more than
23 30 days after its expiration, the licensee, as a condition precedent
24 to renewal, shall also pay the delinquency fee prescribed by this
25 chapter. Renewal under this section shall be effective on the date
26 on which the application is filed, on the date on which the renewal
27 fee is paid, or on the date on which the delinquency fee, if any, is
28 paid, whichever last occurs. If so renewed, the license shall
29 continue in effect through the date provided in Section 8801 which
30 next occurs after the effective date of the renewal, when it shall
31 expire if it is not again renewed.

32 *SEC. 41. Section 9832 of the Business and Professions Code*
33 *is amended to read:*

34 9832. (a) Registrations issued under this chapter shall expire
35 no more than 12 months after the issue date. The expiration date
36 of registrations shall be set by the director in a manner to best
37 distribute renewal procedures throughout the year.

38 (b) To renew an unexpired registration, the service dealer shall,
39 on or before the expiration date of the registration, apply for

1 renewal on a form prescribed by the director, and pay the renewal
2 fee prescribed by this chapter.

3 (c) To renew an expired registration, the service dealer shall
4 apply for renewal on a form prescribed by the director, pay the
5 renewal fee in effect on the last regular renewal date, and pay ~~all~~
6 ~~accrued and unpaid~~ the delinquency ~~and renewal fees.~~ *fee.*

7 (d) Renewal is effective on the date that the application is ~~filed,~~
8 ~~filed and~~ the renewal ~~fee is paid,~~ and ~~all~~ delinquency fees are paid.

9 (e) For purposes of implementing the distribution of the renewal
10 of registrations throughout the year, the director may extend by
11 not more than six months, the date fixed by law for renewal of a
12 registration, except that in that event any renewal fee that may be
13 involved shall be prorated in a manner that no person shall be
14 required to pay a greater or lesser fee than would have been
15 required had the change in renewal dates not occurred.

16 *SEC. 42. Section 9832.5 of the Business and Professions Code*
17 *is amended to read:*

18 9832.5. (a) Registrations issued under this chapter shall expire
19 no more than 12 months after the issue date. The expiration date
20 of registrations shall be set by the director in a manner to best
21 distribute renewal procedures throughout the year.

22 (b) To renew an unexpired registration, the service contractor
23 shall, on or before the expiration date of the registration, apply for
24 renewal on a form prescribed by the director, and pay the renewal
25 fee prescribed by this chapter.

26 (c) To renew an expired registration, the service contractor shall
27 apply for renewal on a form prescribed by the director, pay the
28 renewal fee in effect on the last regular renewal date, and pay ~~all~~
29 ~~accrued and unpaid~~ the delinquency and renewal fees.

30 (d) Renewal is effective on the date that the application is ~~filed,~~
31 ~~filed and~~ the renewal ~~fee is paid,~~ and ~~all~~ delinquency fees are paid.

32 (e) For purposes of implementing the distribution of the renewal
33 of registrations throughout the year, the director may extend, by
34 not more than six months, the date fixed by law for renewal of a
35 registration, except that, in that event, any renewal fee that may
36 be involved shall be prorated in such a manner that no person shall
37 be required to pay a greater or lesser fee than would have been
38 required had the change in renewal dates not occurred.

39 (f) This section shall remain in effect only until January 1, 2023,
40 and as of that date is repealed.

1 *SEC. 43. Section 9884.5 of the Business and Professions Code*
2 *is amended to read:*

3 9884.5. A registration that is not renewed within three years
4 following its expiration shall not be renewed, restored, or reinstated
5 thereafter, and the delinquent registration shall be canceled
6 immediately upon expiration of the three-year period.

7 An automotive repair dealer whose registration has been canceled
8 by operation of this section shall obtain a new registration only if
9 ~~he or she~~ *the automotive repair dealer* again meets the requirements
10 set forth in this chapter relating to registration, is not subject to
11 denial under Section 480, and pays the applicable fees.

12 An expired registration may be renewed at any time within three
13 years after its expiration upon the filing of an application for
14 renewal on a form prescribed by the bureau and the payment of
15 ~~all accrued~~ *the* renewal and delinquency fees. Renewal under this
16 section shall be effective on the date on which the application is
17 filed and ~~all~~ *the* renewal and delinquency fees are paid. If so
18 renewed, the registration shall continue in effect through the
19 expiration date of the current registration year as provided in
20 Section 9884.3, at which time the registration shall be subject to
21 renewal.

