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

POLICY AND ADVOCACY COMMITTEE
Meeting Notice and Agenda - REVISED

April 5, 2019
9:00 a.m.

Department of Consumer Affairs
Lou Galiano Hearing Room
1625 North Market Blvd., #S-102
Sacramento, CA 95834

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.

I. Call to Order, Establishment of Quorum, and Introductions*

II. Approval of February 8, 2019 Committee Meeting Minutes

III. Discussion and Possible Recommendation Regarding Assembly Bill 184 (Mathis) Board of Behavioral Sciences: Registrants and Licensees

IV. Discussion and Possible Recommendation Regarding Assembly Bill 544 (Brough) Professions and Vocations: Inactive License Fees and Accrued and Unpaid Renewal Fees

V. Discussion and Possible Recommendations Regarding Assembly Bill 613 (Low) Professions and Vocations: Regulatory Fees

VI. Discussion and Possible Recommendation Regarding Assembly Bill 769 (Smith) Federally Qualified Health Centers and Rural Health Clinics: Licensed Professional Clinical Counselor

VII. Discussion and Possible Recommendation Regarding Assembly Bill 850 (Lackey) Clinical Social Workers: Licensure Requirements

VIII. Discussion and Possible Recommendation Regarding Assembly Bill 1145 (Garcia) Child Abuse: Reportable Conduct

IX. Discussion and Possible Recommendation Regarding Assembly Bill 1540 (Holden) Music Therapy

X. Discussion and Possible Recommendation Regarding Assembly Bill 1651 (Medina) Licensed Educational Psychologists: Supervision of Associates and Trainees

XI. Discussion and Possible Recommendation Regarding Senate Bill 10 (Beall) Mental Health Services: Peer, Parent, Transition-Age, and Family Support Specialist Certification

XII. Discussion and Possible Recommendation Regarding Senate Bill 163 (Portantino) Healthcare Coverage: Pervasive Developmental Disorder or Autism

XIII. Discussion and Possible Recommendation Regarding Senate Bill 425 (Hill) Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct

XIV. Discussion and Possible Recommendation Regarding Senate Bill 601 (Morrell) State Agencies: Licensees: Fee Waiver

XV. Discussion and Possible Recommendation Regarding Senate Bill 660 (Pan) Postsecondary Education: Mental Health Counselors

XVI. Discussion and Possible Recommendations Regarding Other Legislation Affecting the Board

XVII. 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

XVIII. Update on Board Rulemaking Proposals

XIX. 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)]

XX. Suggestions for Future Agenda Items

XXI. 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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Memo

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

To:	Policy and Advocacy Committee	**Date:**	March 28, 2019
From:	Christina Kitamura Administrative Analyst	**Telephone:**	(916) 574-7830
Subject:	**Agenda Item III**		

Agenda item III (Approval of February 8, 2019 Committee Meeting Minutes) will be provided in a supplemental package and will be posted on the website at that time.

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: AB 184 **VERSION:** INTRODUCED JANUARY 10, 2019

AUTHOR: MATHIS **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

SUBJECT: BOARD OF BEHAVIORAL SCIENCES: REGISTRANTS AND LICENSEES

Summary: This bill would require the Board of Behavioral Sciences (Board) to offer its applicant, registrants, and licensees the option to keep their home address confidential.

Existing Law:

1. Requires specified boards and bureaus under the Department of Consumer Affairs (DCA), including the Board of Behavioral Sciences, Dental Board, Board of Optometry, and Board of Psychology to disclose certain information about its licensees on the internet, including an address of record. (Business and Professions Code (BPC) §27(a))

2. Specifies that an entity must allow a licensee to provide a post office box number or other alternate address as the address of record, instead of the home address. (BPC §27(a))

3. Permits a board or bureau to require a licensee who provides a post office box or alternate address as the address of record, to provide a physical business or residence address for internal board use only. (BPC §27(a))

4. Requires all persons regulated by the board to maintain a current mailing address, and to notify the board within 30 days of any address changes. (California Code of Regulations (CCR) Title 16, §1804)

This Bill: Would require the Board to offer its applicant, registrants, and licensees the option to keep their home address confidential. (BPC §4990.11)

Comment:

1. **Author's Intent.** In their factsheet for the bill, the author's office states that "Through the requirement of a personal home address be made public knowledge, all therapists and social workers under the BBS must live in a state of fear and concern. While it is unlikely that a client may act against their therapist or social worker, allowing for the home address of the individual to be easily searched puts the clinician in potential harm's way." They also note that "Currently, a clinician may

list a PO Box as their "primary residence" should they not feel comfortable listing their home address; however, by only allowing this option, clinicians are penalized for wanting their address kept private."

2. **Permitted Addresses.** It is incorrect that a Board licensee must either provide their home address or a post office box. The law also currently permits a secondary address, such as an office or place of employment, to be used. The address they choose is shown as their address of record if a consumer performs a licensee/registrant search via the Board's website.

   Providing an address of a place of employment appears to be a reasonable alternative to renting a post office box or providing a home address, as this is most likely where the therapist sees clients, and the clients would already have that address.

3. **Purpose of Address of Record.** Providing an address of record for licensees and registrants ensures that consumers have the means to contact a therapist if necessary. The Board does not publish email addresses or phone numbers, but listing a current address provides a point of contact to do things such as request past records or file a lawsuit (in the event of potential misconduct.) Not providing this information could make it very difficult for a consumer to locate a therapist, which in some cases, could have public protection implications.

4. **Conflict in Law.** This proposal creates a conflict in law with BPC section 27, which states that specified boards and bureaus under DCA shall disclose a licensee's address of record.

5. **Other Boards' Requirements.** As noted above, BPC §27 requires specified DCA boards and bureaus to disclose an address of record, although that address may be a post office box or alternate address. The text of §27 is shown in **Attachment A**.

   Several healing arts boards not listed in §27 have a similar requirement stated elsewhere in their law:

   Medical Board of California: BPC §2021(b): *"Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public."*

   California Occupational Therapy Board: 16 CCR §4102(a): *"Each person licensed or issued a limited permit by the board, shall report to the board every change of residence address within 30 days after the change, giving both the old and new addresses. In addition to the residence address, the person may provide the board with an alternate address of record. If an alternate address is the person's address*

of record, he or she may request, in writing, that the residence address not be disclosed to the public."

<u>California Physical Therapy Board:</u> 16 CCR §1396:

§1396*(a) Address of Record. Every applicant and licensee shall provide an address to the Physical Therapy Board of California (Board) that will be designated as their address of record, which will be utilized for all official and formal communications from the Board, and which will be disclosed to the public. An applicant or a licensee need not provide a residence address as the address of record, but may use an alternative address, such as a business address or a P.O. Box, as their address of record. Every applicant and licensee shall report any change of the address of record to the Board no later than thirty (30) calendar days after the address change has occurred. The report of change of address of record shall be in writing and contain the old address, the new address, and the effective date of the change of address.*
(b) Residence Address. Every applicant and licensee shall provide a residence address to the Board. Only if the applicant or licensee also provides an alternative address of record as described in subdivision (a) above shall the Board maintain the residence address as confidential. Every applicant and licensee shall report any change of their residential address to the Board no later than thirty (30) calendar days after the address change has occurred. The report of change of residential address shall be in writing and contain the old address, the new address, and the effective date of the change of address.

6. Support and Opposition.

<u>Support:</u>
None at this time.

<u>Opposition:</u>
None at this time.

7. History
2019
01/24/19 Referred to Com. on B. & P.
01/11/19 From printer. May be heard in committee February 10.
01/10/19 Read first time. To print.

8. Attachments.

Attachment A: BPC §27

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ATTACHMENT A
BUSINESS AND PROFESSIONS CODE (BPC) §27

BPC §27

(a) Each entity specified in subdivisions (c), (d), and (e) shall provide on the Internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the Internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action, including accusations filed pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee's address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of his or her home address, as the address of record. This section shall not preclude an entity from also requiring a licensee, who has provided a post office box number or other alternative mailing address as his or her address of record, to provide a physical business address or residence address only for the entity's internal administrative use and not for disclosure as the licensee's address of record or disclosure on the Internet.

(b) In providing information on the Internet, each entity specified in subdivisions (c) and (d) shall comply with the Department of Consumer Affairs' guidelines for access to public records.

(c) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Board for Professional Engineers, Land Surveyors, and Geologists shall disclose information on its registrants and licensees.

(2) The Bureau of Automotive Repair shall disclose information on its licensees, including auto repair dealers, smog stations, lamp and brake stations, smog check technicians, and smog inspection certification stations.

(3) The Bureau of Household Goods and Services shall disclose information on its licensees and registrants, including major appliance repair dealers, combination dealers

(electronic and appliance), electronic repair dealers, service contract sellers, and service contract administrators.

(4) The Cemetery and Funeral Bureau shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, cemetery managers, crematory managers, cemetery authorities, crematories, cremated remains disposers, embalmers, funeral establishments, and funeral directors.

(5) The Professional Fiduciaries Bureau shall disclose information on its licensees.

(6) The Contractors' State License Board shall disclose information on its licensees and registrants in accordance with Chapter 9 (commencing with Section 7000) of Division 3. In addition to information related to licenses as specified in subdivision (a), the board shall also disclose information provided to the board by the Labor Commissioner pursuant to Section 98.9 of the Labor Code.

(7) The Bureau for Private Postsecondary Education shall disclose information on private postsecondary institutions under its jurisdiction, including disclosure of notices to comply issued pursuant to Section 94935 of the Education Code.

