



# MEMORANDUM

<b>DATE</b>	April 23, 2026
<b>TO</b>	Board Members
<b>FROM</b>	Terri Thorfinnson, J.D. Legislative and Regulatory Specialist
<b>RE:</b>	Agenda Item 17-Discussion and Possible Action on Pending Legislation

## Recommendations for Possible Positions for 2026 Legislation

### AB 1703 (Hart) Title Protection: Osteopath

**Summary:** This bill is a title protection bill that restricts the usage for the title “Osteopath” to licensed Osteopathic Physicians and Surgeons. The bill adds Osteopathic Manipulation Treatment” (OMT) to the scope of practice for licensed physicians and surgeons.

**Discussion:** The purpose of this bill is to clarify that the title “Osteopath” can only be used by a licensed physician and surgeon. It also adds Osteopathic Manipulation Treatment (OMT) to the scope of practice section for licensed physicians and surgeons. This bill is sponsored by the Osteopathic Physicians and Surgeons of California (OPSC). Several years ago, there was a failed attempt for a mega title protection bill that added a list of titles recognized by the American Medical Association (AMA) whose intent was to codify existing titles to clarify for consumers what title is legitimate and requires licensed professionals to wear that title on their name badge while treating patients to remove confusion. While that bill ultimately failed, before it failed the title “Osteopath” was removed from the list of titles to be protected in statute. Attempts to restore the title failed as well.

The problem this bill is trying to solve is to close the loophole in the use of the title Osteopath from being used by unlicensed foreign trained osteopaths who do not have sufficient training to be licensed as an osteopathic physician and surgeon. Current statutory language is vague about the title Osteopath precisely because it does not exist in the statute. Historically, the title “Osteopath” has been used by American Osteopathic Association (AOA), Osteopathic Physicians and Surgeons of California (OPSC) and the Osteopathic Medical Board of California (OMBC) interchangeably to refer to licensed Osteopathic Physicians and Surgeons. This bill clarifies and protects that title in statute to

be continued to be used to refer to licensed Osteopathic Physicians and Surgeons exclusively.

Additionally, by adding Osteopathic Manipulation Treatment (OMT) to the scope of practice for licensed physicians and surgeons, it clarifies that only licensed physicians and surgeons can perform OMT. Yes, M.D.s are authorized to perform OMT, and some do; so, it is an appropriate addition to the scope of practice for physicians and surgeons.

Historically, the Board has instructed foreign trained Osteopaths that they lack the required training to become licensed and as a result cannot use the title “Osteopath.” However, it has come to the Board’s attention through the years that foreign trained Osteopaths are using the title “Osteopaths” in advertising their services in California. The main public safety concern is that foreign trained Osteopaths misrepresent their skills to consumers and lack licensure and perform Osteopathic Manipulation Treatment (OMT) on their patients. The U.S. is the only country in the world that trains Osteopaths in allopathic clinical medicine and comprehensive osteopathic skills. Additionally, there is no standardized osteopathic training or standards throughout the world, which causes significant variation in the skills among foreign trained osteopaths. For this reason, only U.S. trained osteopaths are eligible for licensure in California and the United States.

Existing law prohibits the performance of OMT by an unlicensed physician and surgeon, but the law does not mention the use of the title “Osteopath.” This bill protects public safety and prevents misrepresentation of skills, competence, and licensure for an osteopath. This bill will provide the board with the enforcement authority needed to bring enforcement actions against advertising, misrepresentation and unlicensed activity.

It is worth noting that the statute has a general provision that allows unlicensed health practitioners to notify their patients that they are not licensed and provide wellness care. However, these foreign trained Osteopaths are not using or complying with this provision to the detriment of their patients and the public.

**Recommendation: Support.**

### **SB 1002 ( Niello) License Exemption: Out of State Physicians: Non- Life Threatening Condition**

**Summary:** SB 1002, as introduced, Niello. Out-of-state physicians and surgeons: telehealth: license exemption.

Existing law generally prohibits the practice of medicine without a physician's and surgeon's certificate issued by the board. Existing law authorizes a health care provider to deliver health care via telehealth to a patient pursuant to specified protocols and conditions. Existing law defines "telehealth" as the delivery of health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care, and that telehealth includes synchronous interactions and asynchronous store and forward transfers.

Existing law authorizes an eligible out-of-state physician and surgeon, as defined, to deliver health care via telehealth to an eligible patient. Existing law defines "eligible patient" as a person who, among other requirements, has a **life-threatening disease or condition**, as defined, and has not been accepted to participate in the clinical trial nearest to their home for the immediately life-threatening disease or condition, as specified, or in the medical judgment of a physician and surgeon, as defined, it is unreasonable for the patient to participate in that clinical trial due to the patient's current condition and state of disease.

This bill would also include within the definition of "eligible patient" a patient who's **immediately life-threatening disease or condition is in remission**, and the patient is continuing care with the previously established eligible out-of-state physician and surgeon, and would provide that those patients are not subject to the clinical trial requirement, as specified.

**Discussion:** This bill is similar to a bill last year SB 508 that tried to expand the out of state telemedicine licensure exemption to create an exemption for patients in remission from life threatening conditions, which the Board opposed. That bill did not advance and received concerns by Legislative committee staff about the slippery slope of expanding the license exemption for out of state physicians for non- life-threatening conditions and treatment. The original exemption was created narrowly only in cases of life-threatening conditions or disease, which is not true for this proposal. This bill is a second attempt to expand the licensure exemption to patients with non-life-threatening conditions that are in remission. There is no policy justification for this expansion. This exemption begs the practical question why the patient doesn't move to the state in which their preferred physician is licensed to continue to receive care or why a California physician care is not adequate?

Policy wise, the Board opposes licensure exemptions and in particular license exemptions for telemedicine and out of state physicians that are not otherwise licensed in California treating California patients. This bill poses a significant risk of harm to public safety. This exemption removes the Board’s jurisdiction to protect California patients seeking care through this exemption leaving patients without any enforcement or legal remedy against the out of state unlicensed physician. In fact, this licensure exemption means that there is no oversight of this exemption for compliance and eligibility—none. This exemption creates a huge loophole in licensure that is totally unregulated. Patients harmed under this provision have no legal recourse in California nor in the state in which the physician is licensed because they are not a resident of the state. Their limbo status places them in peril if there is harm. For this reason, this proposed license exemption policy is irresponsible and a risk to public safety.

**Recommendation: Oppose.**

#### **AB 2398 ( Alvarez) Alternative Pathway for Residency Training for M.D.s & D.O.s**

**Summary:** This bill has two major parts: Part I related to the Mexico Pilot Program under the Medical Board of California; Part II proposes an alternative pathway to residency and licensure for graduates of U.S. medical schools and for M.D.s graduates of international medical schools who are not able to get into U.S. residency programs. The first part does not apply to OMBC licensure since all foreign trained osteopaths are ineligible for licensure. The Mexico Pilot Program only applies to M.D.s who are graduates of Mexican medical schools and participate in the pilot program. Part II does apply to OMBC.