22 *SEC. 44. Section 19170.5 of the Business and Professions Code*
23 *is amended to read:*

24 19170.5. (a) Except as provided in Section 19170.3, licenses
25 issued under this chapter expire two years from the date of
26 issuance. To renew ~~his or her~~ *a* license, a licensee shall, on or
27 before the date on which it would otherwise expire, apply for
28 renewal on a form prescribed by the chief, and pay the fees
29 prescribed by Sections 19170 and 19213.1. If a licensee fails to
30 renew ~~his or her~~ *their* license before its expiration, a delinquency
31 fee of 20 percent, but not more than one hundred dollars (\$100),
32 notwithstanding the provisions of Section 163.5, shall be added
33 to the renewal fee. If the renewal fee and delinquency fee are not
34 paid within 90 days after expiration of a license, the licensee shall
35 be assessed an additional penalty fee of 30 percent of the renewal
36 fee.

37 (b) Except as otherwise provided in this chapter, a licensee may
38 renew an expired license within six years after expiration of the
39 license by filing an application for renewal on a form prescribed

1 by the bureau, and paying ~~all accrued renewal, delinquent, the~~
2 ~~renewal, delinquency,~~ and penalty fees.

3 (c) A license that is not renewed within six years of its expiration
4 shall not be renewed, restored, reinstated, or reissued, but the holder
5 of the license may apply for and obtain a new license if both of
6 the following requirements are satisfied:

7 (1) No fact, circumstance, or condition exists which would
8 justify denial of licensure under Section 480.

9 (2) The licensee pays ~~all the~~ renewal, delinquency, and penalty
10 ~~fees that have accrued since the date on which the license was last~~
11 ~~renewed.~~ fees.

12 (d) The bureau may impose conditions on any license issued
13 pursuant to subdivision (c).

14 *SEC. 45. Section 19290 of the Business and Professions Code*
15 *is amended to read:*

16 19290. (a) Permits issued under this chapter expire two years
17 from the date of issuance. To renew a permit, a permittee shall,
18 on or before the date on which it would otherwise expire, apply
19 for renewal on a form prescribed by the chief, and continue to pay
20 the fees prescribed in Sections 19288 and 19288.1. Notwithstanding
21 Section 163.5, if a permittee fails to renew the permit before its
22 expiration, a delinquency fee of 20 percent of the most recent fee
23 paid to the bureau pursuant to Sections 19288 and 19288.1 shall
24 be added to the amount due to the bureau at the next fee interval.
25 If the renewal fee and delinquency fee are not paid within 90 days
26 after expiration of a permit, the permittee shall be assessed an
27 additional fee of 30 percent of the most recent fee paid to the
28 bureau pursuant to Sections 19288 and 19288.1.

29 (b) Except as otherwise provided in this chapter, a permittee
30 may renew an expired permit within two years after expiration of
31 the permit by filing an application for renewal on a form prescribed
32 by the bureau, and paying ~~all accrued~~ fees.

33 (c) A permit that is not renewed within two years of its
34 expiration shall not be renewed, restored, reinstated, or reissued,
35 but the holder of the expired permit may apply for and obtain a
36 new permit as provided in this chapter, upon payment of all fees
37 that accrued since the date the permit was last renewed.

38 (d) The bureau may impose conditions on any permit issued
39 pursuant to subdivision (c).

1 SECTION 1. ~~Section 4073 of the Business and Professions~~
2 ~~Code is amended to read:~~

3 4073. (a) ~~A pharmacist filling a prescription order for a drug~~
4 ~~product prescribed by its trade or brand name may select another~~
5 ~~drug product with the same active chemical ingredients of the same~~
6 ~~strength, quantity, and dosage form, and of the same generic drug~~
7 ~~name as determined by the United States Adopted Names (USAN)~~
8 ~~and accepted by the federal Food and Drug Administration (FDA),~~
9 ~~of those drug products having the same active chemical ingredients.~~

10 (b) ~~In no case shall a selection be made pursuant to this section~~
11 ~~if the prescriber personally indicates, either orally or in the~~
12 ~~prescriber's own handwriting, "Do not substitute," or words of~~
13 ~~similar meaning. Nothing in this subdivision shall prohibit a~~
14 ~~prescriber from checking a box on a prescription marked "Do not~~
15 ~~substitute"; provided that the prescriber personally initials the box~~
16 ~~or checkmark. To indicate that a selection shall not be made~~
17 ~~pursuant to this section for an electronic data transmission~~
18 ~~prescription as defined in subdivision (c) of Section 4040, a~~
19 ~~prescriber may indicate "Do not substitute," or words of similar~~
20 ~~meaning, in the prescription as transmitted by electronic data, or~~
21 ~~may check a box marked on the prescription "Do not substitute."~~
22 ~~In either instance, it shall not be required that the prohibition on~~
23 ~~substitution be manually initialed by the prescriber.~~