(8) The California Board of Accountancy shall disclose information on its licensees and registrants.

(9) The California Architects Board shall disclose information on its licensees, including architects and landscape architects.

(10) The State Athletic Commission shall disclose information on its licensees and registrants.

(11) The State Board of Barbering and Cosmetology shall disclose information on its licensees.

(12) The State Board of Guide Dogs for the Blind shall disclose information on its licensees and registrants.

(13) The Acupuncture Board shall disclose information on its licensees.

(14) The Board of Behavioral Sciences shall disclose information on its licensees and registrants.

(15) The Dental Board of California shall disclose information on its licensees.

(16) The State Board of Optometry shall disclose information on its licensees and registrants.

(17) The Board of Psychology shall disclose information on its licensees, including psychologists, psychological assistants, and registered psychologists.

(18) The Veterinary Medical Board shall disclose information on its licensees, registrants, and permitholders.

(d) The State Board of Chiropractic Examiners shall disclose information on its licensees.

(e) The Structural Pest Control Board shall disclose information on its licensees, including applicators, field representatives, and operators in the areas of fumigation, general pest and wood destroying pests and organisms, and wood roof cleaning and treatment.

(f) The Bureau of Cannabis Control shall disclose information on its licensees.

(g) “Internet” for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

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ASSEMBLY BILL No. 184

Introduced by Assembly Member Mathis

January 10, 2019

An act to add Section 4990.11 to the Business and Professions Code, relating to healing arts.

legislative counsel's digest

AB 184, as introduced, Mathis. Board of Behavioral Sciences: registrants and licensees.

Existing law establishes the Board of Behavioral Sciences within the Department of Consumer Affairs, and requires the board to regulate various registrants and licensees under the Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

This bill would require the board to offer every applicant for an initial registration number or license and every applicant for renewal of a registration number or license under the board's jurisdiction the option to elect to have the applicant's home address be kept confidential.

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 4990.11 is added to the Business and
2 Professions Code, to read:
3 4990.11. The board shall offer every applicant for an initial
4 registration number or license and every applicant for renewal of

1 a registration number or license under the board's jurisdiction the
2 option to elect to have the applicant's home address be kept
3 confidential.

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

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

AUTHOR: **LOW** **SPONSOR:** **AUTHOR**

RECOMMENDED POSITION: **NONE**

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 statue 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) **Support and Opposition.**

Support
- None at this time.

Oppose
- None at this time.

6) **History.**

2019

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.

7) **Attachments:**

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

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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 specifed, the percent change in the Consumer Price Index is equal to:

8.3%

Source: California Department of Industrial Relations. -

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	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 specifed, the percent change in the Consumer Price Index is equal to:

10.3%

Source: California Department of Industrial Relations. -

ASSEMBLY BILL No. 613

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.

Exiting 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.

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Board of Behavioral Sciences

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: **NONE**

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) Support and Opposition.

Support:
California Association for Licensed Professional Clinical Counselors (CALPCC) (Sponsor)

Oppose:
Unknown at this time.

5) History

2019

02/28/19	Referred to Com. on HEALTH.
02/20/19	From printer. May be heard in committee March 22.
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ASSEMBLY BILL **No. 769**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

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

AUTHOR: GARCIA **SPONSOR:** AUTHOR

RECOMMENDED POSITION: NONE

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) Support and Opposition.

Support:
Unknown at this time.

Opposition
Unknown at this time.

7) History

2019
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.

8) 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?”

STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

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 PhyD, ("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 11165.1[1] 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.

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

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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

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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 issue[1]:

"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, *Planned Parenthood Affiliates of California v. John K. Van De Kamp* (1986) 181 Cal. App. 3d 245 (1986); See also, *In re Jerry M.* 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	

"Child" refers to the person that the mandated child abuse reporter is involved with.	**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	

"Child" refers to the person that the mandated child abuse reporter is involved with.	**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.cacscc.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, *Planned Parenthood Affiliates of California v. John K. Van De Kamp* (1986) 181 Cal. App. 3d 245		X

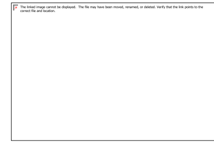
consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship.	(1986) & *In re Jerry M.* 59 Cal. App. 4th 289		
2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, 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.

[Prepared by L. Michael Clark, Senior Lead Deputy County Counsel, Santa Clara County / Revised December 2006]

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california legislature—2019–20 regular session

ASSEMBLY BILL No. 1145

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.

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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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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES Bill Analysis

BILL NUMBER: **AB 1540** **VERSION:** **INTRODUCED FEBRUARY 22, 2019**

AUTHOR: **HOLDEN** **SPONSOR:** **CERTIFICATION BOARD FOR MUSIC THERAPISTS**

RECOMMENDED POSITION: **NONE**

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)

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) **Support and Opposition.**

   Support
   Certification Board for Music Therapists (Sponsor)

   Oppose
   None at this time.

8) **History.**

   2019
   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.

9) **Attachments.**

   Attachment A: Scope of Music Therapy Practice, 2015 (American Music Therapy Association, Certification Board for Music Therapists)

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www.musictherapy.org

Certification Board for Music Therapists
506 East Lancaster Avenue, Suite 102
Downingtown, PA 19335
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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.

<u>Statement of Purpose</u>

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.

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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 introduced, 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.

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
22 (CBMT), an independent, nonprofit corporation fully accredited
23 by the National Commission for Certifying Agencies.
24 (c) The CBMT grants the Music Therapist-Board Certified
25 (MT-BC) credential to music therapists who have demonstrated
26 the knowledge, skills, and abilities for competence in the current
27 practice of music therapy. The purpose of board certification in

1 music therapy is to provide an objective national standard that can
2 be used as a measure of professionalism and competence by
3 interested agencies, groups, and individuals.
4 (d) The MT-BC is awarded by the CBMT to an individual upon
5 successful completion of an academic and clinical training program
6 approved by the AMTA or an international equivalent and
7 successful completion of an objective written examination
8 demonstrating current competency in the profession of music
9 therapy. The CBMT administers this examination, which is based
10 on a nationwide music therapy practice analysis that is reviewed
11 and updated every five years to reflect current clinical practice.
12 (e) Once certified, a music therapist must adhere to the CBMT
13 Code of Professional Practice and recertify every five years through
14 either a program of continuing education or reexamination.
15 4652. It is the intent of the Legislature that this chapter do the
16 following:
17 (a) Provide a statutory definition of music therapy.
18 (b) Enable consumers and state and local agencies to more easily
19 identify qualified music therapists.
20 4653. As used in this chapter:
21 (a) "Music therapy" means the clinical and evidence-based use
22 of music therapy interventions in developmental, rehabilitative,
23 habilitative, medical, mental health, preventive, wellness care, or
24 educational settings to address physical, emotional, cognitive, and
25 social needs of individuals within a therapeutic relationship. Music
26 therapy includes the following:
27 (1) The development of music therapy treatment plans specific
28 to the needs and strengths of the client who may be seen
29 individually or in groups.
30 (2) Music therapy plans shall establish goals, objectives, and
31 potential strategies of the music therapy services appropriate for
32 the client and setting.
33 (b) "Music therapy interventions" include, but are not limited
34 to, music improvisation, receptive music listening, song writing,
35 lyric discussion, music and imagery, singing, music performance,
36 learning through music, music combined with other arts,
37 music-assisted relaxation, music-based patient education, electronic
38 music technology, adapted music intervention, and movement to
39 music.

4654. An individual who provides music therapy shall not refer to oneself using the title of "Board Certified Music Therapist" unless the individual has completed all of the following:

(a) A bachelors degree or its equivalent, or higher, from a music therapy degree program approved by the American Music Therapy Association using current standards, beginning with those adopted on April 1, 2015.

(b) A minimum of 1,200 hours of supervised clinical work through preinternship training at an approved degree program and internship training through an approved national roster or university affiliated internship program, or the equivalent.

(c) The current requirements for certification, beginning with those adopted on April 1, 2015, established by the Certification Board for Music Therapists for the Music Therapist-Board Certified credential.

4655. This chapter shall not be 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 under this division. While the use of music is not restricted to any profession, the use of music shall not imply or suggest that the person is a Board Certified Music Therapist, if they do not meet the criteria specified in Section 4654.

4656. It is an unfair business practice within the meaning of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7, for a person to use the title "Board Certified Music Therapist" if they do not meet the requirements of Section 4654.

O

BBS
Board of Behavioral Sciences

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: NONE

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 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))

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) **Support and Opposition.**

<u>Support</u>
California Association of School Psychologists (Sponsor)

<u>Oppose</u>
None at this time.

5) **History.**

2019
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.

6) **Attachments.**

Attachment A: CASP Presentation Summary: LEPs as BBS Supervisors

Attachment B: BBS Staff Research: LEP Supervision – Affect on License Portability to Other States

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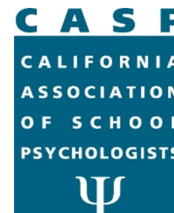
ATTACHMENT A



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 (CASP) 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 ERHMS 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

<u>Florida</u>

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.

<u>Texas</u>

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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AMENDED IN ASSEMBLY MARCH 27, 2019

california legislature—2019–20 regular session

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.

SEC. 2. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) Except as provided in subdivision (b), all applicants shall have an active associate registration with the board in order to gain postdegree hours of supervised experience.

