



NOTICE OF PUBLIC MEETING – Notice is hereby given that a public meeting of the Dental Board of California will be held as follows:

Thursday, February 28, 2013

Holiday Inn on the Bay
1355 North Harbor Drive, San Diego, CA, 92101
(619)232-3861 or (916)263-2300

Notice Regarding This Two-Day Meeting: *During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should items not be completed, it is possible that it could be carried over and be heard beginning at 8:30 a.m. on the following day. Anyone wishing to be present when the Board takes action on any item on this agenda must be prepared to attend the two-day meeting in its entirety.*

General Notice: *Public comments will be taken on agenda items at the time the specific item is raised. The Board may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the President. For verification of the meeting, call (916) 263-2300 or access the Board's Web Site at www.dbc.ca.gov. This Board meeting is open to the public and is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Karen M. Fischer, Interim Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five business days before the meeting will help to ensure availability of the requested accommodation*

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

Thursday, February 28, 2013

8:30 A.M. DENTAL BOARD OF CALIFORNIA – FULL BOARD – OPEN SESSION

ROLL CALL Establishment of a Quorum

CLOSED SESSION – FULL BOARD* **Deliberate and Take Action on Disciplinary Matters**

*The Board will meet in closed session as authorized by Government Code §11126(c)(3)

Deliberate and Take Action on Personnel Matters

*Pursuant to Government Code §11126(a)(1), the Board will convene in closed session to discuss Personnel Matters

CLOSED SESSION – LICENSING, CERTIFICATION, AND PERMITS COMMITTEE** **Issuance of New License(s) to Replace Cancelled License(s)**

**The Committee will meet in closed session as authorized by Government Code §11126(c)(2) to deliberate on applications for issuance of new license(s) to replace cancelled license(s)

OPEN SESSION RESUMES AT APPROXIMATELY 9:30 A.M. OR UPON ADJOURNMENT OF CLOSED SESSION

- AGENDA ITEM 1 Introduction of New Board Members and Oath of Office
- AGENDA ITEM 2 Approval of the December 3-4, 2012 Full Board Meeting Minutes
- AGENDA ITEM 3 President's Report
- AGENDA ITEM 4 Update on Pending Regulatory Packages:
- A. Uniform Standards for Substance Abusing Licensees (*Cal. Code of Regs., Title 16, §§ 1018 and 1018.01*)
 - B. Examination, Permit, and License Fee Increases for Dentists (*Cal. Code of Regs., Title 16, § 1021*): and
 - C. Abandonment of Applications (*Cal. Code of Regs., Title 16, § 1004*)
- AGENDA ITEM 5 Discussion and Possible Action Regarding Reconsideration of Proposed Language and Initiation of a Rulemaking to Amend §1018 and Adopt §1018.01 of Title 16 of the California Code of Regulations Relevant to Uniform Standards for Substance Abusing Licensees
- AGENDA ITEM 6 Discussion and Possible Action Regarding the Subcommittee's Review of § 1005 of Title 16 of the California Code of Regulations Relevant to the Minimum Standards for Infection Control Conducted by the Dental Board of California and the Dental Hygiene Committee of California
- AGENDA ITEM 7 Discussion and Possible Action Regarding Board Policy Decision to Authorize the Use of All Image Receptors to Capture Radiographs During Radiation Safety Instruction and Certification Provided by Educational Programs and Courses in Compliance with California Code of Regulations, Title 16, Sections 1014 and 1014.1

COMMITTEE/COUNCIL MEETINGS – SEE ATTACHED AGENDAS

- ENFORCEMENT COMMITTEE
See attached Enforcement Committee agenda
- LEGISLATIVE AND REGULATORY COMMITTEE
See attached Legislative and Regulatory Committee agenda
- EXAMINATION COMMITTEE
See attached Examination Committee agenda
- LICENSING, CERTIFICATION, AND PERMITS COMMITTEE
See attached Licensing, Certification, and Permits Committee agenda
- DENTAL ASSISTING COUNCIL
See attached Dental Assisting Council agenda

- AGENDA ITEM 8 Report on the January 16, 2013 Meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permits; and Update on the Board's Report to the Legislature January 1, 2013
- AGENDA ITEM 9 Update on the Patient Protection and Affordable Care Act
- AGENDA ITEM 10 Discussion and Possible Action Regarding Changing the Dates and Locations of Dental Board Meetings in 2013

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

Note: The Board may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

FUTURE AGENDA ITEMS

Stakeholders Are Encouraged to Propose Items for Possible Consideration by the Board at a Future Meeting

BOARD MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Note: The Board may not discuss or take action on any matter raised during the Board Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

RECESS



MEMORANDUM

DATE	February 12, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	Agenda Item 1: Introduction of New Board Members and Oath of Office

On January 30, 2013, Governor Brown made two appointments to the Dental Board. Ms. Kathleen King, Executive Director of the Santa Clara Family Health Foundation who will serve as a public member on the Board; and Thomas Stewart, DDS a general dentist from Bakersfield.

Kathleen King retired from Applied Materials, Inc. after twenty years and is currently the Executive Director of the Santa Clara Family Health Foundation, a non-profit foundation focused on the health needs of low income residents of Santa Clara County. She was elected to the Saratoga City Council in November of 2002 and served as Mayor of the city in 2005 and again in 2010.

Ms. King is a native of California. She attended public schools in San Jose, graduated from West Valley College, and Santa Clara University. She resides in Saratoga with her husband and five children.