**Discussion:** This bill proposes to create an alternative pathway to residency for graduate of U.S. medical schools and international medical schools. The proposed pathway consists of supervision by any licensed physician in California. There is no proposed curriculum that would even attempt to mirror the comprehensive topics and skills taught in residency training. Nor does it require any accreditation requirement or otherwise curriculum—simply supervision by any licensed physician.

This proposal lacks any accreditation requirement or curriculum requirement and rotations, or quality control requirement or variety of training by different specialties such as internal medicine, OBGYN, pediatrics, etc. that occurs as part of standardized residency training. After this unaccredited, supervised training by a single physician, the applicant would be eligible for full licensure to go out and practice without the detailed and specific training of accredited residency training. This proposed alternative pathway to residency training is inferior training that would not provide comprehensive training that occurs in residency training and as such would be a risk to public safety.

Additionally, the board would take on the verification of training and, although not specified, the evaluation and monitoring of the supervised training to ensure quality control, competency and the fact there is training going on. These trainees would eventually be licensed to join their peers but would lack the vast majority of the training and skills of their peers who finished accredited residency training.

The role of residency training is both hands on training for physicians, but from a public safety perspective, it is also the competency evaluation that cannot be left to an exam alone. The 3 levels of competency exams in addition to the residency training is the mechanism to ensure all physicians and surgeons have the same training, the same competence and are in fact deemed competent to practice medicine safely. This alternative residency falls short of residency training and competency evaluation—the exact role of residency training. Additionally, without accreditation or required curriculum, there is no standardization of training nor quality control assurance that training is competently performed and that the competence of the trainee can be relied upon for public safety reasons.

This alternative pathway creates a patchwork of pre-licensure training that is different for foreign trained physicians than their U.S. trained counterparts, which raises competency and public safety concerns with this proposal.

The drive behind all of these alternative residency pathway proposals is in part the changes at the federal level to the J1 visa program which now charges \$100,000 for such visas, putting them out of range for most applicants and Federally Qualified Health Centers (FQHCs). The other driver is the shortage of physicians and the desire of foreign trained physicians wanting to become licensed in the U.S... It is counterintuitive to solve the physician shortage issue by lowering the standards for foreign trained physicians to train and qualify for licensure. The more practical solution is to expand medical school capacity and residency program slots for U.S. trained physicians which is a more reliable source of competent trained physicians than opening the flood gates to foreign trained physicians to meet the physician needs of California's health care system. The less obvious driver is cost—it is cheaper to create these alternative training and licensure pathways than to expand existing accredited medical and residency training in the U.S. The choice of creating an alternative residency pathway training that is more affordable, less rigorous medical training is one that ignores the quality and competency concerns that it invites. This is a poor policy choice to swap accredited, U.S. trained medical training for less rigorous unknown foreign trained physicians that will have public safety ramifications for patients who may suffer the harm from care.

From a public safety perspective, the current quality controls in physician training are completion of medical education from accredited medical schools and accredited residency training in addition to passage of all three levels of national examinations. Exams alone are not sufficient to evaluate competency—competency evaluation relies on accredited medical school and residency training evaluations of competency. Removing the key evaluation component of physician competency is reckless and ignores the quality controls that existing laws and accredited training provide to protect public safety. This proposal amounts to a short cut to solving a physician shortage without effective guardrails that ensure competency and protect patient safety.

While the bill lacks any detail about the type of evaluation that occurs in accredited residency training, it is assumed that part of the board’s responsibility in verifying eligibility for licensure would be to approve the supervised training agreement, monitor and evaluate such alternative pathway in order to ensure competence. The board relies on accredited residency training and accreditation organizations to evaluate all accredited residency. The Board is not an expert in accreditation nor competency evaluation. This bill does not meet the licensure requirements for accredited training. For this reason, the board is including the fiscal estimate for supervised training curriculum, monitoring and evaluating the alternative pathway, drafting regulations that detail the requirements, creating a separate application, renewal application and multiple renewal processes and license verification requirements. The Board would need to create monitoring reports to be able to verify training and subject completion.

The accredited residency training is the gold standard for competency-based training and evaluation. This bill would function as a loophole for those not wanting to or able to be accepted into residency programs. At the very least, alternative pathway supervisors should be part of an accredited residency training program, so the trainees have the benefits of accredited residency training. Accreditation ensures that trainers are qualified to train and residents have multiple rotations in different specialties and practice. While some clinics have multiple provider types, clinic-based training lacks hospital training. Unlike clinics, physician offices typically lack a variety of provider types and are not accredited, so this proposed alternative would not be equipped for providing equivalent residency training. Without any required curriculum, there would be huge variation between physician office training and even some clinic-based training. This bill has no other supervisor qualification other than being licensed—that is not enough to ensure the training is effective and results in competency of the trainee.

The more logical solution is to fund more medical schools and residency slots and to develop competency-based evaluation that utilizes a combination of examinations and residency experience and evaluation of residency practice. Competency based evaluation

has remained elusive to national exam regulators and accredited residency training. The concept of competency-based evaluation would create examinations and practice evaluation that would determine one's competency regardless of the time spent in training. If such competency evaluation were created, it would replace the time completion requirement in statutes today with the competency-based evaluation as a criteria for licensure. But, no agency or organization has successfully been able to create a competency-based training model and test it for effectiveness and quality control because doing so is difficult. National regulators have abandoned creation of such a model and now have to contend with short cuts such as this and other bills, which is a policy move that will guarantee more risk to patients in the health care system. This is a bad policy proposal for public safety.

Overall, this is not the right model for an alternative pathway to residency. And, it would be costly for the Board to implement and pose a risk to public safety.

**Recommendation: Oppose.**

#### **AB 2575 (Ortega) A.I. in Health Care**

**Summary:** This bill requires users of A.I. to disclose a list of information about how A.I. was created and trained. The bill also prohibits employers from retaliating or discriminating against workers who override the A.I. using their judgment. Additionally, a violation of this proposed law is deemed a violation of unfair competition provision of BPC 17200. This bill gives OMBC and MBC jurisdiction to enforce these statutory provisions

The list of disclosures is added to Health and Safety Code section 1339.76. which requires:

- (a) A health facility, clinic, physician's office, or office of a group practice that uses or deploys a covered tool for patient care shall disclose required information, described in subdivision (b), to any licensed health care professional or other person using a covered tool or viewing outputs from a covered tool.
- (b) Required information under subdivision (a) shall include all of the following:
  - (1) Details on the covered tool, including developer, funding source, any foundation model used, and description of output.
  - (2) Intended use of the covered tool, including intended patient population, intended users, and intended decisionmaking role.
  - (3) Cautioned out-of-scope use of the covered tool, including known risks and limitations.
  - (4) List of the inputs into the covered tool.
  - (5) Description of how the covered tool generates outputs.