(b) (1) Preregistered postdegree hours of experience shall be credited toward licensure if all of the following apply:

(A) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master's degree or doctoral degree.

(B) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed State of California "Request for Live Scan Service" form with his or her application for licensure.

(C) The board subsequently grants the associate registration.

(2) The applicant shall not be employed or volunteer in a private practice until ~~he or she~~ *the applicant* has been issued an associate registration by the board.

(c) Supervised experience that is obtained for purposes of qualifying for licensure shall be related to the practice of marriage and family therapy and comply with the following:

(1) A minimum of 3,000 hours completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) Hours of experience shall not be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) Hours of experience shall not have been gained more than six years prior to the date the application for licensure was received by the board, except that up to 500 hours of clinical experience 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.

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

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

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

(r) Performing, holding oneself out as being able to perform, offering to perform, or permitting any unlicensed person under supervision to perform, any professional services beyond the scope of the license authorized by this chapter or beyond the person's field or fields of competence as established by the person's education, training, or experience. For purposes of this subdivision, "unlicensed person" includes, but is not limited to, an applicant for licensure, an associate, an intern, or a trainee under the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980)), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991)), or the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10)).

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

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

(u) When employed by another person or agency, encouraging, either orally or in writing, the employer's or agency's clientele to utilize the person's private practice for further counseling without the approval of the employing agency or administration.

(v) Failing to comply with the child abuse reporting 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

Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10)), or any rules or regulations adopted by the board pursuant to those provisions. For purposes of this subdivision, “unlicensed person” is defined as in subdivision (r).

(ad) The violation of any statute or regulation governing the gaining and supervision of experience of an unlicensed person required by the Licensed Marriage and Family Therapist Act (Chapter 13 (commencing with Section 4980)), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991)), or the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10)).

~~SEC. 5.~~

SEC. 6. Section 4996.20 of the Business and Professions Code is amended to read:

4996.20. (a) “Supervisor,” as used in this chapter, means an individual who meets all of the following requirements:

(1) Has held an active license for at least two years within the five-year period immediately preceding any supervision as either:

(A) A licensed professional clinical counselor, licensed marriage and family therapist, psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900), licensed clinical social worker, licensed educational psychologist, or equivalent out-of-state license.

(B) A physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology or an out-of-state licensed physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology.

(2) For at least two years within the five-year period immediately preceding any supervision, has practiced psychotherapy, provided psychological counseling pursuant to subdivision (e) of Section 4989.14, or provided direct clinical supervision of psychotherapy performed by associate clinical social workers, associate marriage and family therapists or trainees, or associate professional clinical counselors. Supervision of psychotherapy performed by a social work intern or a professional clinical counselor trainee shall be accepted if the supervision provided is substantially equivalent to the supervision required for registrants.

(3) Has received training in supervision as specified in this chapter and by regulation.

(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.

(*l*) “Research” means a systematic effort to collect, analyze, and interpret quantitative and qualitative data that describes how social characteristics, behavior, emotion, cognitions, disabilities, mental disorders, and interpersonal transactions among individuals and organizations interact.

(m) “Supervision” means responsibility for, and control of, the quality of mental health and related services provided by the supervisee. Consultation or peer discussion shall not be considered supervision and shall not qualify as supervised experience. Supervision includes, but is not limited to, all of the following:

(1) Ensuring the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the supervisee.

(2) Monitoring and evaluating the supervisee’s assessment, diagnosis, and treatment decisions and providing regular feedback.

(3) Monitoring and evaluating the supervisee’s ability to provide services at the site or sites where the supervisee is practicing and to the particular clientele being served.

(4) Monitoring and addressing clinical dynamics, including, but not limited to, countertransference-, intrapsychic-, interpersonal-, or trauma-related issues that may affect the supervisory or the practitioner-patient relationship.

(5) Ensuring the supervisee’s compliance with laws and regulations governing the practice of licensed professional clinical counseling.

(6) Reviewing the supervisee’s progress notes, process notes, and other patient treatment records, as deemed appropriate by the supervisor.

(7) With the client’s written consent, providing direct observation or review of audio or video recordings of the supervisee’s counseling or therapy, as deemed appropriate by the supervisor.

(n) “Clinical setting” means any setting that meets both of the following requirements:

(1) Lawfully and regularly provides mental health counseling or psychotherapy.

(2) Provides oversight to ensure that the associate’s work meets the experience and supervision requirements set forth in this chapter and in regulation and is within the scope of practice of the profession.

(o) “Community mental health setting,” means a clinical setting that meets all of the following requirements:

(1) Lawfully and regularly provides mental health counseling or psychotherapy.

(2) Clients routinely receive psychopharmacological interventions in conjunction with psychotherapy, counseling, or other psycho-social interventions.

(3) Clients receive coordinated care that includes the collaboration of mental health providers.

(4) Is not a private practice.

SEC. 9. Section 4999.46 of the Business and Professions Code is amended to read:

4999.46. (a) Except as provided in subdivision (b), all applicants shall have an active associate registration with the board in order to gain postdegree hours of supervised experience.

(b) (1) Preregistered postdegree hours of experience shall be credited toward licensure if all of the following apply:

(A) The registration applicant applies for the associate registration and the board receives the application within 90 days of the granting of the qualifying master’s degree or doctoral degree.

(B) For applicants completing graduate study on or after January 1, 2020, the experience is obtained at a workplace that, prior to the registration applicant gaining supervised experience hours, requires completed Live Scan fingerprinting. The applicant shall provide the board with a copy of that completed State of California “Request for Live Scan Service” form with ~~his or her~~ *their* application for licensure.

(C) The board subsequently grants the associate registration.

(2) The applicant shall not be employed or volunteer in a private practice until ~~he or she has~~ *they have* been issued an associate registration by the board.

(c) Supervised experience that is obtained for the purposes of qualifying for licensure shall be related to the practice of professional clinical counseling and comply with the following:

(1) A minimum of 3,000 postdegree hours performed over a period of not less than two years (104 weeks).

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,750 hours of direct clinical counseling with individuals, groups, couples, or families using a variety of

psychotherapeutic techniques and recognized counseling interventions.

(4) Not less than 150 hours of clinical experience in a hospital or community mental health setting, as defined in Section 4999.12.

(5) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to professional clinical counseling that have been approved by the applicant's supervisor.

(6) A maximum of 1,200 hours gained under the supervision of a licensed educational psychologist.

(d) An individual who submits an application for licensure between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements of this section that were in place on January 1, 2015.

(e) Experience hours shall not have been gained more than six years prior to the date the application for licensure was received by the board.

~~SEC. 8.~~

SEC. 10. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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Board of Behavioral Sciences

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)

RECOMMENDED POSITION: NONE

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) Support and Opposition.

Support:

- Association of California Healthcare Districts
- Anti-Recidivism Coalition
- Bay Area Community Services
- California Association of Local Behavioral Health Boards & Commissions
- California Association of Social Rehabilitation Agencies
- California Behavioral Health Planning Council (CBHPC)
- California Coalition for Mental Health
- California State Association of Counties
- Community Mental Health Certificate Program at City College of San Francisco
- County of Santa Clara
- County of Ventura
- Disability Rights California
- Mental Health America of California
- Mental Health Association of San Francisco
- Pacific Clinics
- Project Return Peer Support Network

Oppose:

None at this time.

8) History.

2019

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.

9) 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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PEER CERTIFICATION:

CHAIRPERSON
Cindy Clafin

EXECUTIVE OFFICER
Jane Adcock

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 you[2]"

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

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[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]

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[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 investment[6].

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]

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[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 respites 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 MHSA 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.