Dr. Thomas Stewart has been a dentist in private practice since 1976. He served as a member of the United States Naval Reserve from 1978 to 1997 and as a member of the Dental Corps of the United States Navy from 1972 to 1976. Dr. Stewart earned a Doctor of Dental Surgery degree from Howard University College of Dentistry.

Dr. Stewart has been a volunteer with the California Dental Association (CDA) for 30 years where he served as Vice Chair of the CDA Holding Company Board of Directors, and Chair of the CDA delegation to the American Dental Association. He has also served as the Chair of the TDIC/TDIC Insurance Solutions Board of Directors, Chair of the CDA Council on Dental Health and Trustee of the Kern County Dental Society, President of KCDS in 1985 and past President of CDA in 2010. In addition, he is a fellow of the International College of Dentists, American College of Dentists and Pierre Fauchard Academy. Dr. Stewart is actively involved in the Westchester Kiwanis and is a member of the Teen Challenge of Kern County Advisory Board. He resides and practices in Bakersfield, California.



**Dental Board of California
Meeting Minutes
Monday, December 3, 2012**

Embassy Suites LAX/South
1440 East Imperial Avenue, El Segundo, CA 90245

DRAFT

Members Present:

Bruce Whitcher, DDS President
Huong Le, DDS, Vice President
Fran Burton, Secretary
Steve Afriat, Public Member
Stephen Casagrande, DDS
Luis Dominicus, DDS
Rebecca Downing, Public Member
Judith Forsythe, RDA
Suzanne McCormick, DDS
Steven Morrow, DDS
Thomas Olinger, DDS

Members Absent:

Staff Present:

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel
Greg Salute, Deputy Attorney General

ROLL CALL AND ESTABLISHMENT OF QUORUM

Dr. Bruce Whitcher, President, called the meeting to order at 8:35 a.m. Fran Burton, Secretary, called the roll and a quorum was established. Dr. Whitcher recognized Kit Neacy, former Board President, Dr. Guy Acheson from the California Academy of General Dentistry, and Lori Gagliardi and Lindsay Shubin from the California Association of Dental Assisting Teachers and thanked them for attending the Board meeting.

AGENDA ITEM 1: Update on Pending Regulatory Packages:

Sarah Wallace, Legislative and Regulatory Analyst, gave an overview of the Board's pending regulatory packages. Ms. Wallace reported that she has been working on wrapping up two of the regulatory packages; the Sponsored Free Health Care Events and the Notice to Consumers.

The Notice to Consumers, which was the package that required dentists to disclose that they are licensed and regulated by the Dental Board of California, was approved by the Office of Administrative Law (OAL) and became effective on November 28, 2012.

The Sponsored Free Health Care Events regulatory package, which allows out of state practitioners, with authorization from the Board, to participate in Sponsored Free Health Care Events in California, was approved by OAL and became effective December 7, 2012.

Ms. Wallace reported that the Board approved moving forward with the Abandonment of Applications regulatory package and she is working on the initial rulemaking documents along with rulemaking documents for Uniform Standards for Substance Abusing Licensees and Examination, Permit and License Fee Increases for Dentists.

AGENDA ITEM 2: Discussion and Possible Action Regarding the Review and Prioritization of Regulatory Packages and Subcommittee Assignments

Richard DeCuir, Executive Officer, reported that Sarah Wallace, the Board's Legislative and Regulatory Analyst is working on four regulatory packages deemed priorities by the Board last year, four subcommittees developing regulatory framework for various programs and requirements and three Dental Assisting Council subcommittees helping with the review of dental assisting course requirements.

In the event that staff encounters difficulty addressing all of these priorities during Ms. Wallace's absence during the first half of 2013, the Board is requested to reprioritize and specify the top three issues.

Dr. Morrow suggested that Portfolio remain at the top of the list as there are statutory deadlines that must be met. There was discussion regarding what and how to prioritize.

M/S/C (Morrow/Olinger) to prioritize work on the regulatory packages of Dentistry Fee Increase, Portfolio Examination Requirements and Uniform Standards for Substance Abusing Licensees in that order. The motion passed unanimously.

Dr. Le suggested that as far as the regulatory framework for various programs and requirements goes, because there are statutory requirements, Minimum Standards for Infection Control should be the only priority we should be taking on at this time.

M/S/C (McCormick/Le) to prioritize work with the subcommittees as Radiation Safety Course Requirements and Minimum Standards for Infection Control in that order.

Dr. Lori Gagliardi, representing the California Association of Dental Assisting Teachers (CADAT) requested that Radiation Safety Course Requirements be the top priority and provided her rationale as to why. There was discussion surrounding the pros and cons of digital versus analog radiography.

The previous motion passed unanimously.

Mr. DeCuir clarified the prioritization as:

1. Dentistry Fee Increase
2. Portfolio Examination Requirements
3. Uniform Standards for Substance Abusing Licensees
4. Radiation Safety Course Requirements
5. Minimum Standards for Infection Control

AGENDA ITEM 3: Discussion and Possible Action Regarding Adoption of the Dental Board of California's 2013 – 2015 Strategic Plan

Dr. Witcher reported that the public workshop facilitated by the SOLID Training Unit was very successful. Karen Fischer, Interim Executive Officer, discussed the DRAFT Plan that had been prepared by the SOLID Training Unit as a result of workshop. She stated that if the Plan is adopted by the Board, SOLID staff will reconvene with Board staff to develop tasks and measures to ensure the goals and objectives for the future will be met.