- (6) Development details of the covered tool, including, but not limited to, all of the following:
- (A) Description of the training set or clinical research underlying recommendations, including demographic representativeness and known biases based on protected characteristics.
  - (B) Description of the relevance of training data to deployed setting.
  - (C) Process used to ensure fairness in development of the intervention.
- (7) Description of the validation process.
- (8) Qualitative measures of performance.
- (9) Description of ongoing maintenance of intervention implementation and use.
- (10) Description of updates and continued validation or fairness assessment process.
- (11) Notice that health care entities and developers are liable for harm that results from the use of artificial intelligence in patient care.
- (12) Notice that a worker providing direct patient care is permitted to override the output of a covered tool if, in the judgment of the worker acting in their scope of practice, such an override is appropriate for the patient, or as necessary to comply with applicable law, including civil rights law.
- (c) (1) A disclosure made pursuant to this section shall be provided at the time the licensed health care professional or other person uses the covered tool or views any recommendation or output generated by the covered tool.
- (2) The disclosure shall be provided in plain language to, and linked in the health record of, any patient whose care was affected by the output of the covered tool or whose health information was used as an input to the covered tool.
- (3) The disclosure shall be provided with ample time for the licensed health care professional or other person to review and make reasoned decisions based on their professional judgment on whether and how to use the covered tool.
- (d) (1) A violation of this section by a licensed health facility is subject to the enforcement mechanisms described in Article 4 (commencing with Section 1290) of Chapter 2.
- (2) A violation of this section by a licensed clinic is subject to the enforcement mechanisms described in Article 4 (commencing with Section 1235) of Chapter 1.
- (3) A violation of this section by a physician is subject to the jurisdiction of the Medical Board of California or the Osteopathic Medical Board of California, as appropriate.
- (4) A violation of this section constitutes “unfair competition” as defined in Section 17200 of the Business and Professions Code and is punishable as prescribed in Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code.
- (e) For purposes of this section, the following definitions shall apply:
- (1) “Artificial intelligence” means an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.

- (2) “Clinic” has the same meaning as defined in Section 1200.
  - (3) “Clinical decision support system” means a computerized system or tool that does both of the following:
    - (A) Supports decision-making related to patient care based on algorithms, or models, based in clinical practice guidelines or that derive relationships from training data, including such algorithms or models that are developed using unsupervised learning models.
    - (B) Produces an output that results in a prediction, classification, recommendation, evaluation, or analysis.
  - (4) “Covered tool” means artificial intelligence or a clinical decision support system.
  - (5) “Health facility” has the same meaning as defined in Section 1250.
  - (6) “Office of a group practice” has the same meaning as defined in Section 1339.75.
  - (7) “Patient clinical information” has the same meaning as defined in Section 1339.75.
  - (8) “Physician’s office” has the same meaning as defined in Section 1339.75.
- SEC. 3.

[Assembly Health Committee Analysis 4.3.2026](#)

[Assembly Labor and Employment Committee Analysis 4.7.2026](#)

**Discussion:** The purpose of this bill is to provide meaningful regulation and protections for patients from their health provider using A.I. to provide their care. There is little overall regulation of the use of A.I. in health care beyond general disclosure that it is being used. This bill builds on disclosure by adding more meaningful information in the disclosure for patients and providers to understand whether they want to use or trust A.I. use in the provision of their care. The specificity of this list of information gets to the heart of A.I. training, bias, and potential errors in A.I.

The bill also provides provisions in the alternative to protect health providers who want to override A.I. and use their professional judgment. This is a valid concern that this bill addresses.

Overall, this is a good, proposed policy to regulate the use of A.I. in health care—protecting patients and providers.

**Recommendation: Support.**

### **SB 903 (Padilla) AI consent: Mental Health Professionals**

**Summary:** This bill would regulate the use of artificial intelligence by licensed professionals providing psychotherapy services, as defined. The bill, among other things,

would prohibit an individual, corporation, or entity from using artificial intelligence to record or transcribe psychotherapeutic communications or sessions or to triage or screen a person for the need for psychotherapy services unless the patient or their authorized representative is informed that artificial intelligence will be used and provides consent, as specified. The bill would prohibit a licensed professional from allowing artificial intelligence to perform certain acts, including making independent therapeutic decisions or detecting emotions or mental states. The bill would make a violation of the bill's provisions subject to the jurisdiction of the appropriate health care professional licensing board or enforcement agency, as specified, and would authorize those boards and enforcement entities to pursue any remedies authorized by law.

This bill would require the use of artificial intelligence in psychotherapy records to comply with the confidentiality requirements of the above-described provision of the Confidentiality of Medical Information Act. An individual, corporation, or entity shall not use artificial intelligence to record or transcribe psychotherapeutic communications, psychotherapy sessions, or triage or screening unless the patient or patient representative consents. The bill provides that a patient does not surrender any of their rights to care if the patient or their legally authorized representative does not provide consent to the use of artificial intelligence. The appropriate health care professional licensing board may pursue an injunction or restraining order to enforce the provisions of this chapter, as authorized by Section 125.5.

**Discussion:** This bill provides more specific oversight of how A.I. can be used in behavioral health services by better defining patient consent, definition of what constitutes counseling and then restricting A.I. use in those defined counseling services. The bill defines and carves out what is defined as non-therapeutic counseling to include religious and peer counseling and self-help materials available to the public as not regulated by this bill. The bill allows for use of A.I. in administrative support but not therapeutic services.

Telemedicine counseling during COVID accelerated the use of telemedicine counseling by licensed professionals. However, telemedicine companies are not honoring patient voluntary consent for the usage of A.I. and designing A.I. tools that involve patient interaction. Telemedicine companies are popping up all over the country and California offering convenience to both providers and patients but not implementing ethical and legal constraints to ensure patients and providers are protected. Counseling services is an area that is using unregulated A.I., which poses risks for both patients and providers. This bill provides essential guardrails for A.I. that provide meaningful protection to both patients and providers.

One area the bill does not however reach is individual use of A.I. as a substitute for licensed counseling services. Such use has increased and has resulted in some users committing suicide. Consumers are increasingly turning to A.I. for the widespread benefits it offers from research, writing, companionship and even counseling. In this instance, the A.I. is software not imposed on the consumer but rather the consumer willingly pays a subscription fee for its usage. The consumer usage and resulting harm is the subject of numerous lawsuits that the software does effectively restrict bots from advising clients on self-harm or harm to others or even plots to create public harm. What is being litigated in these lawsuits is the inadequacy of A.I. training that protects people from harm and software company liability.

Overall, the bill provides much needed common-sense regulation of the usage of A.I. in behavioral health care services.

**Recommendation: Support.**

#### **AB 2164 (Bauer-Kahan) Reproductive Health Protection: Prohibits extradition**

**Summary:** Existing law, the Reproductive Privacy Act, declares it is contrary to the public policy of this state for a law of another state that authorizes a person to bring a civil action against a person or entity that engages in certain activities relating to obtaining or performing an abortion. Existing law prohibits the state from applying an out-of-state law to a case or controversy in state court or enforcing or satisfying a civil judgment under the out-of-state law.

This bill would specify that the protections applicable to persons who engage in legally protected health care activity, as defined, apply to a person who previously has undertaken one or more acts or omissions while in another United States jurisdiction to aid or encourage, or attempt to aid or encourage, any person in the exercise and enjoyment, or attempted exercise and enjoyment, of rights to reproductive health care services or gender affirming health care services that would have been protected if undertaken in this state and the acts or omissions were permissible under the laws of the jurisdiction in which the person was located at the time of the acts or omissions.