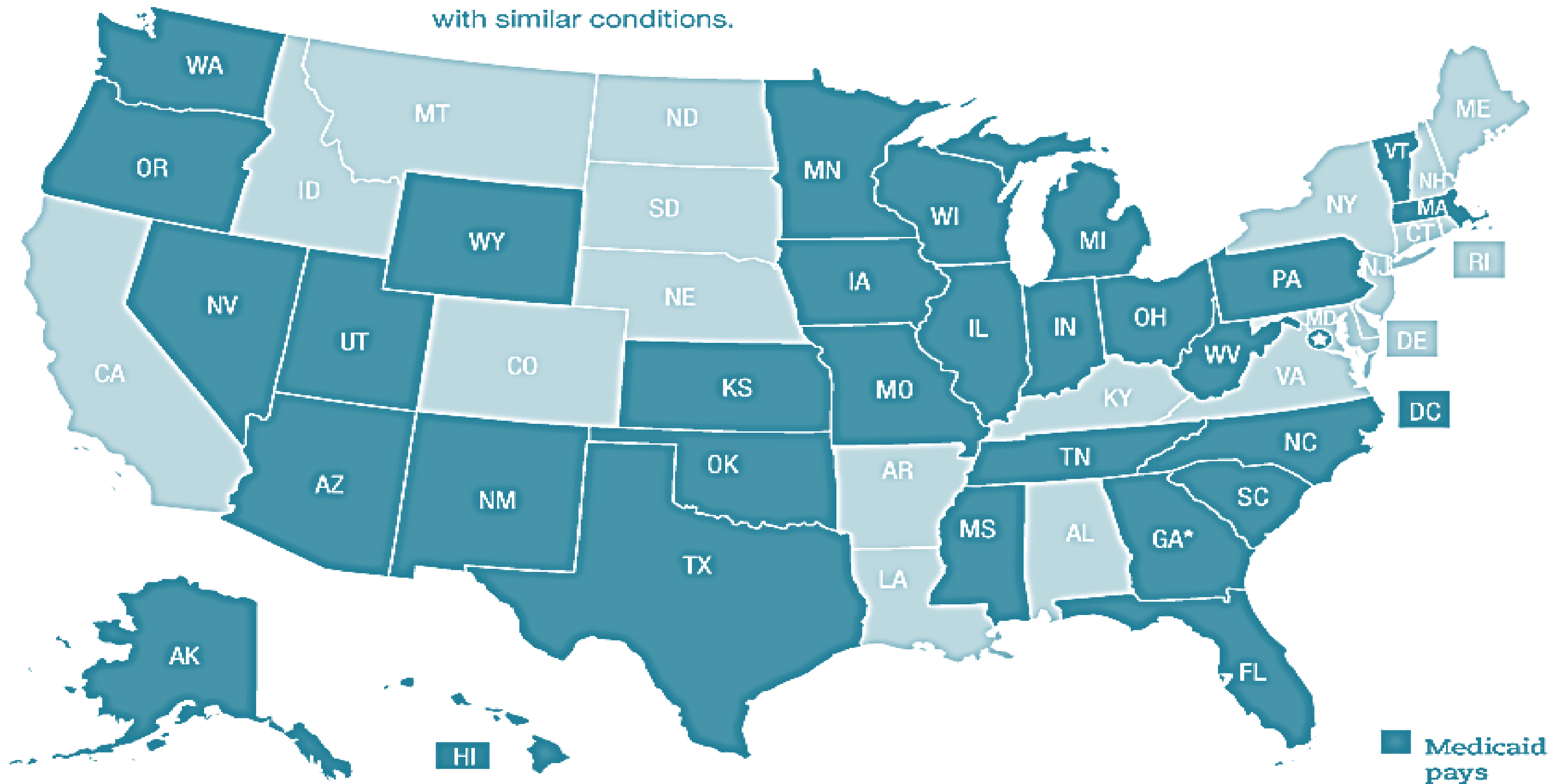
The CMHPC has been following and supporting the efforts of Inspired at Work, California Association of Mental Health Peer Run Organizations (CAMHPRO), United Advocates for Children and Families (UACF), National Alliance on Mental Illness (NAMI) and the former Working Well Together Group to bring this 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,

STATELINE **INFOGRAPHIC**

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

http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/09/11/peers-seen-easing-mental-health-worker-shortage#map

2013

Final Report: Recommendations from the Statewide Summit on Certification of Peer Providers

Working Well Together

Training and Technical Assistance Center

Report prepared for CAMHPRO-PEERS
under Working Well Together
by Inspired at Work
Lucinda Dei Rossi, MPA, CPRP and
Debra Brasher, MS, CPRP

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DRAFT

ACKNOWLEDGEMENTS

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

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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

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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.

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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.

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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.

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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.

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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

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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.

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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 ⅔ 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

adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(g) "Department" means the State Department of Health Care Services.

(h) "Family peer support specialist" means a person with lived experience as a self-identified family member of an individual experiencing mental illness, substance use disorder, or both, and the skills learned in formal training to assist and empower families of individuals experiencing mental illness, substance use disorder, or both. For the purpose of this subdivision, "family member" includes a sibling or kinship caregiver, and a partner of that family member.

(i) "Parent" means a person who is parenting or has parented a child or individual experiencing mental illness, substance use disorder, or both, and who can articulate ~~his or her~~ *the parent's* understanding of ~~his or her~~ *their* experience with another parent or caregiver. This person may be a birth parent, adoptive parent, or family member standing in for an absent parent.

(j) "Parent peer support specialist" means a parent with formal training to assist and empower families parenting a child or individual experiencing mental illness, substance use disorder, or both.

(k) "Peer support specialist services" means 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. Peer support specialist services shall include, but are not limited to, support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified adult peer support specialist, a certified transition-age youth peer support specialist, a certified family peer support specialist, or a certified parent peer support specialist.

(*l*) "Recovery" means a process of change through which an individual improves ~~his or her~~ *their* health and wellness, lives a self-directed life, and strives to reach ~~his or her~~ *their* full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based 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 (OSHPD), 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.*

(b) The department may seek any federal waivers or other state plan amendments as necessary to implement the certification program provided for under this article.

14045.23. The department may utilize Mental Health Services Act moneys to fund state administrative costs related to developing and administering this article, subject to an express appropriation in the annual Budget Act for these purposes, and to the extent authorized under the Mental Health Services Act. These funds shall be available for purposes of claiming federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. ~~1396),~~ *1396 et seq.),* contingent upon federal approval.

14045.24. Medi-Cal reimbursement for peer support specialist services shall be implemented only if, and to the extent that, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

14045.25. The department may establish a certification fee schedule and may require remittance as contained in the certification fee schedule for the purpose of supporting the activities associated with the ongoing administration of the peer, parent, transition-age, and family support specialist certification program. Certification fees charged by the department shall reasonably reflect the expenditures directly applicable to the ongoing administration of the peer, parent, transition-age, and family support specialist certification program.

14045.26. For the purpose of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance.

14045.27. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of informal notices, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. The department shall adopt regulations by July 1, 2022, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. 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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BBS
Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 163 **VERSION:** INTRODUCED JANUARY 24, 2019

AUTHOR: PORTANTINO **SPONSOR:** DIR/ FLOORTIME COALITION OF CALIFORNIA

RECOMMENDED POSITION: NONE

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.

<u>This Bill:</u>

1) Modifies the definition of "behavioral health treatment." The new definition specifies that it means professional services and treatment programs <u>*based on behavioral, developmental, behavior-based, or other evidence-based models,*</u> including applied behavior analysis and <u>*other*</u> 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. The amendments provide a definition of what qualifies as evidence-based practice, specifying that it is an approach to treatment using the best available evidence, matched to consumer circumstances and preferences, rather than a specific treatment. (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, Statues 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.

Support and Opposition.

Support

DIR/Floortime Coalition of California (sponsor)

Oppose

None at this time.

History

2019

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.

Attachments

Attachment A: Definitions in 17 CCR §54342 *(Partial: only includes pages with relevant definitions)*

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ATTACHMENT A

THOMSON REUTERS
WESTLAW California Code of Regulations

§ 54342. Types of Services.
17 CA ADC § 54342
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
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) Sterotypical 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 transportating 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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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 introduced, 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
12 does not require any benefits to be provided that exceed the
13 essential health benefits that all health plans will be required by

1 federal regulations to provide under Section 1302(b) of the federal
2 Patient Protection and Affordable Care Act (Public Law 111-148),
3 as amended by the federal Health Care and Education
4 Reconciliation Act of 2010 (Public Law 111-152).
5 (3) This section shall not affect services for which an individual
6 is eligible pursuant to Division 4.5 (commencing with Section
7 4500) of the Welfare and Institutions Code or Title 14
8 (commencing with Section 95000) of the Government Code.
9 (4) This section shall not affect or reduce any obligation to
10 provide services under an individualized education program, as
11 defined in Section 56032 of the Education Code, or an individual
12 service plan, as described in Section 5600.4 of the Welfare and
13 Institutions Code, or under the federal Individuals with Disabilities
14 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
15 regulations.
16 (b) Every health care service plan subject to this section shall
17 maintain an adequate network that includes qualified autism service
18 providers who supervise or employ qualified autism service
19 professionals or paraprofessionals who provide and administer
20 behavioral health treatment. A health care service plan is not
21 prevented from selectively contracting with providers within these
22 requirements.
23 (c) For the purposes of this section, the following definitions
24 shall apply:
25 (1) "Behavioral health treatment" means professional services
26 and treatment ~~programs,~~ *programs based on behavioral,*
27 *developmental, behavior-based, or other evidence-based models,*
28 including applied behavior analysis and *other* evidence-based
29 behavior intervention programs, that develop or restore, to the
30 maximum extent practicable, the functioning of an individual with
31 pervasive developmental disorder or autism and that meet all of
32 the following criteria:
33 (A) The treatment is prescribed by a physician and surgeon
34 licensed pursuant to Chapter 5 (commencing with Section 2000)
35 of, or is developed by a psychologist licensed pursuant to Chapter
36 6.6 (commencing with Section 2900) of, Division 2 of the Business
37 and Professions Code.
38 (B) The treatment is provided under a treatment plan prescribed
39 by a qualified autism service provider and is administered by one
40 of the following:

(i) A qualified autism service provider.

(ii) A qualified autism service professional supervised by the qualified autism service provider.

(iii) 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 that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

(i) Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

(ii) Designs an intervention plan that includes the service type, number of hours, and parent ~~participation~~ *participation, when clinically appropriate,* needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported. *When clinically appropriate, the plan shall include parent or caregiver participation that is individualized to the patient and that takes into account the ability of the parent or caregiver to participate in therapy sessions and other recommended activities.*

(iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism. *"Evidence-based practice" means a decisionmaking process that integrates the best available scientifically rigorous research, clinical expertise, and individuals' characteristics. Evidence-based practice is an approach to treatment rather than a specific treatment. Evidence-based practice promotes the collection, interpretation, integration, and continuous evaluation of valued, important, and applicable individual- or family-reported, clinically observed, and research-supported evidence. The best available evidence, matched to consumer circumstances and preferences, is applied to ensure the quality of clinical judgment and facilitate the most cost-effective care.*

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite~~, day care,~~ *daycare,* or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 1374.72.