M/S/C (Olinger/Dominicis) to adopt the DRAFT Plan.

Dr. Guy Acheson commented on access to care issues in California and the true numbers of the workforce. He stated that there seems to be some discrepancy as to who the authority is when it comes to the correct numbers. He would like to see the Dental Board of California be the only authority on the number of dentists in the workforce and clarify the definition of "Full Time".

Bill Lewis, California Dental Association (CDA), complimented the Board and staff on the Strategic Plan and the transparency in which they conducted the formulation of the Plan.

The motion passed unanimously.

AGENDA ITEM 4: Subcommittee Report and Possible Action Regarding Future Legislation to Require Dental Labs to Register with the Dental Board

Sarah Wallace, Legislative and Regulatory Analyst, reported that at the May 2012 Board meeting, the California Dental Association (CDA) appeared before the Board and requested that the Board review a proposal requiring Dental Laboratory registration and disclosure of material content.

The purpose of CDA's proposal was to promote patient protection by requiring dental laboratories, who conduct business in California, to register with the Board in order to engage in the manufacture or repair of dental prosthetic appliances, and to disclose the material content, point of origin, and the location of manufacturer of the restoration, to the dentist issuing the work order.

At that meeting, Board President, Dr. Witcher, appointed a subcommittee of Dr. Dominicis and Dr. Olinger to work on the project. Prior to the August 2012 Board meeting, a teleconference was held with the subcommittee, CDA, staff and stakeholders to perform a preliminary review of what had been proposed. It was decided at that meeting that the best way to move forward would be for CDA to draft proposed language for the subcommittee to review. The draft language was received in mid-October.

The subcommittee reviewed the draft and held another teleconference with CDA representatives on November 1, 2012. Subcommittee members voiced their concerns regarding CDA's proposal including the Board's ability to enforce some of the provisions.

The Board does not typically see cases regarding dental laboratories and prosthetics. However, if this were to become law, the Board could see an increase in consumer complaints and enforcement activity, including the filings of administrative action against dental labs and dentists.

The subcommittee provided additional comments and recommendations regarding the proposal which were:

- It would be beneficial if dental laboratory registration be required biennially, rather than annually, to maintain consistency with other Board renewal requirements.
- It would be beneficial if the statute could specify all of the registration requirements rather than having to go through the regulatory process (i.e. registration fee, renewal fee, change of address requirements, notification to Board of dental laboratory closure, etc.)
- It would be of importance for the proposal to include a provision authorizing the Board to hire additional staff to facilitate the dental lab registration. The number of dental laboratories that would register with the Board as a result of these requirements is unknown and it is difficult to estimate the impact the Board would be facing from a staffing perspective. The Board does not have current staff resources to coordinate the provisions of this proposal.

The outcome of the teleconference was that the subcommittee ultimately expressed concern regarding unintended consequences that the proposal could place on California licensed dentists. The subcommittee did **not** recommend moving forward with a legislative proposal and suggested that the issue may be better addressed in a way other than legislatively, given the unknown variables. The subcommittee suggested that Dental Associations could launch a marketing campaign promoting better communication between the dentists and dental laboratories that may better serve the intent of the proposal. Once more information can be collected to address the unknowns of this draft proposal, another legislative proposal could then be considered.

Ms. Wallace stated that she had received a letter dated November 30, 2012 from the Dental Laboratory Owners Association of California (DLOAC) which is a state organization that has been representing California dental laboratory owners for over 70 years. Their letter stated:

We feel the subcommittee identified many of the potential negative issues that would result within the industry if the bill, as currently drafted, were passed. Most of our members feel lab registration would increase lab costs without providing the intended patient protection which was the initial driving force behind this effort. When it comes to material safety, FDA protections that require overseas manufacturers to register and submit to inspections are already in place. We fully support the recommendation of the

subcommittee to **not** recommend moving forward with a legislative proposal” at this time.

The DLOAC went on to say that within their industry, both laboratories and manufacturers are committed to quality and transparency and they already provide material disclosure, ongoing educational events, and industry certifications. They encourage all dentists to establish relationships with quality-oriented laboratories as a way to protect patient health and safety.

Dr. McCormick stated that she felt that there was a significant public safety issue and she would like to revisit this issue within eighteen months.

Dr. Whitcher commented that this is in the very preliminary stages and may be brought back once CDA has passed it through their policy committee.

Bill Lewis, California Dental Association (CDA), commented that it was the intent of CDA to begin the process and get feedback from the Board’s subcommittee as part of CDA’s own deliberations in working with the Dental Lab community and the Legislature to decide if they wanted to sponsor a bill this coming year. If CDA decides to move forward they will continue to seek the Board’s input and certainly take into consideration the subcommittee’s recommendations and comments. He thanked Drs. Dominicis and Olinger and staff for their involvement in the subcommittee process.

Richard DeCuir, Executive Officer, expressed his concern that the industry asked the Board to establish a subcommittee to look into the necessity for proposed legislation. The subcommittee and the industry recommended **not** moving forward with legislation but CDA is considering going ahead with the process. Mr. DeCuir also asked if there was a demonstrated need.