Existing law prohibits a state or local law enforcement agency or officer from knowingly arresting or knowingly participating in the arrest of any person for performing, supporting, or aiding in the performance of legally protected health care activity, if the health care activity is lawful in this state. Existing law prohibits a state or local public agency from cooperating with or providing information to an individual or agency from another state or a federal law enforcement agency, as specified, regarding a legally

protected health care activity that is lawful in this state. Under existing law, the Governor may surrender, on demand of executive authority of any other state, any person in this state charged in the other state, as specified, with committing an act in this state, or in a 3rd state, intentionally resulting in a crime in the state whose executive authority is making the demand.

This bill would authorize the Governor to extradite any person in this state and who is charged in another state only if the acts for which extradition is sought would be punishable by the laws of this state if the consequences claimed to have resulted therefrom in the demanding state had taken effect in this state. The bill would prohibit the Governor from recognizing a request for extradition of a person subject to criminal liability based on the alleged provision or receipt of, assistance in the provision or receipt of, material support for, or in any theory of vicarious, joint, several, or conspiracy liability for any legally protected health care activity, except as specified.

**Discussion:** This bill is protecting health care providers and patients from hostile criminal prosecution or civil actions by other states that criminalize reproductive health care or make it subject to civil actions by individuals. This bill is needed to ensure both physicians and patients remain free from hostile legal action from other states regarding reproductive health care that is legal in California but illegal in other states. The board has supported such legislation in the past. In this hostile political climate, California remains a sanctuary for physicians and their patients for reproductive health care, so this bill is necessary to continue to protect physicians and patients.

**Recommendation: Support.**

**Menopause Trailer Bill Language, 2026-27 Governor's Budget-- version Published February 2, 2026.**

[Governor Newsom's Press Release Announcement](#) -- Published February 2, 2026

**Summary:** This is a budget trailer bill, which means that it is a bill that implements the approved budget. This bill is similar to AB 432 (Bauer-Kahan) Menopause CME and insurance coverage for menopause treatments. Unlike the bill that was vetoed, this bill does not mandate CMEs but does retain the concept of offering double the hourly credit for training. The bill requires insurance to cover treatments and evaluate each year what FDA approved treatment options exist with notification to providers about those treatments. This provision would become effective July 1, 2027.

The bill also requires health insurers to provide coverage for medically necessary evaluations and treatments for perimenopause and menopause, as specified. This

coverage is subject to health plan utilization review to determine necessity based on current FDA approved treatments. Such treatments could include hormone replacement therapy, low-dose anti-depressants, anticonvulsants, medications to prevent or treat osteoporosis, nonhormonal medications for vasomotor-related symptoms, and bioidentical hormones. Insurers are required to create a program to ensure insured women have access to current menopause information and covered items and services. Insurers must also provide contracted primary care and OB/GYN providers with information about current clinical care recommendations for menopause care. The bill also has similar language medically necessary, and FDA approved treatments pertaining to Medi-Cal fee for service. The bill references both FDA approved treatments and “generally accepted standards of menopause care,” which is defined as:

*“Generally accepted standards of menopause care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties including, but not limited to, gynecology, endocrinology, and family practice. Valid, evidence-based sources establishing generally accepted standards of menopause care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.”*

### **Medical Practice Act vs Osteopathic Act Provisions**

The bill has a separate provision for M.D.s than D.O.s like the original bill. The bill references Title 16 section 1635 and creates BPC section 2454.7:

*“Beginning July 1, 2027, an osteopathic physician and surgeon who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care shall receive two hours of credit for each hour completed of that coursework, for a total earned credit that does not exceed eight course hours, toward the requirement set forth in Section 1635 of Title 16 of the California Code of Regulations.”*

The language for M.D.s is narrower and would be more complex to implement. In comparison, there is no such restriction on who is eligible to receive credit for such training. Once again, the legislature is creating different CME standards for M.D.s and D.O.s and creating separate statutory sections within both the Medical Practice Act and the Osteopathic Act. By creating a separate section in the Osteopathic Act, it overrides the provisions of the Medical Practice Act that apply to Osteopathic Physicians; thus, resulting in a patch work of CME requirements. In this case, the separate language will be easier to implement for OMBC, but in general, CME requirements should be the same for both boards and be contained in the CME article 10 of the Medical Practice Act.

One of the differences in language that causes vagueness for D.O.s is that in the M.D. version there is an age requirement of 65 years and under. Initially, I thought the age language was a mistake until you realize that this bill does not apply to women age 65 and older who are generally covered by Medicare. The insurance sections cite age 40 years and over for coverage so women 65 and older covered by employer-based insurance not Medicare would be covered. Which could imply that in implementing this OMBC could utilize the 40 years and older standard for defining patients or could simply allow anyone who wants to take the training to receive the credit. This will be an issue for drafting our regulations to implement this bill.

### **Coverage Exemptions**

The bill specifically exempts Medi-Cal Managed Care and Medicare supplemental health care service plan contracts and only applies to specialize health care service plants to the extent they provide coverage for the treatment of symptoms resulting from menopause. With this exemption, the provision would only apply to Medi-Cal fee for service which is a small percentage of Medi-Cal coverage—most Medi-Cal is Managed Care.

**Discussion:** The board supported AB 432 when it required mandatory CME. Now that it is not mandatory, it will be easier for the board to implement. It also incentivizes physicians to take courses in menopause by awarding double credit for each hour of training. The bill mirrors the prior vetoed bill that sets out two separate requirements for M.D.s and D.O.s by placing the requirements for M.D.s in the Medical Practice Act and the requirement for D.O.s in the Osteopathic Act, which the Board supported last year.

In terms of coverage and access to this new treatment, this would apply to employer-based health insurance and Medi-Cal fee for services but does not apply to Medi-Cal Managed Care that covers the majority of Medi-Cal patients. The bill does not apply to Medicare, likely because that is a federal program whose benefits are determined by Congress and the Federal Administration.

Overall, the bill is a good policy despite the bifurcation of CME standards. It provides that health insurers set up a program, utilization review, and notification of providers. The medically necessary determination is meant to screen out unapproved treatments, but it could also function as a treatment authorization request depending on how it is implemented.

**Recommendation: Support.**

**AB 2256 (Chen) Radiology Assistant Act: No Regulatory Oversight for Act/Profession**

**Summary:** Existing law, the Radiologic Technology Act, prohibits a person from administering or using diagnostic or therapeutic X-rays on human beings in this state, unless that person either qualifies for a specified exemption or has been certified or granted a permit by the State Department of Public Health, as specified, is acting within the scope of that certification or permit, and is acting under the supervision of a healing arts licensee. A person who violates a provision of the Radiologic Technology Act or regulation of the department adopted pursuant to that act is guilty of a misdemeanor.

This bill would prohibit a person from holding themselves out as a radiologist assistant unless the person meets certain requirements, including that they have passed the radiologist assistant examination, as specified, and that they maintain current registration with prescribed entities. The bill would require a radiologist assistant to work only under the supervision of a radiologist and would prohibit a radiologist assistant from functioning in that capacity independent of a supervising radiologist. The bill, among other things, would authorize a radiologist assistant to communicate and document initial clinical and imaging observations or procedures only to a radiologist for the radiologist's use. The bill would authorize a supervising radiologist to delegate to a radiologist assistant, as the radiologist determines appropriate to the assistant's competence, those tasks or services that a radiologist usually performs and is qualified to perform. The bill would provide that a violation of its provisions does not constitute a misdemeanor.