(3) "Qualified autism service provider" means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying ~~Agencies,~~ *Agencies or the American National Standards Institute,* and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider. *However, the services shall be consistent with the experience, training, or education of the professional.*

(B) Is supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

~~(D) Is a behavioral service provider who meets~~

(D) Is a behavioral service provider who meets one of the following criteria:

(i) Meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an ~~Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant,~~ *associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant,* or ~~Behavior Management Program.~~ *behavior management program.*

(ii) Possesses a bachelor of arts or science degree and meets one of the following qualifications:

(I) One year of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider and 12 semester units from an accredited institution of higher learning in either applied behavioral analysis or clinical coursework in behavioral health.

(II) Two years of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider.

~~(E) Has training and experience in providing services for pervasive developmental disorder~~

(III) The person is a registered psychological assistant or ~~autism~~ *registered psychologist* pursuant to ~~Division 4.5~~ *Chapter 6.6* (commencing with Section ~~4500)~~ *2900)* of ~~the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~ *Division 2 of the Business and Professions Code. A registered psychological assistant or registered psychologist may not supervise a qualified autism service paraprofessional until the registered psychological assistant or registered psychologist has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.*

(IV) The person is an associate clinical social worker registered with the Board of Behavioral Sciences pursuant to Section 4996.18 of the Business and Professions Code. An associate clinical social worker may not supervise a qualified autism service paraprofessional until the associate clinical social worker has obtained at least 500 hours of experience in designing or implementing behavioral health treatment.

1 *(V) The person is a registered associate marriage and family*
2 *therapist with the Board of Behavioral Sciences pursuant to Section*
3 *4980.44 of the Business and Professions Code. A registered*
4 *associate marriage and family therapist may not supervise a*
5 *qualified autism service paraprofessional until the registered*
6 *associate marriage and family therapist has obtained at least 500*
7 *hours of experience in designing or implementing behavioral health*
8 *treatment.*
9 *(VI) The person is a registered associate professional clinical*
10 *counselor with the Board of Behavioral Sciences pursuant to*
11 *Section 4999.42 of the Business and Professions Code. A registered*
12 *associate professional clinical counselor may not supervise a*
13 *qualified autism service paraprofessional until the registered*
14 *associate professional clinical counselor has obtained at least 500*
15 *hours of experience in designing or implementing behavioral health*
16 *treatment.*
17 *(VII) The person is credentialed or certified by a national entity,*
18 *including, but not limited to, the Behavior Analyst Certification*
19 *Board, which is accredited by the National Commission for*
20 *Certifying Agencies or the American National Standards Institute*
21 *to provide applied behavior analysis or behavioral health*
22 *treatment, which may include case management and case*
23 *supervision under the direction and supervision of a qualified*
24 *autism service provider.*
25 *(E) Has training and experience in providing services for*
26 *pervasive developmental disorder or autism.*
27 (F) Is employed by the qualified autism service provider or an
28 entity or group that employs qualified autism service providers
29 responsible for the autism treatment plan.
30 *(G) Has completed a background check performed by a*
31 *Department of Justice approved agency, with subsequent*
32 *notification to the person's employer pursuant to Section 11105.2*
33 *of the Penal Code.*
34 (5) "Qualified autism service paraprofessional" means an
35 ~~unlicensed and uncertified~~ individual who meets all of the
36 following criteria:
37 (A) Is supervised by a qualified autism service provider or
38 qualified autism service professional at a level of clinical
39 supervision that meets professionally recognized standards of
40 practice.

1 (B) Provides treatment and implements services pursuant to a
2 treatment plan developed and approved by the qualified autism
3 service provider.
4 ~~(C) Meets~~
5 *(C) Meets one of the following:*
6 *(i) For applied behavioral analysis,* the education and training
7 qualifications described in Section 54342 of Title 17 of the
8 California Code of Regulations.
9 *(ii) For other evidence-based behavioral health treatments, all*
10 *of the following qualifications:*
11 *(I) Possesses an associate's degree or has completed two years*
12 *of study from an accredited college or university with coursework*
13 *in a related field of study.*
14 *(II) Has 40 hours of training in the specific form of behavioral*
15 *health treatment developed by a qualified autism service provider*
16 *and administered by a qualified autism service provider or*
17 *qualified autism service professional competent in the form of*
18 *behavioral health treatment to be practiced by the*
19 *paraprofessional.*
20 *(III) Has adequate education, training, and experience, as*
21 *certified by a qualified autism service provider.*
22 *(iii) Is credentialed or certified in applied behavior analysis or*
23 *behavioral health treatment for paraprofessionals or technicians*
24 *by a national entity that is accredited by the National Commission*
25 *for Certifying Agencies or the American National Standards*
26 *Institute.*
27 *However, upon successful completion of the training and*
28 *education necessary for certification or a credential described in*
29 *this clause, if the applicant is otherwise qualified under this section,*
30 *the applicant may provide treatment and implement services for*
31 *up to 180 days while in the process of obtaining the certification*
32 *or credential.*
33 (D) Has adequate education, training, and experience, as
34 certified by a qualified autism service provider or an entity or
35 group that employs qualified autism service providers.
36 (E) Is employed by the qualified autism service provider or an
37 entity or group that employs qualified autism service providers
38 responsible for the autism treatment plan.
39 *(F) Has completed a background check performed by a*
40 *Department of Justice approved agency, with subsequent*

notification to the person's employer pursuant to Section 11105.2 of the Penal Code.

(d) This section shall not apply to ~~the following:~~ *a specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.*

~~(1) A specialized health care service plan that does not deliver mental health or behavioral health services to enrollees.~~

~~(2) A health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).~~

(e) This section does not limit the obligation to provide services under Section 1374.72.

(f) As provided in Section 1374.72 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) (1) The setting, location, or time of treatment recommended by the qualified autism service provider shall not be used as the only reason to deny or reduce coverage for medically necessary services. The setting shall be consistent with the standard of care for behavioral health treatment. This subdivision does not require a health care service plan to provide reimbursement for services delivered by school personnel pursuant to an enrollee's individualized educational program for the purpose of accessing educational services, unless otherwise required or permitted by federal and state law. This subdivision does not require a health care service plan to cover services rendered outside of the plan's service area unless the services are urgently needed services, as described in subdivision (h) of Section 1345, or emergency services, as defined in Section 1317.1, or unless the benefit plan expressly covers out-of-area services.

(2) Parent or caregiver participation may be associated with greater improvements in functioning and should be encouraged. However, the lack of parent or caregiver participation shall not be used as a basis for denying or reducing coverage of medically necessary services.

SEC. 2. Section 10144.51 of the Insurance Code, as amended by Chapter 385 of the Statutes of 2017, is amended to read:

10144.51. (a) (1) Every health insurance policy shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 10144.5.

(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(3) This section shall not affect services for which an individual is eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individual service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing regulations.

(b) Pursuant to Article 6 (commencing with Section 2240) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, every health insurer subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise or employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A health insurer is not prevented from selectively contracting with providers within these requirements.

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

(1) "Behavioral health treatment" means professional services and treatment ~~programs,~~ *programs based on behavioral, developmental, behavior-based, or other evidence-based practice models,* including applied behavior analysis and *other* evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an

1 individual with pervasive developmental disorder or autism, and
2 that meet all of the following criteria:
3 (A) The treatment is prescribed by a physician and surgeon
4 licensed pursuant to Chapter 5 (commencing with Section 2000)
5 of, or is developed by a psychologist licensed pursuant to Chapter
6 6.6 (commencing with Section 2900) of, Division 2 of the Business
7 and Professions Code.
8 (B) The treatment is provided under a treatment plan prescribed
9 by a qualified autism service provider and is administered by one
10 of the following:
11 (i) A qualified autism service provider.
12 (ii) A qualified autism service professional supervised by the
13 qualified autism service provider.
14 (iii) A qualified autism service paraprofessional supervised by
15 a qualified autism service provider or qualified autism service
16 professional.
17 (C) The treatment plan has measurable goals over a specific
18 timeline that is developed and approved by the qualified autism
19 service provider for the specific patient being treated. The treatment
20 plan shall be reviewed no less than once every six months by the
21 qualified autism service provider and modified whenever
22 appropriate, and shall be consistent with Section 4686.2 of the
23 Welfare and Institutions Code pursuant to which the qualified
24 autism service provider does all of the following:
25 (i) Describes the patient's behavioral health impairments or
26 developmental challenges that are to be treated.
27 (ii) Designs an intervention plan that includes the service type,
28 number of hours, and parent ~~participation~~ *participation, when*
29 *clinically appropriate,* needed to achieve the plan's goal and
30 objectives, and the frequency at which the patient's progress is
31 evaluated and reported. *When clinically appropriate, the plan shall*
32 *include parent or caregiver participation that is individualized to*
33 *the patient and that takes into account the ability of the parent or*
34 *caregiver to participate in therapy sessions and other*
35 *recommended activities.*
36 (iii) Provides intervention plans that utilize evidence-based
37 practices, with demonstrated clinical efficacy in treating pervasive
38 developmental disorder or autism. *"Evidence-based practice"*
39 *means a decisionmaking process that integrates the best available*
40 *scientifically rigorous research, clinical expertise, and individuals'*

characteristics. Evidence-based practice is an approach to treatment rather than a specific treatment. Evidence-based practice promotes the collection, interpretation, integration, and continuous evaluation of valued, important, and applicable individual- or family-reported, clinically observed, and research-supported evidence. The best available evidence, matched to consumer circumstances and preferences, is applied to ensure the quality of clinical judgment and facilitate the most cost-effective care.

(iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The treatment plan is not used for purposes of providing or for the reimbursement of respite~~, day care,~~ *daycare,* or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the insurer upon request.

(2) "Pervasive developmental disorder or autism" shall have the same meaning and interpretation as used in Section 10144.5.

(3) "Qualified autism service provider" means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying ~~Agencies,~~ *Agencies or the American National Standards Institute,* and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

(4) "Qualified autism service professional" means an individual who meets all of the following criteria:

(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider. *However, the services shall be consistent with the experience, training, or education of the professional.*

(B) Is supervised by a qualified autism service provider.

(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.

~~(D) Is a behavioral service provider who meets~~

(D) Is a behavioral service provider who meets one of the following criteria:

(i) Meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an ~~Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant,~~ *associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant,* or ~~Behavior Management Program.~~ *behavior management program.*

(ii) Possesses a bachelor of arts or science degree and meets one of the following qualifications:

(I) One year of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider and 12 semester units from an accredited institution of higher learning in either applied behavioral analysis or clinical coursework in behavioral health.

(II) Two years of experience in designing or implementing behavioral health treatment supervised by a qualified autism service provider.

~~(E) Has training and experience in providing services for pervasive developmental disorder~~

(III) The person is a registered psychological assistant or ~~autism~~ *registered psychologist* pursuant to ~~Division 4.5~~ *Chapter 6.6* (commencing with Section ~~4500)~~ *2900)* of ~~the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~ *Division 2 of the Business and Professions Code. A registered psychological assistant or registered psychologist may not supervise a qualified autism service paraprofessional until the registered psychological assistant or registered psychologist has obtained at least 500 hours*

1 *of experience in designing or implementing behavioral health*
2 *treatment.*
3 *(IV) The person is an associate clinical social worker registered*
4 *with the Board of Behavioral Sciences pursuant to Section 4996.18*
5 *of the Business and Professions Code. An associate clinical social*
6 *worker may not supervise a qualified autism service*
7 *paraprofessional until the associate clinical social worker has*
8 *obtained at least 500 hours of experience in designing or*
9 *implementing behavioral health treatment.*
10 *(V) The person is a registered associate marriage and family*
11 *therapist with the Board of Behavioral Sciences pursuant to Section*
12 *4980.44 of the Business and Professions Code. A registered*
13 *associate marriage and family therapist may not supervise a*
14 *qualified autism service paraprofessional until the registered*
15 *associate marriage and family therapist has obtained at least 500*
16 *hours of experience in designing or implementing behavioral health*
17 *treatment.*
18 *(VI) The person is a registered associate professional clinical*
19 *counselor with the Board of Behavioral Sciences pursuant to*
20 *Section 4999.42 of the Business and Professions Code. A registered*
21 *associate professional clinical counselor may not supervise a*
22 *qualified autism service paraprofessional until the registered*
23 *associate professional clinical counselor has obtained at least 500*
24 *hours of experience in designing or implementing behavioral health*
25 *treatment.*
26 *(VII) The person is credentialed or certified by a national entity,*
27 *including, but not limited to, the Behavior Analyst Certification*
28 *Board, which is accredited by the National Commission for*
29 *Certifying Agencies or the American National Standards Institute*
30 *to provide applied behavior analysis or behavioral health*
31 *treatment, which may include case management and case*
32 *supervision under the direction and supervision of a qualified*
33 *autism service provider.*
34 *(E) Has training and experience in providing services for*
35 *pervasive developmental disorder or autism.*
36 (F) Is employed by the qualified autism service provider or an
37 entity or group that employs qualified autism service providers
38 responsible for the autism treatment plan.
39 *(G) Has completed a background check performed by a*
40 *Department of Justice approved agency, with subsequent*

notification to the person's employer pursuant to Section 11105.2 of the Penal Code.

(5) "Qualified autism service paraprofessional" means an ~~unlicensed and uncertified~~ individual who meets all of the following criteria:

(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 implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.

~~(C) Meets~~

(C) Meets one of the following:

(i) For applied behavioral analysis, the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.

(ii) For other evidence-based behavioral health treatments, all of the following qualifications:

(I) Possesses an associate's degree or has completed two years of study from an accredited college or university with coursework in a related field of study.

(II) Has 40 hours of training in the specific form of behavioral health treatment developed by a qualified autism service provider and administered by a qualified autism service provider or qualified autism service professional competent in the form of behavioral health treatment to be practiced by the paraprofessional.

(III) Has adequate education, training, and experience, as certified by a qualified autism service provider.

(iii) Is 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.

However, upon successful completion of the training and education necessary for certification or a credential described in this clause, if the applicant is otherwise qualified under this section, the applicant may provide treatment and implement services for

up to 180 days while in the process of obtaining the certification or credential.

(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.

(F) Has completed a background check performed by a Department of Justice approved agency, with subsequent notification to the person's employer pursuant to Section 11105.2 of the Penal Code.

(d) This section shall not apply to ~~the following:~~ *a specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.*

~~(1) A specialized health insurance policy that does not cover mental health or behavioral health services or an accident only, specified disease, hospital indemnity, or Medicare supplement policy.~~

~~(2) A health insurance policy in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).~~

(e) This section does not limit the obligation to provide services under Section 10144.5.

(f) As provided in Section 10144.5 and in paragraph (1) of subdivision (a), in the provision of benefits required by this section, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

(g) (1) The setting, location, or time of treatment recommended by the qualified autism service provider shall not be used as the only reason to deny or reduce coverage for medically necessary services. The setting shall be consistent with the standard of care for behavioral health treatment. This subdivision does not require a health insurer to provide reimbursement for services delivered by school personnel pursuant to an enrollee's individualized educational program for the purpose of accessing educational services, unless otherwise required or permitted by federal and state law. This subdivision does not require a health insurer to

cover services rendered outside of the health insurer's service area unless the services are urgently needed services to prevent serious deterioration of a covered person's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the covered person returns to the insurer's service area, or emergency services, as defined in Section 1317.1 of the Health and Safety Code, or unless the benefit plan expressly covers out-of-area services.

(2) Parent or caregiver participation may be associated with greater improvements in functioning and should be encouraged. However, the lack of parent or caregiver participation shall not be used as a basis for denying or reducing coverage of medically necessary services.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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Board of Behavioral Sciences

California State Board of Behavioral Sciences Bill Analysis

Bill Number:	**SB 425**	**Version:**	**Introduced February 21, 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 and clinics, health care service plans, or other entities that make arrangements for a healing arts licensee to practice in 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. Conviction of a crime in this state or another state;

    b. A judgement or settlement 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, health clinic, an administrator of a health care service plan, or other entity that makes arrangement allowing healing arts licensees to practice in 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 or clinic, health care service plan, 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, plan or applicable 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. (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, 2232.5, 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, the administrator or chief executive officer of a health care service plan, or other entity that makes arrangements for a healing arts licensee to practice in 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 in 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. Unfortunately, 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. Support and Opposition.

Support:
None at this time.

Opposition:
None at this time.

5. History.

2019
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.

6. 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 licentiate 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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SENATE BILL **No. 425**

Introduced by Senator Hill

February 21, 2019

An act to amend Sections 800, 2221, and 2234 of, and to add Sections 805.8 and 2232.5 to, the Business and Profession Code, relating to healing arts.

legislative counsel's digest

SB 425, as introduced, 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

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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, or other entity that makes any arrangement under which a healing arts licensee is allowed to practice in 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, 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, 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, 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, or other entity from incurring civil or criminal liability as a result of making a report.

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.

The bill would authorize the board or its designee, upon receipt of information that the public health, safety, or welfare requires emergency action, to place a physician's and surgeon's certificate on suspension pending formal proceedings and would require the board to inform the licensee of the facts or conduct warranting the suspension. The bill would require the board to post reference to the emergency order of suspension on its internet website. The bill would authorize the holder of the suspended license to request a hearing for an interim suspension order and would specify how the hearing is to be conducted.