Steve Killian, Board member of the National Association of Dental Laboratories, commented that in his opinion state registration of dental laboratories are a benefit to the consumer/patient. He stated that with an estimated 1,500 dental labs in the state, competition drives some laboratories to cut corners and use less expensive and sometimes more dangerous materials to remain competitive. Registration, including continuing education, would help stop these dangerous practices. Many other states currently require registration and disclosure. Regulations could possibly be garnered from those already in place. Mr. Killian expressed his opposition to the opinion in the letter from DLOAC that stated *“most of our members feel lab registration would increase lab costs without providing the intended patient protection....”* He stated that to his knowledge the membership had not been polled. In his opinion they are misrepresenting the membership and he asked the Board to request that DLOAC provide proof of their statement.

M/S/C (Casagrande/Olinger) to accept the subcommittee’s report. The motion passed unanimously.

COMMITTEE/COUNCIL MEETINGS

The Full Board reconvened at 3:10 p.m.

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

There were no public comments.

FUTURE AGENDA ITEMS

There were no future agenda items requested.

BOARD MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Dr. Morrow commented that at the Board's August meeting, representatives from the American Board of Dental Examiners (ADEX) gave a presentation. Dr. Morrow asked that the Board consider adding the ADEX examination to its list of licensing opportunities.

Ms. Judith Forsythe shared some highlights of her trip to Ethiopia where she along with a group of volunteers were able to provide care for 1900 patients in five days at a dental clinic they had set up. She is planning on continuing this service next year.

The meeting adjourned at 3:17 p.m. until the next morning, Tuesday, December 4, 2012 at 8:30 a.m.

DRAFT



**Dental Board of California
Meeting Minutes
Tuesday, December 4, 2012**

Embassy Suites LAX/South
1440 East Imperial Avenue, El Segundo, CA 90245

DRAFT

Members Present:

Bruce Witcher, DDS President
Huong Le, DDS, Vice President
Fran Burton, Secretary
Steve Afriat, Public Member
Stephen Casagrande, DDS
Luis Dominicus, DDS
Rebecca Downing, Public Member
Judith Forsythe, RDA
Suzanne McCormick, DDS
Steven Morrow, DDS
Thomas Olinger, DDS

Members Absent:

Staff Present:

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel
Greg Salute, Deputy Attorney General

Dr. Bruce Witcher, President, called the meeting of the Dental Board of California to order at 8:33 a.m. Fran Burton, Secretary, called the roll and a quorum was established.

The Board immediately went into Closed Session to discuss disciplinary matters.

The Board returned to open session at 10:35 a.m.

AGENDA ITEM 5A: Approval of the August 16-17, 2012 Full Board Meeting Minutes
M/S/C (Afriat/Le) to approve the August 16-17, 2012 Full Board meeting minutes. The motion passed unanimously.

AGENDA ITEM 5B: Approval of the October 24, 2012 Dental Board Teleconference

Minutes

M/S/C (Dominicis/McCormick) to approve the October 24, 2012 Dental Board Teleconference minutes. The motion passed with two abstentions.

AGENDA ITEM 6: President's Report

Dr. Whitcher gave an overview of his activities since the last Board meeting including attendance at the California Dental Association (CDA) Cares event in Sacramento, the California Association of Oral and Maxillofacial Surgeons (CALAOMS) meeting in San Diego, and, along with many of the other Board members, the American Dental Association (ADA) meeting in San Francisco. Dr. Whitcher recognized members of the audience including, Teri Lane, Vickie Williams, Denise Macy, investigative staff from the Dental Board's Orange county office, and Dr. Rich Liebig, one of the Dental Board's Consultants. Dr. Whitcher presented awards to Richard DeCuir, Executive Officer, and Denise Johnson, Assistant Executive Officer in honor of their retirements. Ms. Angie English from Senator Curran Price's office presented Mr. DeCuir with a California State Resolution in honor of his dedication and service to the people of California. Bill Lewis commented that on behalf of the California Dental Association (CDA), he would like to express their gratitude for the work that Mr. DeCuir has done and wish him well on his retirement. Dr. Whitcher presented Shawn Cook, Deputy District Attorney from Orange County, with a special recognition from the Board for his outstanding service to the Dental Board. Greg Salute expressed gratitude on behalf of the Attorney General's office for the service Mr. DeCuir and Ms. Johnson have provided through the years. Dr. Lori Gagliardi also congratulated and thanked Richard and Denise on behalf of CADAT. Dr. Whitcher thanked Rebecca Downing for her service on the Dental Board. He also thanked Dr. John Bettinger, past Board president, for his service on the Dental Board and he presented them both with commemorative plaques. Dr. Whitcher thanked Dr. Luis Dominicis for his service on the Dental Board, he has reapplied to continue serving on the Board and we are awaiting his reappointment. Dr. Whitcher welcomed Karen Fischer as the Interim Executive Officer.

The Board recessed until 11:15 a.m.

AGENDA ITEM 8: Election of Dental Board of California Officers for 2013

M/S/C (Burton/Afriat) to nominate Dr. Huong Le for President of the Dental Board of California. There were no other nominations. The motion passed unanimously.

Dr. Whitcher opened the floor to nominations for Vice President. Ms. Rebecca Downing nominated Ms. Fran Burton for Vice President; Dr. Suzanne McCormick nominated Dr. Thomas Olinger as Vice President. The vote was taken and the majority of votes went to Ms. Fran Burton. Dr. Whitcher declared Ms. Burton the new Vice-President of the Dental Board of California.