**Discussion:** The intent of the bill is to create a profession for Radiology Assistants so they are billable. However, this creates a profession that does not have a state regulatory body overseeing it. While the Department of Public Health issues permits based on meeting their qualifications, they are set up for investigating non-compliance but not discipline. It is not clear that the Department of Public Health is set up to receive consumer complaints related to competence or harm. Enforcement jurisdiction that can bring disciplinary actions in response to consumer complaints.

To create a new profession without any regulatory oversight is irresponsible and a risk to public safety. Without a regulatory board overseeing this new profession, consumers are without a remedy for harm and to submit enforcement complaints. It is unclear how currently radiology assistants are being paid because they are performing within California's health care system, so it is unclear the urgency of creating this profession without a regulatory board. The key policy issue for the board is ensuring there is a regulatory board overseeing the profession. If the bill were to be amended to include a regulatory oversight board, it would remove the Board's opposition.

**Recommendation: Oppose or Oppose Unless Amended.**

## SB 849 (Weber-Pierson) Sexual Misconduct

**Summary:** Existing law, the Medical Practice Act, provides for the licensure and regulation of the practice of medicine by the Medical Board of California (MBC) and Osteopathic Medical Board of California (OMBC). The act requires the board to automatically revoke a license under certain circumstances and authorizes the person to petition the board for reinstatement or modification of penalty after a specified period of time. Existing law prohibits the board from reinstating the certificate of a person under specified circumstances relating to the commission of sexual misconduct or sexual offenses.

This bill would require automatic revocation of a person's certificate if the certificate was revoked based on a finding by the board that the person committed one of those specified acts or offenses and the certificate was subsequently reinstated by the board on or after January 1, 2020. The bill would prohibit the person from petitioning the board for reinstatement or renewal of the certificate.

**Discussion:** The Board did not take a position on this bill last year when it was first introduced because it tries to retroactively apply to eligible disciplinary cases which became final after January 1, 2020, but prior to when the new law prohibiting the Board from reinstating certain revocations became effective. OMBC does not have any cases that would be impacted by this bill. However, the bill is written in such a way that OMBC would be potentially subject to litigation over the law. Additionally, there is case law that deems such retroactive action as an interference with the Board's enforcement authority. While the Board generally supports policy to strengthening laws and enforcement involving sexual misconduct; as written this is not good policy nor does it strengthen enforcement related to cases involving sexual misconduct. The bill remains unchanged as of the date of this analysis. It is unclear whether the author intends to amend the bill to close other potential loopholes or not.

The MBC has taken a support if amended position and is proposing amendments to this bill that would strengthen the enforcement for cases involving sexual misconduct that the Board may want to consider supporting if amended in order to further strengthen enforcement involving licensees' sexual misconduct.

The MBC amendments do the following:

- Strengthen existing laws that prevent issuance of a license to an applicant who has committed criminal sexual offenses in or outside California, including for the commission of crimes that have been dismissed or expunged following a conviction.
- Mandate license revocation for a licensee who is found by the Board to have committed any act of sexual misconduct or sexual exploitation with a current or former patient or client.
- Prevent someone from seeking reinstatement if their license was revoked (or surrendered by the licensee while a Board accusation was pending against them) due to any act of sexual misconduct or exploitation with a current or former patient or client.
- Prevent someone from seeking reinstatement if their license was revoked because they were convicted of a crime that required them to register as a sex offender, regardless of their relationship to the victim. Establishes a similar requirement for sexual criminal offenses that occurred outside California.

To accomplish above here are the proposed amendments that starts with removal of the current proposed language of SB 849 and replace it with language to amend the following sections of the Business and Professions Code, as shown below:

**2221.** (c) Notwithstanding any other law, the board shall deny a physician's and surgeon's certificate to an applicant who is *or has ever been* required to register pursuant to Section 290 of the Penal Code *or comparable law outside of California, regardless of a dismissal pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42, or 1203.425 of the Penal Code, or a comparable dismissal or expungement, or who meets the criteria described in subparagraph (C) of paragraph 1, of subdivision (i) of section 2307.* 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.

**2246.** Any proposed decision or decision issued under this article that contains any finding of fact that the licensee violated Section 726 or subdivision (a) of Section 729, engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge.

**2307.** (i) (1) The board shall not reinstate the certificate of a person under any of the following circumstances:

(A) The person's certificate ~~has been~~ *was* surrendered while a board accusation was pending against their license that alleges ~~because~~ the person committed an act of sexual abuse, misconduct, or relations with a patient pursuant to Section 726 or sexual exploitation as defined in subdivision (a) of Section 729.

(B) The person's certificate has been revoked based on a finding by the board that the person committed an act of sexual abuse, misconduct, or relations with a patient pursuant to Section 726 or sexual exploitation as defined in subdivision (a) of Section 729.

(C) The person was convicted in a court in or outside of this state of any offense that, if committed or attempted in this state, based on the elements of the convicted offense, would have been punishable as one or more of the offenses described in subdivision (c) of Section 290 of the Penal Code, ~~and the person engaged in the offense with a patient or client, or with a former patient or client if the relationship was terminated primarily for the purpose of committing the offense.~~

(D) Notwithstanding any other law, the person is or has ever been required to register as a sex offender pursuant to the provisions of Section 290 of the Penal Code or comparable law outside of California, regardless of whether the conviction has been appealed, and regardless of a dismissal pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42, or 1203.425 of the Penal Code, or a comparable dismissal or expungement, ~~and the person engaged in the offense with a patient or client, or with a former patient or client if the relationship was terminated primarily for the purpose of committing the offense.~~

(2) A plea or a verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

(3) 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.

**Recommendation: Support if amended.**

## WATCH LIST BILLS

### AB 2386 (Alvarez) Alternative Pathway to Residency Training: Foreign Trained M.D.s,

**Summary:** This bill proposes an alternative pathway for residency and licensure through the Medical Board of California's (MBC) existing Mexico Pilot Program for Mexican physicians to train and practice in California and expands it to apply to all foreign trained physicians. Existing law establishes within the act the Licensed Physicians from Mexico Program, which authorizes the board to issue a limited number of nonrenewable 3-year physician's and surgeon's licenses to licensed physicians from Mexico who meet specified

criteria. Under current law, participants of the Mexico Pilot Program are required to complete residency and pass all three levels of USMLE examination that this bill proposes to exempt.

This bill would require the board to issue a full and unrestricted physician's and surgeon's license to a person who has completed the 3-year term of the program in good standing upon satisfaction of specified requirements, including having an offer of continued employment from a health care facility or practice in California.

This bill would establish the Provisional License for Qualified International Physicians Act, which would require the board to issue a provisional license to an applicant who holds a full and unrestricted license to practice medicine in another country who meets specified requirements. The bill would make the license valid for 5 years and renewable for one additional 5-year period. The bill would require the board to issue a full and unrestricted physician's and surgeon's license to a provisional licensee applicant who meets specified requirements, including having completed at least 5 years of practice under the provisional license without any disciplinary actions. The bill would require the board to establish application, initial licensure, renewal, and conversion fees for the provisional license, as specified.