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 ~~California Board~~
4 ~~of Podiatric Medicine,~~ *Podiatric Medical Board of California,* the
5 Board of Psychology, the Dental Board of California, the Dental
6 Hygiene Board of California, the Osteopathic Medical Board of
7 California, the State Board of Chiropractic Examiners, the Board
8 of Registered Nursing, the Board of Vocational Nursing and
9 Psychiatric Technicians of the State of California, the State Board
10 of Optometry, the Veterinary Medical Board, the Board of
11 Behavioral Sciences, the Physical Therapy Board of California,
12 the California State Board of Pharmacy, the Speech-Language
13 Pathology and Audiology and Hearing Aid Dispensers Board, the
14 California Board of Occupational Therapy, the Acupuncture Board,
15 and the Physician Assistant Board shall each separately create and
16 maintain a central file of the names of all persons who hold a

1 license, certificate, or similar authority from that board. Each
2 central file shall be created and maintained to provide an individual
3 historical record for each licensee with respect to the following
4 information:
5 (1) Any conviction of a crime in this or any other state that
6 constitutes unprofessional conduct pursuant to the reporting
7 requirements of Section 803.
8 (2) Any judgment or settlement requiring the licensee or ~~his or~~
9 ~~her~~ *the licensee's* insurer to pay any amount of damages in excess
10 of three thousand dollars ($3,000) for any claim that injury or death
11 was proximately caused by the licensee's negligence, error or
12 omission in practice, or by rendering unauthorized professional
13 services, pursuant to the reporting requirements of Section 801 or
14 802.
15 (3) Any public complaints for which provision is made pursuant
16 to subdivision (b).
17 (4) Disciplinary information reported pursuant to Section 805,
18 including any additional exculpatory or explanatory statements
19 submitted by the licentiate pursuant to subdivision (f) of Section
20 805. If a court finds, in a final judgment, that the peer review
21 resulting in the 805 report was conducted in bad faith and the
22 licensee who is the subject of the report notifies the board of that
23 finding, the board shall include that finding in the central file. For
24 purposes of this paragraph, "peer review" has the same meaning
25 as defined in Section 805.
26 (5) Information reported pursuant to Section 805.01, including
27 any explanatory or exculpatory information submitted by the
28 licensee pursuant to subdivision (b) of that section.
29 (b) (1) Each board shall prescribe and promulgate forms on
30 which members of the public and other licensees or certificate
31 holders may file written complaints to the board alleging any act
32 of misconduct in, or connected with, the performance of
33 professional services by the licensee.
34 (2) If a board, or division thereof, a committee, or a panel has
35 failed to act upon a complaint or report within five years, or has
36 found that the complaint or report is without merit, the central file
37 shall be purged of information relating to the complaint or report.
38 (3) Notwithstanding this subdivision, the Board of Psychology,
39 the Board of Behavioral Sciences, and the Respiratory Care Board

of California shall maintain complaints or reports as long as each board deems necessary.

(c) (1) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or ~~his or her~~ *the licensee's* counsel or representative~~, shall have the right to~~ *may* inspect and have copies made of ~~his or her~~ *the licensee's* complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may 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. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

(2) The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

(3) Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

(4) These disclosures shall effect no change in the confidential status of these records.

SEC. 2. Section 805.8 is added to the Business and Professions Code, to read:

805.8. (a) As used in this section, the following terms shall have the following meanings:

(1) "Agency" means the relevant state licensing agency with regulatory jurisdiction over a healing arts licensee listed in paragraph (3).

1 (2) “Health care service plan” means a health care service plan
2 licensed under Chapter 2.2 (commencing with Section 1340) of
3 Division 2 of the Health and Safety Code.
4 (3) “Healing arts licensee” or “licensee” means a licensee
5 licensed under Division 2 (commencing with Section 500) or any
6 initiative act referred to in that division. “Healing arts licensee”
7 or “licensee” also includes a person authorized to practice medicine
8 pursuant to Sections 2064.5, 2113, and 2168.
9 (4) “Other entity” includes, but is not limited to, a postsecondary
10 educational institution as defined in Section 66261.5 of the
11 Education Code.
12 (b) A health facility or clinic, the administrator or chief
13 executive officer of a health care service plan, or other entity that
14 makes any arrangement under which a healing arts licensee is
15 allowed to practice in or provide care for patients shall file a report
16 of any allegation of sexual abuse or sexual misconduct made
17 against a healing arts licensee to the agency within 15 days of
18 receiving the allegation of sexual abuse or sexual misconduct. An
19 arrangement under which a licensee is allowed to practice in or
20 provide care for patients includes, but is not limited to, full staff
21 privileges, active staff privileges, limited staff privileges, auxiliary
22 staff privileges, provisional staff privileges, temporary staff
23 privileges, courtesy staff privileges, locum tenens arrangements,
24 and contractual arrangements to provide professional services,
25 including, but not limited to, arrangements to provide outpatient
26 services.
27 (c) An employee or a healing arts licensee that works in any
28 health facility or clinic, health care service plan, or other entity
29 that subdivision (b) applies to who has knowledge of any allegation
30 of sexual abuse or sexual misconduct by a healing arts licensee
31 shall file a report with the agency that has regulatory jurisdiction
32 over the healing arts licensee and the administration of the health
33 facility or clinic, health care service plan, or other entity within
34 15 days of knowing about the allegation of sexual abuse or sexual
35 misconduct.
36 (d) A willful failure to file the report described in subdivision
37 (b) shall be punishable by a fine not to exceed one hundred
38 thousand dollars ($100,000) per violation. The fine may be imposed
39 in any civil or administrative action or proceeding brought by or
40 on behalf of any agency having regulatory jurisdiction over the

1 licensee regarding whom the report was or should have been filed.
2 If the person who is designated or otherwise required to file the
3 report under this section is a licensed physician and surgeon, the
4 action or proceeding shall be brought by the Medical Board of
5 California. If the person who is designated or otherwise required
6 to file the report required under this section is a licensed doctor of
7 podiatric medicine, the action or proceeding shall be brought by
8 the Podiatric Medical Board of California. The fine shall be paid
9 to that agency, but not expended until appropriated by the
10 Legislature. A violation of this subdivision may constitute
11 unprofessional conduct by the licensee. A person who is alleged
12 to have violated this subdivision may assert any defense available
13 at law. As used in this subdivision, "willful" means a voluntary
14 and intentional violation of a known legal duty.
15 (e) Except as provided in subdivision (d), any failure to file the
16 report described in subdivision (b) shall be punishable by a fine
17 not to exceed fifty thousand dollars ($50,000) per violation. The
18 fine may be imposed in any civil or administrative action or
19 proceeding brought by or on behalf of any agency having
20 regulatory jurisdiction over the person regarding whom the report
21 was or should have been filed. If the person who is designated or
22 otherwise required to file the report required under this section is
23 a licensed physician and surgeon, the action or proceeding shall
24 be brought by the Medical Board of California. If the person who
25 is designated or otherwise required to file the report required under
26 this section is a licensed doctor of podiatric medicine, the action
27 or proceeding shall be brought by the Podiatric Medical Board of
28 California. The fine shall be paid to that agency, but not expended
29 until appropriated by the Legislature. The amount of the fine
30 imposed, not exceeding fifty thousand dollars ($50,000) per
31 violation, shall be proportional to the severity of the failure to
32 report and shall differ based upon written findings, including
33 whether the failure to file caused harm to a patient or created a
34 risk to patient safety; whether any person who is designated or
35 otherwise required by law to file the report required under this
36 section exercised due diligence despite the failure to file or whether
37 the person knew or should have known that a report required under
38 this section would not be filed; and whether there has been a prior
39 failure to file a report required under this section. The amount of
40 the fine imposed may also differ based on whether a health care

facility or clinic is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(f) 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, or other entity shall not incur any civil or criminal liability as a result of making a report required by this section.

(g) The agency shall investigate the circumstances underlying a report received pursuant to this section.

SEC. 3. Section 2221 of the Business and Professions Code is amended to read:

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

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

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

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

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

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

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

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

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

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

(d) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of ~~his or her~~ *their* application, except that the ~~board may,~~ *board,* in its discretion and for good cause demonstrated, *may* permit reapplication after not less than one year has elapsed from the effective date of the denial.

(e) The board shall disclose a probationary physician's and surgeon's certificate issued pursuant to this section and the operative statement of issues to an inquiring member of the public and shall post the certificate and statement on the board's internet website for 10 years from issuance.

SEC. 4. Section 2232.5 is added to the Business and Professions Code, to read:

2232.5. (a) Notwithstanding any other law, the board or its designee, upon receipt of information that the public health, safety, or welfare requires emergency action, may place a physician's and surgeon's certificate on suspension pending formal proceedings in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code). An emergency order of suspension shall be issued to the licensee informing the licensee of the facts or conduct warranting the emergency suspension, pending an investigation. A reference to the emergency order of suspension shall be posted on the board's internet website.

(b) Upon placement of the physician's and surgeon's certificate on emergency suspension pursuant to this section, the holder of the certificate may request a hearing for an interim suspension order, which shall be held within 180 days of the certificate holder's request. The hearing shall be conducted in accordance with Section 11529 of the Government Code.

SEC. 5. Section 2234 of the Business and Professions Code is amended to read:

2234. The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other

provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

~~(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.~~

~~(h)~~

(g) The ~~repeated~~ failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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Board of Behavioral Sciences

CALIFORNIA STATE BOARD OF BEHAVIORAL SCIENCES BILL ANALYSIS

BILL NUMBER: SB 601 **VERSION:** INTRODUCED FEBRUARY 22, 2019

AUTHOR: MORRELL **SPONSOR:** R STREET INSTITUTE

RECOMMENDED POSITION: NONE

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 displacement by a declared emergency.

Existing Law:

1. Defines three types of 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 by a declared emergency. (GC §11009.5)

2. Requires this to be done within one year of the declared emergency and requires the requestor to demonstrate displacement 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 experience 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 displacement. Alternatively, the Board could choose to leave this decision to be made on a case-by-case basis.

5. **Support and Opposition.**

   Support:
   R Street Institute (Sponsor)

Opposition:
None at this time.

6. **History**

2019

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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SENATE BILL **No. 601**

Introduced by Senator Morrell

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 introduced, 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 by a declared 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:
3 11009.5. (a) Notwithstanding any other law, a state agency
4 that issues any business license may, within one year of the
5 declaration of an emergency as defined in Section 8558, reduce
6 or waive any required fees for licensure, renewal of licensure, or
7 the replacement of a physical license for display if a person or

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1 business establishes to the satisfaction of the state agency that the
2 person or business has been displaced by the declared emergency.
3 (b) For purposes of this section, “license” includes, but is not
4 limited to, a certificate, registration, or other required document
5 to engage in business.

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Board of Behavioral Sciences

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: **NONE**

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:

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) Support and Opposition.