Dr. Whitcher opened the floor to nominations for Secretary. Ms. Fran Burton nominated Dr. Thomas Olinger for Secretary. There were no other nominations. The vote was unanimous. Dr. Whitcher declared Dr. Thomas Olinger the new Secretary of the Dental Board of California.

M/S/C (Morrow/Afriat) to reconsider Agenda Item 2: Discussion and Possible Action Regarding the Review and Prioritization of Regulatory Packages and Subcommittee Assignments. The motion passed unanimously. Dr. Morrow clarified that while the dental education community is moving rapidly toward the exclusive use of digital imaging for diagnostic radiographs; he did

not mean to imply that the dental education community is eliminating the analog method of imaging from its instruction programs. Dr. Witcher stated that when rewriting the regulations for our Radiation Safety Standards course, it is important that we focus on safety issues not technology issues.

AGENDA ITEM 7: Executive Officer's Report - Attorney General Expenditures for the Dental Assisting Program

Richard DeCuir, Executive Officer wished Karen Fischer, Interim Executive Officer, the best of luck and stated that the Board was in very capable hands. He reported that he had frozen the Attorney General's expenditures for Registered Dental Assistant Cases. He will explain further during the budget report. Mr. DeCuir reported that he has been in contact with the Appointments Office and they are preparing files to take to the Governor for signature. He stated that the contract with OPES to perform the Occupational Analysis on WREB will be completed by June 2013. Karen Fischer, Interim Executive Officer, reported that the Diversion Evaluation Committee (DEC) is recruiting for DEC members. Northern California is recruiting for two dentist positions and southern California is recruiting for one Dental Auxiliary. Ms. Fischer thanked Greg Salute, Deputy Attorney General, and Teri Lane, Supervising Investigator Southern California, for their outreach efforts at the Dental Schools. They have been very well received by the fourth year dental students where they make presentations regarding areas to be careful about when they go into practice. Ms. Fischer also recognized Shirley Boldrini and Inspector in the Sacramento office who has maintained her RDA license and regularly volunteers in the community most recently at the CDA Cares event at Cal Expo. Ms. Fischer thanked the Board for giving her the opportunity to assist the Board. Dr. Le thanked the Board for their vote of confidence in electing her Board President. Dr. Le thanked Dr. Witcher for his mentoring, his leadership and his service as the Board's President.

AGENDA ITEM 9: Update from the Department of Consumer Affairs Executive Office

The Department of Consumer Affairs Executive Office was unable to attend due to other commitments.

AGENDA ITEM 10: Update on Dental Hygiene Committee of California (DHCC)

Activities

The Dental Hygiene Committee of California was unable to participate due to the fact that their Committee meeting was scheduled on the same day as the Board meeting.

AGENDA ITEM 11: Budget Reports: Dental Fund & Dental Assisting Fund

Richard DeCuir, Executive Officer reported that for Fiscal Year (FY) 2012-13, the Board's budget is broken into two separate appropriation accounts which together total a Board appropriation of \$13,140,000 [\$11,410,000 (Dentistry Fund) + \$1,730,000 (Dental Assisting Fund) = \$13,140,000 (Total Board Appropriation)].

Documents provided were intended to give an expenditure summary of the current fiscal year for the Dentistry and Dental Assisting funds. In addition, documents were enclosed that are called Fund Conditions, they projected the Board's fiscal solvency in each fund for the current and future fiscal years. For the Dental Assisting Fund, a letter was included from Senior Assistant Attorney General Alfredo Terrazas to the Department of Consumer Affairs Director Denise Brown confirming the temporary suspension of processing of low priority dental assisting enforcement cases.

The specifics surrounding the Board's two appropriations and expenditures are as follows:

Dentistry

The Board's Dentistry expenditures are based upon the September CALSTARS report that came out in October 2012. According to that report, the Board spent roughly \$2.6 million of its (FY) 2012-13 Dentistry budget appropriation. Approximately \$1.2 million of the expenditures was Personnel Services, and roughly \$1.3 million of the expenditures was Operating Expense & Equipment (OE&E). Based on these expenditures, the Board is projected to revert back to the Dentistry Fund approximately \$560,000.

Also attached are Fund Conditions which are intended to project future revenues, expenditures, and balances. The Dentistry Fund Condition includes repayment of the remaining \$2.7 million outstanding loan repayment split into multiple fiscal years; \$1.35 million in (FY) 2013-14, and \$1.35 million in (FY) 2014-15.

(At the end of Fiscal Year (FY) 2011-12, the Dentistry Fund was repaid \$1.7 million of the \$4.4 million outstanding loan repayment.) Based on the fund condition analysis, the Dental Board will end (FY) 2014-15 with a **negative balance** of \$2,545 million. However, this does not take into account the Dental Board fee increase for licensure that is projected to take place within the next twelve (12) to eighteen (18) months. Underexpenditures which have been averaging approximately \$1million/year are also not factored into these projections.