**Discussion:** There are three proposed bills creating alternative pathways introduced this session: AB 2398 (Alvarez), 2386 (Alvarez) and SB 1179 (Menjivar). This bill has two parts: Part I: expands the existing MBC's Mexico Pilot Program that allows Mexican trained physicians to practice at Federally Qualified Health Center (FQHCs) for three years and if they meet the requirement are eligible for full licensure as a physician and surgeon without restrictions on practice locations or practice. This Mexico Pilot Program was originally set up to funnel Mexican physicians into FQHCs and to increase the number of Spanish speaking physicians. However, this program did not provide for full licensure. This bill proposes to expand this Mexico Pilot Program to allow eligibility for full licensure as a physician and surgeon without restrictions.

Part II: Creates a "Qualified Provisional License for Qualified International Physicians Act" that creates an alternative pathway to residency and licensure for foreign trained physicians to train in the California under the supervision of any licensed physician. There is no accreditation or curriculum requirement for this alternative pathway, which creates an exemption to the otherwise residency requirements that requires training at an accredited residency training program. This alternative pathway is similar to the one proposed in AB 2398 by the same author.

Among the public safety and licensure concerns related to this proposal is there is no curriculum requirements that mirror accreditation residency programs, which functions as a full exemption to accredited residency training. While it allows for a renewable five year provisional practice license for supervised training with a license physician, it creates a less rigorous training option for foreign trained physicians. Existing MBC law requires out of state physicians and surgeons trained in the U.S. and licensed in another state must practice for four years before being eligible for reciprocity licensure in California. In contrast, this bill proposes that foreign trained physicians only need to be licensed in their respective country for three years. U.S trained physicians must attend accredited residency training programs that include rotations in a wide variety of specialties at hospitals and clinics and must complete a minimum of 36 months of residency training as a condition of renewing their license. This bill would not meet this requirement and is silent on this non-compliance thus making it unclear whether it creates an exemption for this alternative residency pathway from the requirement of completion of 36 months of accredited residency training. If in fact this is an exemption for this license requirement, it carves out a less rigorous training program and provides license exemption not available to U.S. trained physicians and surgeons.

This alternative pathway creates a patchwork of pre-licensure training that is different for foreign trained physicians than their U.S. trained counterparts, which raises competency and public safety concerns with this proposal.

The drive behind all of these alternative residency pathway proposals is changes at the federal level to the J1 visa program which now charges \$100,000 for such visas putting them out of range for most applicants and FQHCs. The other driver is the shortage of physicians. It is counterintuitive to solve the physician shortage issue with lowering the standards for foreign trained physicians to train and qualify for licensure. The more practical solution is to expand medical school capacity and residency program slots for U.S. trained physicians which is a more reliable source of competent trained physicians than opening the flood gates to foreign trained physicians to meet the physician needs of California's health care system. The less obvious driver is cost—it is cheaper to create these alternative training and licensure pathways than to expand existing accredited medical and residency training in the U.S. This choice of a more affordable, less rigorous medical training is one that ignores the quality and competency concerns that it invites. This is a poor policy choice to swap accredited, U.S. trained medical training for less rigorous foreign trained physicians that will have public safety ramifications for patients who may suffer the harm from care.

From a public safety perspective, the current quality controls in physician training are completion of medical education from accredited medical schools and accredited

residency training in addition to passage of all three levels of national examinations. Exams alone are not sufficient to evaluate competency—competency evaluation relies on accredited medical school and residency training evaluations of competency. Removing the key evaluation component of physician competency is reckless and ignores the quality controls existing laws and accredited training provide to public safety. This proposal amounts to a short cut to solving a physician shortage without effective guardrails that ensure competency and protect patients’ safety.

The more logical solution is to fund more medical schools and residency slots and to develop competency-based evaluation that utilizes a combination of examinations and residency experience and evaluation of residency practice. Competency based evaluation has remained elusive to national exam regulators and accredited residency training. The concept of competency-based evaluation would create examinations and practice evaluation that would determine one’s competency regardless of the time spent in training. If such competency evaluation were created, it would replace the time completion requirement in statutes today with the competency-based evaluation as a criteria for licensure. But, no agency or organization has successfully been able to create a competency-based training model and test it for effectiveness and quality control. National regulators have seemingly abandoned creation of such a model and now have to contend with short cuts such as this and other bills, which is a policy move that will guarantee more risk to patients in the health care system. This is a bad policy proposal for public safety.

Overall, this bill is not ready for prime time and needs more thoughtful development of training that is equivalent to accredited residency training programs to ensure licensees are truly competent to practice medicine safely. This bill is not even close to developing such training that would be equivalent to accredited residency training programs and competency-based evaluation of competency prior to licensure. However, it does highlight that FQHCs multidisciplinary staffing model is ripe for being an accredited residency training pathway with the development of FQHC based accredited training programs and integration into the existing residency accreditation training and additional slots

**Recommendation: Watch.**

### **SB 1179 (Menjivar) Physicians from El Salvador**

**Summary:** Existing law establishes within the act the Licensed Physicians from Mexico Program, which authorizes the board to issue a limited number of nonrenewable 3-year physician’s and surgeon’s licenses to physicians from Mexico who are licensed, certified,

or recertified and in good standing in their medical specialty in Mexico and who meet specified other requirements.

This bill would establish the Doctors from El Salvador Program for the purpose of permitting licensed physicians from El Salvador to practice medicine in California for up to 3 years. The bill would establish a program administration committee and would designate Clínica Monseñor Oscar A. Romero to serve as the primary administrator and lead representative of the committee. The bill would require the committee to, among other things, develop an interview examination for each specialty area, develop an orientation program, and recruit and vet candidates for the program. The bill would require the board to issue a nonrenewable 3-year physician and surgeon's license to a person who is licensed, certified, or recertified, and in good standing in the applicable medical specialty in El Salvador and who meets other requirements of the program.

The bill would require a licensee in the program to only practice medicine in California at a federally qualified health center and any corresponding hospital. The bill would require a federally qualified health center employing a licensee in the program to take certain actions, including creating and maintaining medical quality assurance protocols for those licensees. The bill would also require the federally qualified health centers to work with a California medical school or residency program to conduct 10 secondary reviews of randomly selected patient encounters with each of those licensees every 6 months, as specified. The bill would also require the faculty from the medical school or residency program and federally qualified health center chief medical officers to jointly develop 2 quality assurance seminars to be attended by the licensees.

**Discussion:** This proposed alternative pathway is modeled after the Mexico Pilot Program that provides “orientation” rather than accredited training that introduces foreign trained physicians to the U.S. health care system and requirements in California. While it is tempting to copy an existing pilot program, this proposal does not improve the model to ensure training mirrors accredited residency training. The bill restricts practice to FQHCs and hospitals in California, which functions as a pipeline for FQHCs. However, this and the Mexico Pilot program are not equivalent training to accredited residency training and may be the hesitation by the Legislature to allow it as a formal pathway to licensure by exempting applicants from licensure requirements that U.S. trained physician must comply with for licensure. The bill does not include language that would provide participants with this pilot program with eligibility for full, unrestricted licensure as AB 2386 proposes. However, it is possible that the eligibility for licensure would come from AB 2386 provisions.