24 (c) ~~Selection pursuant to this section is within the discretion of~~
25 ~~the pharmacist, except as provided in subdivision (b). The person~~
26 ~~who selects the drug product to be dispensed pursuant to this~~
27 ~~section shall assume the same responsibility for selecting the~~
28 ~~dispensed drug product as would be incurred in filling a~~
29 ~~prescription for a drug product prescribed by generic name. There~~
30 ~~shall be no liability on the prescriber for an act or omission by a~~
31 ~~pharmacist in selecting, preparing, or dispensing a drug product~~
32 ~~pursuant to this section. In no case shall the pharmacist select a~~
33 ~~drug product pursuant to this section unless the drug product~~
34 ~~selected costs the patient less than the prescribed drug product.~~
35 ~~Cost, as used in this subdivision, is defined to include any~~
36 ~~professional fee that may be charged by the pharmacist.~~

37 (d) ~~This section shall apply to all prescriptions, including those~~
38 ~~presented by or on behalf of persons receiving assistance from the~~
39 ~~federal government or pursuant to the California Medical~~
40 ~~Assistance Program set forth in Chapter 7 (commencing with~~

1 ~~Section 14000) of Part 3 of Division 9 of the Welfare and~~
2 ~~Institutions Code.~~

3 ~~(e) When a substitution is made pursuant to this section, the use~~
4 ~~of the cost saving drug product dispensed shall be communicated~~
5 ~~to the patient and the name of the dispensed drug product shall be~~
6 ~~indicated on the prescription label, except where the prescriber~~
7 ~~orders otherwise.~~

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Board of Behavioral Sciences

Memo

1625 North Market Blvd., Suite S-200
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www.bbs.ca.gov

To: Board Members
From: Rosanne Helms
Legislative Analyst
Date: May 2, 2019
Telephone: (916) 574-7897
Subject: Legislative Update

Board staff is currently pursuing the following legislative proposals:

1. SB 679 (Bates) Healing Arts: Therapists and Counselors: Licensing

This bill proposal represents the work of the Board's License Portability Committee and seeks to remove some of the barriers to inter-state licensure. It proposes a pathway for LMFTs, LCSWs, and LPCCs who are actively licensed in another state and have been so for at least two years, to become licensed in California if they complete continuing education coursework specific to the psychotherapy environment in this state, and if they pass a California law and ethics exam.

Status: This bill is on second reading in the Senate.

2. AB 630 (Low) Board of Behavioral Sciences: Marriage and Family Therapists: Clinical Social Workers: Educational Psychologists: Professional Clinical Counselors: Required Notice

This bill proposes requiring all settings where psychotherapy is performed to provide clients, prior to initiating services, with a printed notice disclosing where to file a complaint about the therapist.

Status: This bill has passed the Assembly and is now in the Senate.

3. SB 786 (Senate Business, Professions, and Economic Development Committee): Healing Arts (Omnibus Bill) This bill proposal, approved by the Board at its November 30, 2018 meeting, makes minor, technical, and non-substantive amendments to add clarity and consistency to current licensing law.

The Board requested eight items be included in the bill. At this time, the Committee has indicated one item has been rejected for inclusion. All other requested items will likely be included. The rejected item is as follows:

Amend BPC Sections 4980.50, 4989.22, 4992.1, and 4999.52 –Pending Complaints or Investigations and Examinations

Identification of the Problem: These sections outline, for each of the Board's four license types, the parameters regarding examination when an applicant has a pending complaint against him or her or is under Board investigation. The sections permit the Board to deny admission to an exam, or to refuse to issue a license if an accusation or a statement of issues has been filed against the applicant. The Board's Enforcement Unit also sees cases where it issues a petition to revoke probation (due to violations of probationary terms), while the applicant is in the process of applying to take a Board exam or is applying for licensure. The Board believes it is also appropriate to deny exam admission or refuse to issue a license in this case as well.

Status: This bill is in the Senate Appropriations Committee.