Dental Assisting

For Dental Assisting, the Board requested an update of Dental Assisting expenditures based on the October CALSTARS report that came out in November 2012. According to this report, the Board had spent roughly \$644,000 of its current year budget appropriation. Approximately \$181,000 of the expenditures were Personnel Services, and roughly \$463,000 of the expenditures were Operating Expense & Equipment. Due to the enormous increase in Attorney General (AG) Expenditures for Dental Assisting, the Board is not projecting a reversion back to the Dental Assisting Fund. In fact, the current year expenditure report projected an over expenditure of approximately \$170,000. The primary reason for the continued over expenditure is the Attorney General line item. For the last fiscal year the Board's AG budget was approximately \$60,000, while the actual expenditures exceeded \$255,000. For the current year, the Board's Dental Assisting budget is approximately \$67,000. Projected expenditures are estimated at \$270,000. [NOTE: There is a provision in the Government Code that specifies that if the Executive Officer knowingly overspends his/her budget; he/she can be held professionally and personally liable. (Something neither Mr. DeCuir nor Ms. Fischer intend to see occur)]. They have taken steps to ensure that the Dental Board spends within their total authorization including minimizing overtime unless absolutely necessary and mission critical, and more importantly, suspending the AG processing of dental assisting cases, except priority cases. The letter referenced above from Alfredo Terrazas confirmed this temporary suspension. Mr. DeCuir and Ms. Fischer have been in contact with the Department of Consumer Affairs Budget Office and Department of Finance to secure a current year budget augmentation to cover the projected AG expenditures. This augmentation could take 30-90 days to secure. If approved, the suspension will be lifted. Once the augmentation has been granted, Ms. Fischer will facilitate a Budget Change Proposal (BCP) to make the augmentation permanent. Mr. Afriat commented that there is a cost recovery associated with cases. Isn't that supposed to cover the cost of the cases? Mr. DeCuir answered that that was certainly the intent but there is not full cost recovery on stipulations. Spencer Walker, Senior Legal Counsel stated that the law only allows for a "reasonable amount" on cost recovery. An Administrative Law Judge may lower the amount

of cost recovery in a proposed decision. Ms. Denise Johnson, Assistant Executive Officer added that there is generally no cost recovery in revocation cases. Ms. Burton asked if in the review of the seventy-six RDA cases at the Attorney General's Office any trends were found that could be addressed by working with the schools. Mr. DeCuir stated that a high percentage of the cases stem from prior convictions.

AGENDA ITEM 12: Update Regarding the Dental Board of California (DBC) and the Dental Hygiene Committee of California (DHCC) Annual Review of the Minimum Standards for Infection Control

Sarah Wallace, Legislative and Regulatory Analyst reported that Dr. Witcher, Dental Board President, and Alex Calero, Dental Hygiene Committee of California (DHCC) President, appointed members to a subcommittee to review and provide recommendations to the DHCC, Dental Assisting Council, and the Board regarding the annual review of the Minimum Standards for Infection Control. (California Code of Regulations, Title 16, Section1005)

The subcommittee members and assigned staff are as follows:

Huong Le, DDS – DBC Member
Noel Kelsch, RDHAP – DHCC Member
Denise Romero, RDA – Dental Assisting Council Member
Lori Hubble, DHCC Executive Officer
Sarah Wallace, Dental Board Legislative/Regulatory Analyst

Subcommittee members were provided with a copy of the current regulatory text. They were asked to review it, note any questions, comments and concerns, and to email those comments to Ms. Wallace so that a subcommittee working document can be developed. A preliminary review of the Center for Disease Control (CDC) Guidelines for Infection Control indicated that there have not been any new recommendations regarding infection control in the dental setting.

Staff will contact the subcommittee after the holidays to schedule a teleconference meeting sometime mid to late January 2013 to discuss the review and how to move forward.

AGENDA ITEM 13: Enforcement Committee Report

Dr. Le, Vice Chair of the Enforcement Committee reported that under the leadership of Chief Kim Trefry the Enforcement Unit continues to improve. She stated that for the first time ever the Enforcement Unit has a procedure Manual which has been used to conduct training. She reported that staff is struggling to get its vehicle fleet updated. Dr. Le also reported that Sarah Wallace developed a printable notice for the Dental Board's website for the implementation of the Notice to Consumers and has received very positive feedback on the simplicity of downloading and printing the notice making compliance with this new regulation very easy. M/S/C (Afriat/Dominicis) to accept the committee report. The motion passed unanimously.

AGENDA ITEM 14: Examination Committee Report

Dr. Casagrande, Chair of the committee reported that OPES will conclude their analysis of the WREB examination by June 2013. He reported that Portfolio is closer to implementation. The candidate handbook and Examiner Training Manual have been drafted and will be reviewed in the next two weeks. Dr. Witcher asked that the Dean's of the Dental schools be kept informed regarding the progress of Portfolio. The American Dental Association (ADA) is waiting for us to complete our Portfolio program so that they can use it as a template for a National program of

a Portfolio type examination. Dr. Casagrande stated that he is hopeful that the graduating dental school class of 2014 will be able to experience Portfolio. M/S/C (Afriat/McCormick) to accept the committee report. The motion passed unanimously.

AGENDA ITEM 15: Licensing, Certification & Permits Committee Report

Dr. Olinger, Chair of the committee reported that during Closed Session the committee voted to reinstate 1 dental license and 3 RDA licenses. He reported that the committee reviewed the Licensure, Certification and Permits statistics. Dr. Olinger mentioned that the committee noticed that no one failed an evaluation but some were non-compliant which raised the question as to what non-compliant meant. Ms. Denise Johnson informed the committee that those who failed to set up an appointment for an evaluation were deemed non-compliant. Ms. Sarah Wallace informed the committee that the Sponsored Free Health Care Events regulations are complete and would go into effect Friday December 7, 2012. Notifications were sent out and the Board's website was updated. Dr. Witcher commented that he has taught the calibration course for new General Anesthesia/Conscious Sedation Evaluators that is traditionally held in the Spring. He stated that with the help of staff member Jessica Olney they are going to try giving the course via webinar. Hopefully this will broaden the participant base and bring in new evaluator candidates. Dr. Bettinger commented that AB 269 required the Board to collect data on licensees; he asked if those statistics were being reported. Dr. Witcher stated that there was a subcommittee report given at the last Board meeting regarding those statistics. Dr. Bettinger asked if there was a license associated with coronal polishing or if it was just a certificate of completion. Denise Johnson, Assistant Executive Officer stated that Coronal Polish is a certification. M/S/C (Olinger/Dominicis) to accept the Licensing, Certification and Permits Committee report. The motion passed unanimously.