Clinica Monseñor Oscar A. Romero Federally Qualified Health Center is a multi-disciplinary clinic that offers primary care, pediatrics, OBGYN, psychiatry, vision, pharmacy, comprehensive dental, behavioral health and substance abuse treatment services under one roof, which makes it more prepared to provide a variety of rotations within its proposed training than a single physician providing supervised training as the other bills propose.

The bill requires collaboration with accredited medical schools and residency training programs by having those entities review peer review interviews. However, interviews are not the same as the clinic program incorporating curriculum and training from accredited residency programs. The peer review is characterized as “interviews” as are the examinations are also characterized as “interviews,” which are not the same as clinical evaluations, so it still falls short of quality controls of accredited medical school and residency training programs.

Participants of this alternative training are not required to pass all three levels of the USMLE national boards, only that they pass the boards in their country so there is no U.S. examination evaluation for these participants that would ensure U.S. level of competency for public safety purposes. Similarly, while the multi-disciplinary composition of FQHCs ensure exposure to a variety of specialties and faculty that are employed by the clinic, there is no provision for a clinic examination evaluation to measure competency. And, the collaboration with accredited medical schools and residency training program is more informal than working with both entities to design a competency-based examination and evaluation of competency, which would be appropriate and address concerns about the quality of training.

One notable provision is limiting foreign trained OBGYN from deliveries until they have performed 50 live deliveries according to U.S. standards. Since deliveries are a complex specialty involving both fetal and maternal mortality, this restriction is helpful to ensure these foreign trained OBGYN’s are prepared to perform high quality deliveries to protect patient safety.

Another notable provision is the requirement for fingerprint clearance like U.S. trained applicants are subject to as a condition of licensure.

Another key requirement is the program receive MBC approval. Which on its face sounds like a quality control provision until you look more closely and realize that MBC has through the years shed their evaluation of foreign training and defaulted to requiring foreign trained physician having to complete more accredited residency training to ensure they are U.S. competent. However, this bill and the others skirt that process

entirely leaving MBC to once again be the training evaluators-- something that they currently rely on accreditation of residency training to evaluate and ensure competency. So, this reference to Board approval rings empty since MBC is no longer in the business of evaluating foreign training.

Another concern is the bill states that health plans cannot deny credentials of these clinic trained physicians. This declaration attempts to force health insurance plans to accept physicians who are exempt from licensure requirements imposed on U.S. trained physicians. Health plans heavily rely on accreditation of medical schools and residency programs and statutory licensure requirements for their credentialing approval, so it is unclear whether that will function as more than an intention or a real requirement.

Another exemption is the requirement that applicants do not have to supply a social security number or Individual Taxpayer Identification Number (ITIN) until after they are licensed. These provisions occur after the license is issued rather than delaying the licensure. This is impractical to implement because once the license is issued, it cannot be unissued except for disciplinary reasons.

Overall, this bill is not ready for prime time and needs more thoughtful development of training that is equivalent to accredited residency training programs to ensure licensees are truly competent to practice medicine safely. This bill is not even close to developing such training that would be equivalent to accredited residency training programs and competency-based evaluation of competency prior to licensure. However, it does highlight that FQHCs multidisciplinary staffing model is ripe for being an accredited residency training pathway with the development of FQHC based accredited training programs and integration into the existing residency accreditation training and additional slots.

**Recommendation: Watch and provide feedback to the author.**

#### **AB 1558 (Arambula) Emergency Physician Volunteer Health Act**

**Summary:** This bill is trying to create an emergency registration system for out-of-state and territory health care providers that would authorize them to practice in California without a license in the event of an emergency. It is unclear whether the proposed system creates a uniform registration for emergency health care workers given that there are federal laws that apply. The bill references but does not indicate whether this bill is in compliance with those existing federal laws nor does it indicate why the bill is needed with other federal laws and entities in existence to verify emergency personnel qualification.

It authorizes license boards enforcement jurisdiction over volunteer health providers and the ability to modify, restrict or deny practice of a specified volunteer applicant. Applicants can come from any of the 50 states and U.S. Territories. It does not mention the licensing board's role in verifying licensure, disciplinary records or eligibility so it is unclear whether the Board would be responsible for verifying licensure and running discipline checks. It is also unclear whether Emergency Medical Services Administration will have fingerprint check authority or will they rely on the respective licensing boards to verify that information.

It appears that the bill will utilize the existing federal Emergency System for Advance Registration or Volunteer Health Professionals (ESAR-VHP) and for local disasters the Medical Reserve Corps and any other designated entity registration system.

**Discussion:** Since Osteopathic Physician licensed in the 50 states would be the only D.O.s eligible to be volunteers. Those physicians licensed in the Territories that are licensed as Medical Doctors (M.D.s) would be the only physicians eligible for voluntary services under this bill. The bill adheres to existing state law scope of practice. Given the bill's reiteration of adherence to state law in defining scope of practice and licensure, it appears not to create a loophole for D.O.s from the Territories to be deemed eligible to become volunteers.

The bill does not specify the exact role of the board in terms of workload so the board has to assume its role will be license verification and criminal background checks and any enforcement action related to any volunteer. Under prior emergencies, the Board conducted verifications on demand. It did not have enforcement jurisdiction so that is a new and makes sense policy wise for protection of public safety.

**Recommendation: Watch.**

### **AB 1587 (Ta) Pharmacist Prescription Authority: Life-Threatening Conditions**

**Summary:** Authorizes a pharmacist to provide up to a 30-day supply for a prescription drug for a life-threatening condition, as defined, if the pharmacy, or another pharmacy under common control with the pharmacy, has previously furnished that drug to the patient and the patient is unable to secure a new prescription for the drug before their supply is exhausted. States that the pharmacist or pharmacy shall not incur any liability for dispensing a medication pursuant to this legislation.

**Discussion:** This bill was recently amended to remove the expansion of this authority as proposed in the original version and simply requires notification to the patient's physician. As a result, I would remove recommending a position on this bill.

**Recommendation: Watch.**

### **AB 2140 (Johnson) Mandatory Reporting: Settlements, Arbitration, Judgments: Fine increase**

**Summary:** The introductory version of the bill appears to raise the minimum non-compliance fee for BPC section 802 (a) from \$50 to \$100.

Existing law makes failure of a licensee of the Medical Board of California, the Podiatric Medical Board of California, the Board of Psychology, the Dental Board of California, the Dental Hygiene Board of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, the Acupuncture Board, or the Physician Assistant Board, a claimant, or their counsel to report a settlement, judgment, or arbitration award over \$3,000 of a claim or action for damages for death or personal injury caused by negligence, error or omission in practice, or by the unauthorized rendering of professional services, by a person who holds a license, certificate, or other similar authority from one of those boards, who does not possess professional liability insurance as to the claim, within 30 days to the agency that issued the license, certificate, or similar authority, punishable by a fine of not less than \$50 or more than \$500, as specified.

**Discussion:** There is a lot more that could be amended related to these sections related to conflicting sections and which section apply to which boards. So, if that is the intent of the bill, more amendments could be coming. But, overall, simply raising the non-compliance fee would generate no additional workload and fiscally would generate at most a few hundred dollars. The Board does not get many (less than 3 per year if any) non-compliance fees or issues violations of BPC section 802.