Board of Behavioral Sciences

Memo

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To: Board Members

Date: May 2, 2019

From: Christy Berger
Regulatory Analyst

Telephone: (916) 574-7817

Subject: Status of Board Rulemaking Proposals

Substantial Relationship & Rehabilitation Criteria (AB 2138 Regulations)

This proposal would result in changes necessary in order to meet the requirements of Assembly Bill (AB) 2138 (Chapter 995, Statutes of 2018). This proposal includes modifying the Board's substantial relationship criteria, which helps to evaluate whether a crime or act was substantially related to the profession, as well as criteria to evaluate the rehabilitation of an individual when considering denying, suspending or revoking a license. The proposal was approved by the Board at its meeting in February 2019 and was submitted to the Department of Consumer Affairs (DCA) to begin the initial review process on April 18, 2019.

Enforcement Process

This proposal would result in updates to the Board's disciplinary process. It would also make updates to the Board's "Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (Revised October 2015)," which are incorporated by reference into the Board's regulations. The proposed changes fall into three general categories:

1. Amendments seeking to strengthen certain penalties that are available to the Board;
2. Amendments seeking to update regulations or the Uniform Standards/Guidelines in response to statutory changes to the Business and Professions Code; and
3. Amendments to clarify language that has been identified as unclear or needing further detail.

The proposal was approved by the Board at its meeting in February 2017 and was submitted to DCA to begin the initial review process in July 2017. This regulation package was placed on hold due to the passage of AB 2138 and remains on hold pending passage of the AB 2138 regulations.

Examination Rescoring; Application Abandonment; APCC Subsequent Registration Fee

This proposal would amend the Board's examination rescoring provisions to clarify that rescoring pertains only to exams taken via paper and pencil, since all other taken electronically are automatically rescored. This proposal would also make clarifying, non-substantive changes to the Board's application abandonment criteria, and clarify the fee required for subsequent Associate Professional Clinical Counselor registrations. The proposal was approved by the Board at its meeting in November 2017, was submitted to DCA to begin the initial review process in April 2018, and was approved in January 2019 for filing with the Office of Administrative Law (OAL). The public comment period ended on April 8, 2019, and the package was submitted to DCA to initiate the final review process in April 2019.

Supervision

This proposal would:

- Revise the qualifications to become supervisor;
- Require supervisors to perform a self-assessment of qualifications and submit the self-assessment to the Board;
- Set forth requirements for substitute supervisors;
- Update and strengthen supervisor training requirements;
- Strengthen supervisor responsibilities, including provisions pertaining to monitoring and evaluating supervisees;
- Strengthen requirements pertaining to documentation of supervision;
- Make supervision requirements consistent across the three licensed professions;
- Address supervision gained outside of California; and
- Address documentation requirements when a supervisor is incapacitated or deceased.
- Set forth terms relating to registrant placement by temporary staffing agencies.