AGENDA ITEM 16: Dental Assisting Council Report

Judy Forsythe, Chair of the Council reported that April Alameda has assumed the duties as Manager of the Dental Assisting unit. Ms. Forsythe stated that Sarah Wallace conducted a training session for the Dental Assisting Council members regarding, among other topics, the Legislative Process and the Bagley-Keene Open Meeting Act and how they relate to the Council. The training was well received and attendees agreed that it helped provide clarity to a series of procedural questions. Ms. Forsythe reported that an update was given regarding the status of Dental Assisting Programs and Courses. She stated that Dental Assisting Licensure and Permit statistics, as well as examination statistics were also reviewed. Ms. Forsythe reported that the new Registered Dental Assistant (RDA) written examination was implemented in March 2012. An updated RDA Law and Ethics examination was implemented in November 2012, the Orthodontic Assistant written examination is in the final stages of being updated and staff has contracted with the Office of Professional Examination Services (OPES) to review and possibly update the Registered Dental Assistant in Extended Functions (RDAEF) examination and the Dental Sedation Assistant examination. Ms. Forsythe stated that there was discussion regarding the need for retaining an RDA license once an RDAEF license has been obtained. Staff and Board Council are researching this issue and will report back at a future meeting. The California Association of Dental Assisting Teachers (CADAT) submitted proposed regulatory amendments to Radiation Safety Course requirements. The subcommittee of Anne Contreras and Emma Ramos conducted a review of CADAT's proposal and provided comments. The proposal was posted on the Board's website and staff, Board members and stakeholders were encouraged to submit comments directly to Sarah Wallace or Karen Fischer by December 28, 2012.

M/S/C (Afriat/McCormick) to accept the Dental Assisting Council Report.

During the public comment period, Dr. Bettinger, past Board President, requested that the Dental Assisting Council place an item on their next agenda to discuss a definitive procedure for Coronal Polish so that it can become a billable procedure with an American Dental Association (ADA) code. Dr. Witcher stated that ADA decides codes not the Dental Board. Dr. Witcher appointed Judy Forsythe and Anne Contreras to a subcommittee to work on the Regulations related to Radiation Safety Course Requirements.

The previous motion to accept the Dental Assisting Council report passed unanimously.

AGENDA ITEM 17: Legislative and Regulatory Committee Report

Fran Burton, Chair of the Legislative and Regulatory Committee reported that the tentative Legislative calendar had yet to be released. She remarked that the Legislative and Regulatory Committee acted on an unprecedented number of bills last year most notably SB 540 also known as Sunset Review, which extended the existence of the Dental Board until January of 2016. The committee reviewed provisions for inclusion in the Omnibus Bill package. She stated that the Committee voted to submit technical changes to Section 1630 regarding the Dental Board Seal which currently refers to the Board as the Board of Dental Examiners. A second proposal regarding the use of the Board's logo was reviewed but it was decided that a discussion with the Business and Professions Committee was needed before bringing the item back. She further reported that there was discussion regarding Mobile Dental Clinics particularly those operated by Dental Schools. There was a request to gather information to present at a future meeting regarding how many Mobile Dental Clinics are operated by Dental Schools and how they are registered.

Dr. John Bettinger, past Board President, proposed an Agenda Item regarding the Board's website and the wording related to Botox and Dermal Fillers. He stated that Botox is a brand name of a neurotoxin and needs to be generalized and there is no mention of dermal fillers. He asked that a subcommittee be appointed and volunteered to be a part of the process.

M/S/C (Burton/Afriat) to accept the Legislative and Regulatory Committee report. The motion passed unanimously.

AGENDA ITEM 18: Report on the October 3, 2012 meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; and Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permits

Dr. Witcher, Board President, reported that the Elective Facial Cosmetic Surgery (EFCS) Committee met via teleconference on October 13, 2012. The Committee revisited proposed regulatory language that was presented at the April meeting. The Committee provided feedback to staff on the proposed regulatory changes. They reviewed and discussed the new application for an EFCS permit and provided staff with direction regarding necessary additions and modifications. A subcommittee was developed to discuss various issues regarding the application process providing staff with more conclusive documentation to bring to the Committee.

In closed session the Committee reviewed two applications. The Committee recommended that the Board grant applicant number one, Dr. Alexander V. Antipov, unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but not limited to, rhinoplasty and otoplasty) and Category II (cosmetic soft tissue

contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

M/S/C (Dominicis/Afriat) to accept the Elective Facial Cosmetic Surgery Committee's recommendation. The motion passed unanimously.

The EFCS Committee recommended rejection of Applicant number two, Dr. S.R.' request for unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but not limited to, rhinoplasty and otoplasty), and have staff request clarification on what procedures the applicant intends to perform.