**Recommendation: Watch.**

## **AB 1637 (Caloza) Physician: Medical Records**

**Summary:** Adds a new law to the Medical Practice Act to state that a physician’s medical document is the responsibility of that physician and that the physician’s patient notes, after-visit summaries, and diagnosis and treatment plans shall not be changed by anyone other than the authoring physician.

**Discussion:** The intent of this bill appears to be to add another guardrail against the corporate intrusion and control of physicians’ practice of medicine. Medical records are at the heart of such control. This bill declares that those medical records belong to the physician and cannot be altered in any fashion by anyone other than the physician. For corporate practice of medicine lawsuits, this law provides clarity with respect to who controls patient medical records—the physician.

In this context, as currently written, it is unclear the enforcement mechanism behind this proposed violation. While it cites the Medical Practice Act, the section cite applies to physicians’ duty to keep accurate medical records, which could result in discipline if found to violate this section. However, in this bill the violator would not be the physician, it would likely be management or a health care owner other than the physician. The Board only has jurisdiction over the physician, not their management or owners of the business for which they are employed.

**Recommendation: Watch.**

## **AB 2311 (Schiavo) Health Facilities Hiring Physicians**

**Summary:** Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons or doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. Existing law, the Local Health Care District Law, regulates the organization and management of health care districts.

This bill would create an exemption to the general prohibition described above by authorizing health care districts and nonprofit corporations with a health care district as its sole corporate member that own or control a general acute care hospital to employ physicians and surgeons and charge for professional services. The bill would prohibit the health care district from interfering with, controlling, or otherwise directing the professional judgment of a physician or surgeon.

**Discussion:** This bill proposes yet another exemption to the Corporate Practice of Medicine that prohibits employing physicians. Prior exemptions justified the reason behind the exemption, but this bill does not. In the context of hospitals going bankrupt and being purchased by non-health care investors or entities, the trend that endangers the corporate practice of medicine is that entities that own hospital and some medical groups are driven by profits not mission driven to provide excellent quality health care. In this context, continuing to exempt entities from the corporate practice of medicine further endangers the protection surrounding physician independence from corporate interference and control of the physician practice of medicine.

**Recommendation: Watch.**

### AB 1598 (Quirk-Silva) Behavioral Sciences

**Summary:** The LMFTA, the CSWPA, and the LPCCA each contain varying provisions limiting their application to the practice of certain medical and other behavioral science professionals, attorneys, and certain religious personnel, including priests, rabbis, and ministers of the gospel of any religious denomination.

This bill would revise and recast those provisions to make them consistent across those 3 acts. Specifically, the bill would provide that LMFTA, the CSWPA, and the LPCCA do not prevent qualified members of other professional groups, including those referenced above, from doing work of a psychosocial nature consistent with the standards, ethics, and scope of practice of their respective professions. The bill would prohibit those other professionals from stating or implying that they are licensed or registered under the LMFTA, the CSWPA, or the LPCCA, as specified. The bill would exempt a religious official of any denomination, including those specified above and imams, when providing faith-based counseling services as part of their regular professional duties for an established and legally recognizable faith-based entity if certain criteria are met.

**Discussion:** The intention behind this bill seems to further clarify who is licensed to provide behavioral health services and represent to the public as such. The only reason this bill is on our watch list is because it lists physicians and surgeons in this bill characterizing them as other authorized providers. What the Board is monitoring is any wording that in fact interferes with the Medical Practice Act and Osteopathic Act and scope of practice. Recent amendments March 18, 2026, removed reference to physicians and surgeons, which was a good amendment that removed initial concerns.

**Recommendation: Watch.**

### **AB 408 (Berman)MBC Wellness Program (2025)**

**Summary:** This is MBC's proposed wellness program that is proposed as an alternative substance abuse alternative to recovery programs administered by other boards.

**Discussion:** This bill does not apply to OMBC because the Board already has a recovery program.

**Recommendation: Watch.**

### **AB 485 Labor Commissioner: Unsatisfied Judgments: non-payment of wages (2025)**

**Summary:** This is a bill from last session that would require the Board to enforce specific Labor Commissioner unsatisfied judgments for employer non-payment of wages. The mode of enforcement proposed is license suspension until judgment order satisfied.

**Discussion:** This bill has not changed since last session but given the fact that it requires the Board to enforce specific Labor Commissioner judgment orders by license suspension, it is still recommended to be monitored with no position recommended.

**Recommendation: Watch.**

### **AB 967 (Valencia) Physician Expedite Fee (2025)**

**Summary:** This is a bill from last session that would provide for a special expedite fee for qualifying licensees that pay a fee.

**Discussion:** The board discussed this bill in detail and did not favor the policy of adding another expedited category that would prioritize application processing if applicants paid a fee. The Board also did not support charging an expedite fee that would disadvantage poorer applicants who could not afford to pay the fee. The bill continues to be directed at the Medical Board of California (MBC) by amending their fee section, not the OMBC's fee section. MBC does not support this bill. The bill continues to be active, perhaps to be available as a spot bill in this session.

**Recommendation: Watch.**

## **SB 626 (Smallwood-Cuevas) Prenatal Care screening and treatment**

**Summary:** Requires patients to be screened for perinatal mental health condition in accordance with applicable clinical guidelines and standards of care appropriate to the practitioner's scope of practice. Requires practitioners to diagnose and treat their patients according to the standards appropriate to the provider's license, training. And scope of practice. Requires insurers to develop a perinatal mental health program designated to promote quality and cost-effective outcomes, as specified.

**Discussion:** This bill adds the requirement that perinatal care includes screening for mental health.

**Recommendation: Watch.**

## **AB 2195 ( Rodriguez ) Child Support: Suspension of License**

**Summary:** Existing law requires a local child support agency to maintain a list of those persons included in certain child support cases. Existing law requires the Department of Child Support Services to consolidate and certify the local child support agency lists and provide the consolidated list to specified state entities that are responsible for the regulation of licenses, including, but not limited to, the Department of Motor Vehicles. Existing law requires those entities, prior to the issuance or renewal of a license, to determine whether the applicant is on the most recent certified consolidated list provided by the department and authorizes the entity to withhold issuance or renewal of the license of an applicant on the list, as specified.

Existing law prohibits the department from including in the list sent to the Department of Motor Vehicles, for the purpose of denying, withholding, or suspending a driver's license, the information of a support obligor whose annual household income is at or below 70% of the median income for the county in which the department or the local child enforcement agency believes the support obligor resides. Commencing January 1, 2027, existing law would only apply this prohibition to noncommercial driver's licenses.

This bill would expand the prohibition on the department to also prohibit the department from sending the above-described income information to all boards, as defined, that issue a license, certificate, credential, permit, registration, or any other authorization to engage in a business, occupation, or profession, or operate a motor vehicle, for the purpose of denying, withholding, or suspending a license.

**Discussion:** This bill changes what information is provided to DCA Family Support unit that coordinates license suspensions with each board. Generally, the Board does not have discretion in enforcing family support violations.

**Recommendation: Watch.**