Support:
California Faculty Association (Sponsor)

Opposition:
None at this time.

5) History.

2019

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.

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SENATE BILL No. 660

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

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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.

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BBS
Board of Behavioral Sciences

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

Memo

To: Board Members **Date:** March 28, 2019

From: Rosanne Helms
Legislative Analyst **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.

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.

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.

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Memo

To: Policy and Advocacy Committee **Date:** March 28, 2019

From: Christy Berger
Regulatory Analyst **Telephone:** (916) 574-7817

Subject: Status of Board Rulemaking Proposals

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 began the DCA initial review process in July 2017. This regulation package is currently on hold due to the passage of AB 2138.

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 and began the DCA initial review process in April 2018 and was approved for filing with OAL on January 11, 2019. The approved documents were filed with OAL in order to begin the 45-day public comment period, which begins on February 22, 2019. The regulation hearing will be held on April 8, 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.

The proposal was approved by the Board at its meeting in November 2016 and was held aside while awaiting passage of the Board's supervision legislation (AB 93). Staff is currently preparing the documents necessary to begin the DCA initial review process.

Registrant Employment – Temporary Staffing Agencies

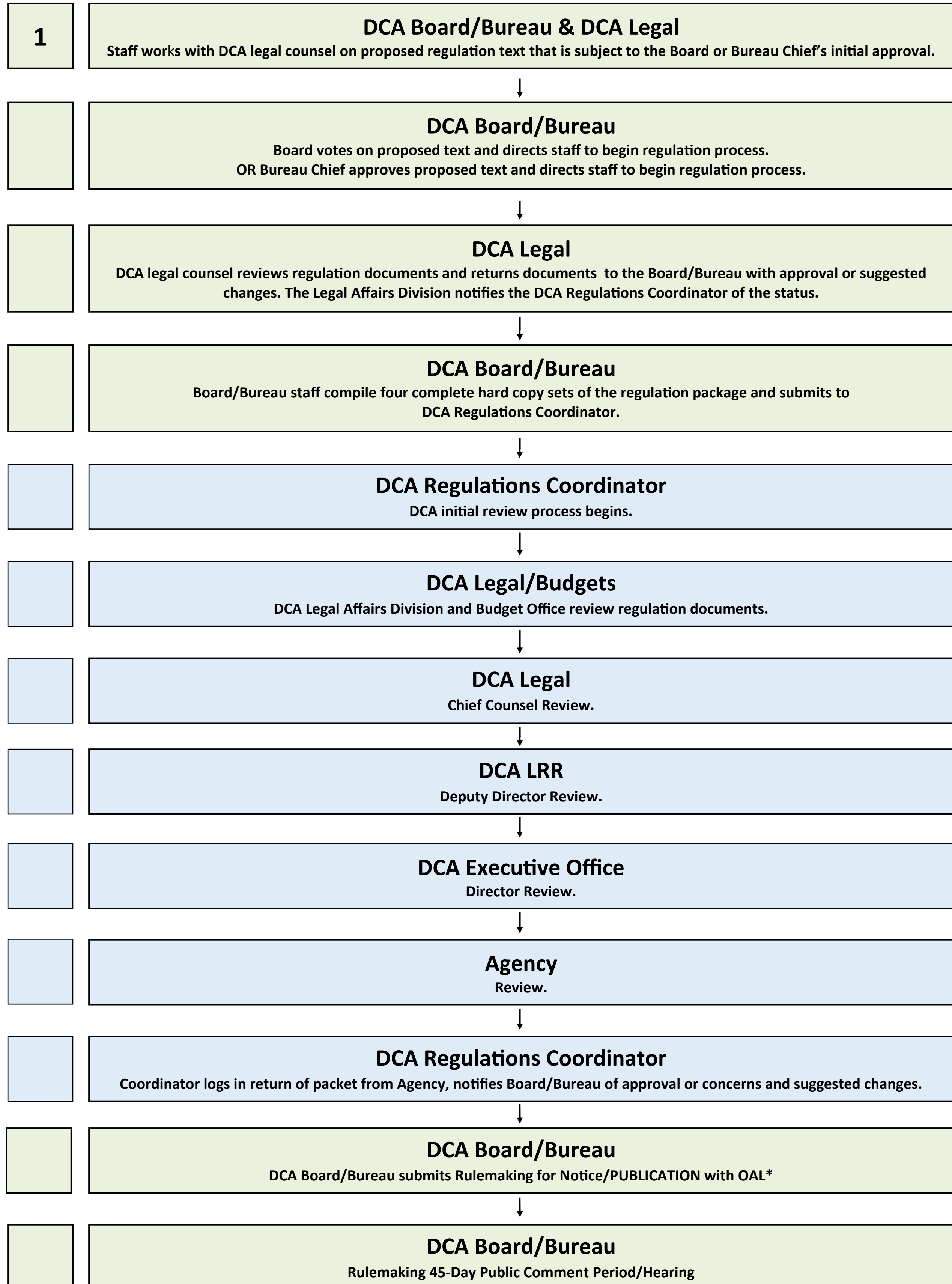
At its November 2018 meeting, the Board approved a proposal that will address registrant employment by temporary staffing agencies. This language will be added into the "Supervision" regulation package listed above.

Attachments

Attachment A: DCA Regulation Process
Attachment B: BBS Regulation Timeline

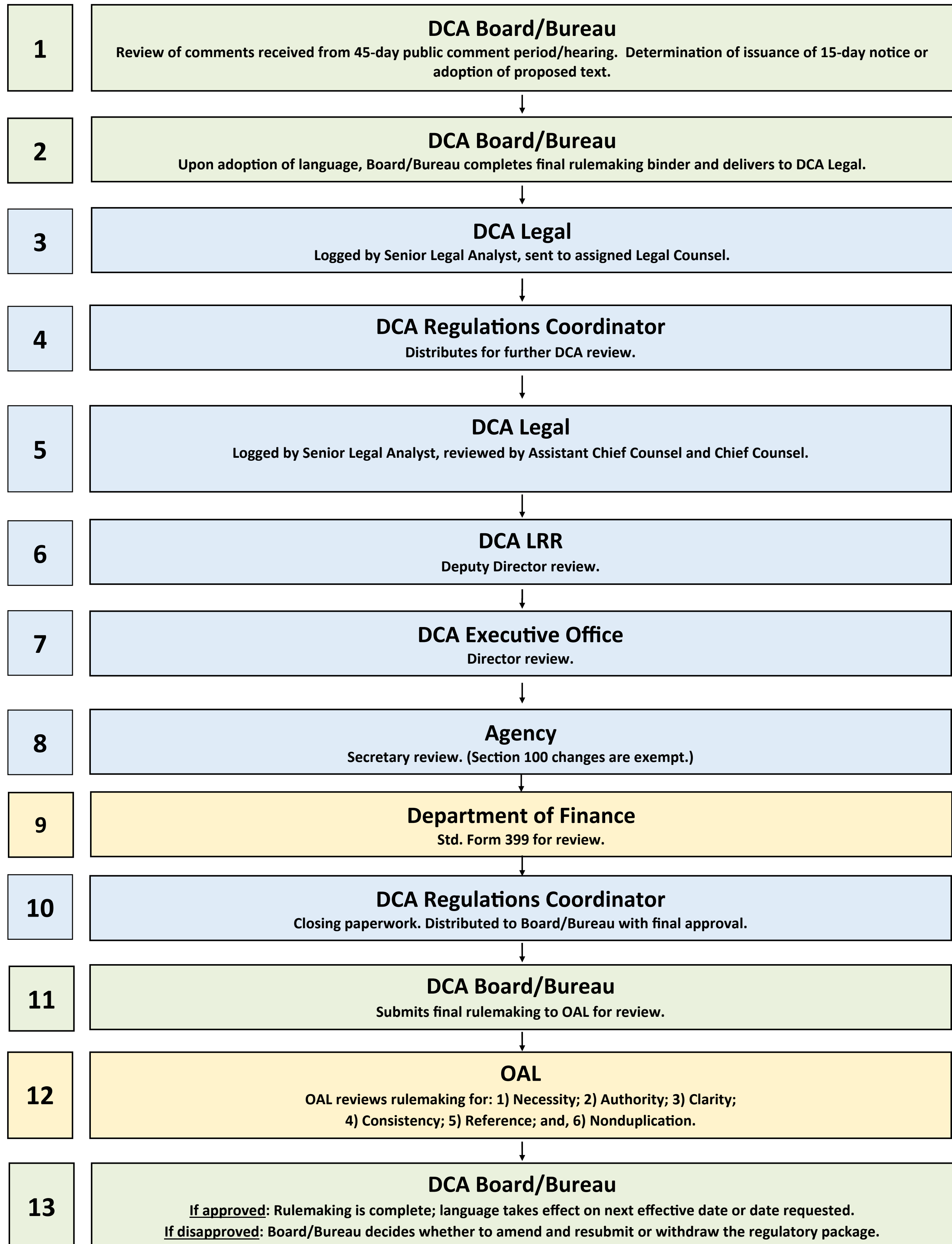
ATTACHMENT A

REGULAR RULEMAKING PROCESS—DCA BOARDS/BUREAUS



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** **MARCH 19, 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
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	To be noticed on 2/22/19	4/8/19				
Supervision	11/4/16**								

*This package is on hold due to the passage of AB 2138

**This regulation package was held pending passage of AB 93 and is in the process of being prepared for initial review.

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.