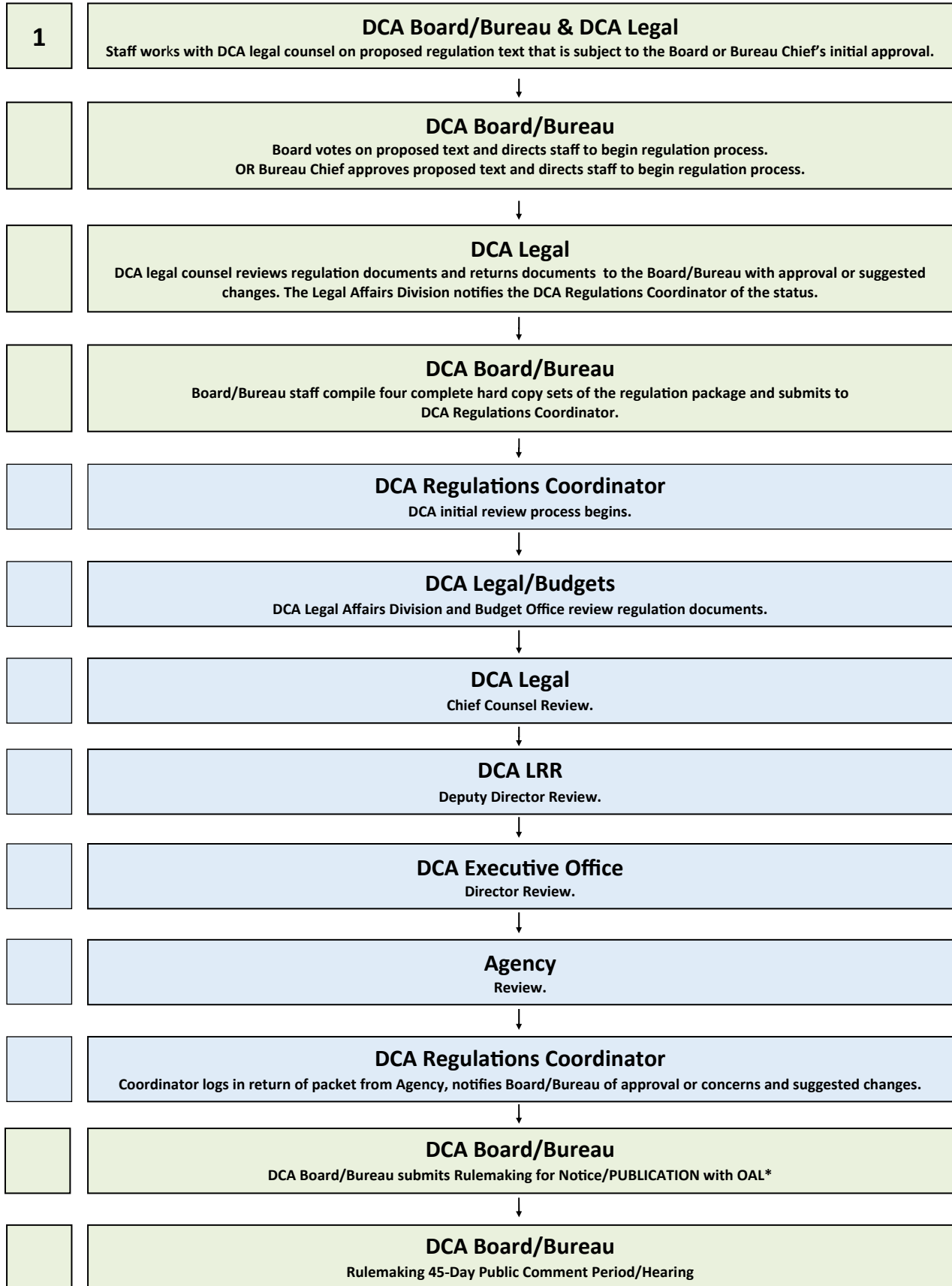
The proposal was approved by the Board at its meeting in November 2016 and was held aside while awaiting passage of AB 93 (Chapter 743, Statutes of 2018), the Board's supervision legislation. This proposal was submitted to DCA to begin the initial review process in April 2019.

Attachments

Attachment A: DCA Regulation Process

Attachment B: BBS Regulation Timeline

INITIAL PHASE



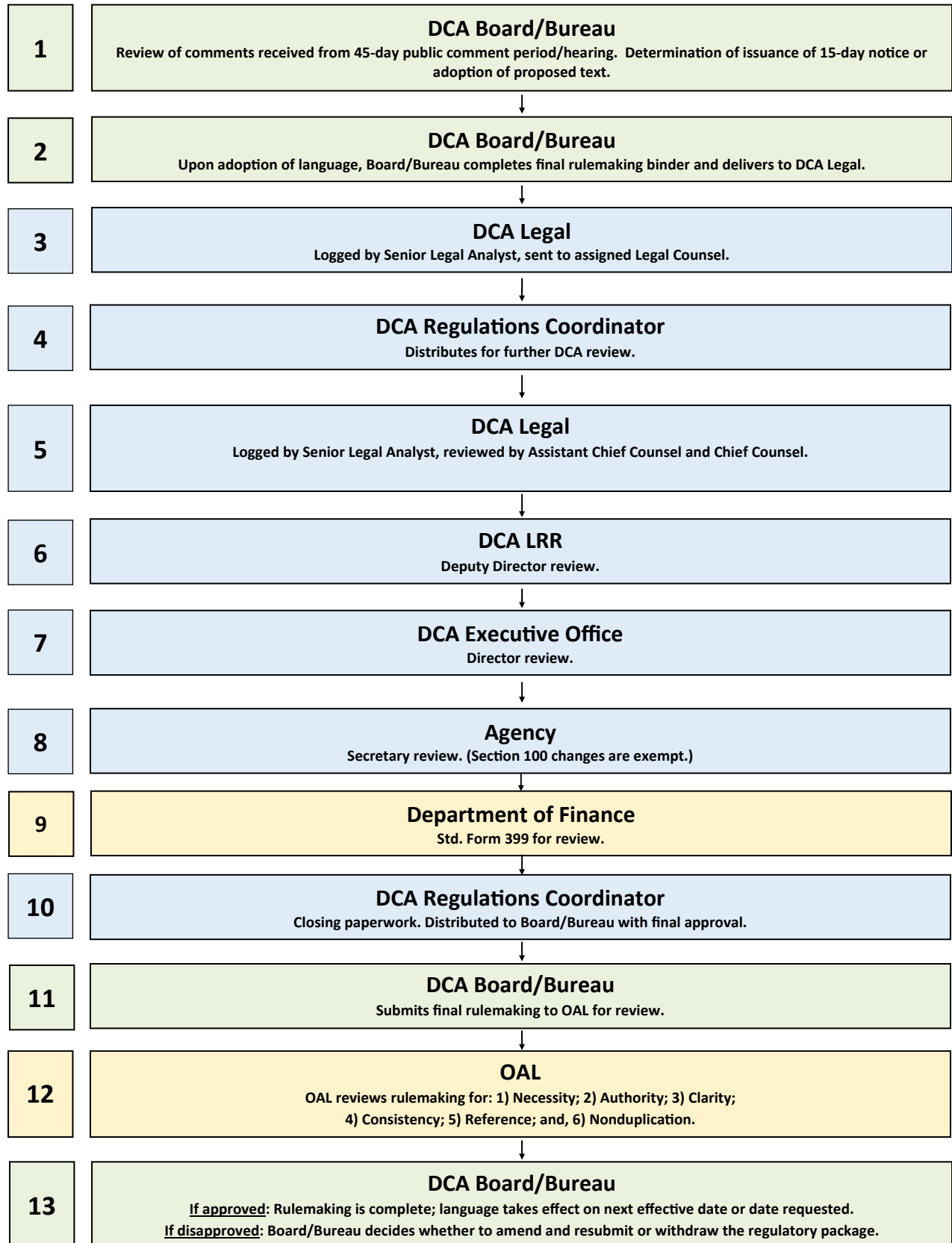
Legend

DCA – Department of Consumer Affairs
 LRR – Division of Legislative Regulatory Review
 OAL – Office of Administrative Law

* If any changes to language last approved by the Board are needed, a vote by the Board may be necessary.

REGULAR RULEMAKING PROCESS—DCA BOARDS/BUREAUS

FINAL PHASE



Legend

DCA – Department of Consumer Affairs

LRR – Division of Legislative Regulatory Review

OAL – Office of Administrative Law

DOF – Department of Finance

Std. Form 399 – Economic and Fiscal Impact Statement

ATTACHMENT B

BBS REGULATION TIMELINE

APRIL 23, 2019

| Regulation Package Name | Board Approval | Submitted to DCA: Initial Review | Submitted to Agency: Initial Review | Noticed | Public Hearing | Submitted to DCA: Final Review | Submitted to Agency: Final Review | Submitted to DOF | Date Submitted to OAL/ Date OAL Approved |
|---|-----------------------|---|--|----------------|-----------------------|---------------------------------------|--|-------------------------|---|
| Substantial Relationship & Rehabilitation Criteria (AB 2138 Regs) | 03/01/19 | 4/18/19 | | | | | | | |
| Enforcement Update to Disciplinary Guidelines | 3/3/17 | 7/11/17 | 9/13/18* | | | | | | |
| Examination Rescoring; Application Abandonment; APCC Subsequent Registration Fee | 11/2/17 | 4/6/18 | 9/12/18 | 2/22/19 | 4/8/19 | 4/24/19 | | | |
| Supervision | 11/4/16** | 4/18/19 | | | | | | | |

*This package was held due to the passage of AB 2138 and continues to be on hold pending approval of AB 2138 regulations.

**This package was held pending passage of AB 93.

DCA and Agency Initial Review Process: Following review by the Board's attorney and required document preparation (Notice, Initial Statement of Reasons, Fiscal Impact), the package is submitted to DCA's Legislative and Policy Review Division, who routes it for approvals from the budget and legal offices, the DCA Executive Office and Agency. Once approved by Agency, the Board can submit the package to the Office of Administrative Law (OAL) to Notice the proposed regulation change.

Notice and Public Hearing: The Notice initiates the 45-day public comment period and a public hearing. The Board must consider all comments submitted. If any substantive changes to the text of the proposal, the Board must approve the language again, and provide a 15-day public comment period. If no changes are made to the proposal, the package goes to DCA for final review.

DCA and Agency Final Review: The initial review process is repeated.

Submission to DOF and OAL for Final Approval: Both the Department of Finance and the Office of Administrative Law must approve the regulation package. The review may occur at the same time. However, OAL is the final approval. Once OAL approves the regulation package, the proposal is adopted, and it is assigned an effective date.