M/S/C (Olinger/ McCormick) to accept the Elective Facial Cosmetic Surgery Committee's recommendation and have staff request clarification on what procedures the applicant intends to perform. The motion passed unanimously.

Dr. Casagrande asked that the Board be apprised on any Enforcement issues regarding EFCS permit holders. Karen Fischer, Interim Executive Officer stated that the Board is required to send a report to the Legislature every four years regarding the EFCS permit holder program. Staff is in the process of preparing that administrative report letting them know how many permit holders there are and if any complaints have been filed against them. Spencer Walker, Board Counsel stated that the Board can be apprised of the receipt of a complaint but no names can be given.

Dr. John Bettinger, past Board President, asked if the injection of neurotoxins and dermal fillers is within the scope of the EFCS Committee because we are issuing permits for the use of those products. Although the Medical community considers them to be non-surgical procedures; the EFCS statute, 1638.1 refers to Cosmetic Surgical Procedures performed on normal tissue. Dr. Bettinger asked that the EFCS Committee place this item on their next agenda for discussion.

AGENDA ITEM 19: Update on Actions Taken to Implement the Patient Protection and Affordable Care Act

Sarah Wallace, Legislative and Regulatory Analyst reported that on January 1, 2014, the federal Patient Protection and Affordable Care Act (PPACA) will require a health insurance issuer that offers coverage in a small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. The PPACA requires each state to establish an American Health Benefits Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014. The PPACA defines a qualified health plan as a plan that, among other requirements, provides an essential health benefits package.

Existing state law created the California Health Benefit Exchange (Exchange) and their Board. In the last year two bills have been signed by the Governor; AB 1453 and SB 951. The bills were contingent upon each other. One made changes to the Health and Safety Code and impacted the Department of Managed Health Care Services and the other made changes to the insurance code and impacted the Department of Insurance. The bills adopted uniform, minimum, essential benefits requirements for the state regulated health care coverage. Ms. Wallace stated that at this time it is unknown what the impact will be on the Dental Board and dentistry in California for adults but it is known that there will be changes to pediatric dentistry coverage.

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

There were no public comments.

FUTURE AGENDA ITEMS

Dr. John Bettinger, past Board President, asked that his previous request for an agenda item regarding the posted description of the use of Botox be agendaized and discussed as neurotoxins instead. He went on to relate the problems he sees with the current description. He stated that he would be happy to work with staff. He stated that he was asked by the Southern California Association of General Dentists (SCAGD), who are sponsoring Botox courses, to comment on what the Board policy was.

BOARD MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Dr. Casagrande thanked Dr. Witcher for his service as President and he wished Dr. Le luck as President next year. Dr. Olinger echoed those sentiments.

The meeting was adjourned at 1:25 p.m.



MEMORANDUM

DATE	February 13, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	Agenda Item 3: President's Report

The President of the Dental Board of California, Dr. Huong Le, will give a report.



MEMORANDUM

DATE	January 16, 2013
TO	Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item 4: Update on Pending Regulatory Packages:

A. Uniform Standards for Substance Abusing Licensees (California Code of Regulations, Title 16, §§ 1018 and 1018.01):

At its May 18, 2012 meeting, the Board discussed and approved new proposed regulatory language relative to uniform standards for substance abusing licensees. The Board directed staff to initiate a rulemaking. As the rulemaking documents were being prepared, staff became aware of necessary substantive amendments to the proposed language. The Board will be reconsidering approval of the proposed language during its meeting on Thursday, February 28th. If the Board accepts staff's recommended changes at the meeting, the rulemaking documents will be filed with the Office of Administrative Law on Tuesday, March 5th. The rulemaking would be published in the California Regulatory Notice Register on Friday, March 15th; the 45-day public comment period would begin on March 15th and end on April 29th. A regulatory hearing would be held on Monday, April 29th. The Board would be able to consider comments received during the public comment period and at the hearing at its next meeting in May.

B. Examination, Permit, and License Fee Increases for Dentists (California Code of Regulations, Title 16, § 1021):

At its August 17, 2012 meeting, the Board discussed and approved proposed regulatory language relative to examination, permit, and license fee increases for dentists. The Board directed staff to initiate a rulemaking. Staff is currently drafting the initial rulemaking documents and will be filing the proposed language with the Office of Administrative Law in the near future.

C. Abandonment of Applications (California Code of Regulations, Title 16, §1004):

At its May 18, 2012 meeting, the Board discussed and approved proposed regulatory language relative to the abandonment of applications. The Board directed staff to initiate a rulemaking. At its December meeting, the Board deemed three other regulatory packages as top priority; those regulatory packages were relative to the fee increase, the Uniform Standards for Substance Abusing Licensees, and the Portfolio

Examination Requirements. Staff will continue working on the initial rulemaking documents in priority order.

Action Requested:

No action necessary.



MEMORANDUM

DATE	January 10, 2013
TO	Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item 5 : Discussion and Possible Action Regarding Reconsideration of Proposed Language and Initiation of a Rulemaking to Amend §1018 and Adopt §1018.01 of Title 16 of the California Code of Regulations Relevant to Uniform Standards for Substance Abusing Licensees

Background

On September 28, 2008, Senate Bill 1441 (Chapter 548, Statutes of 2008) was signed by Governor Arnold Schwarzenegger and established the Substance Abuse Coordination Committee (SACC) comprised of the executive officers of the Department of Consumer Affairs' (Department) healing arts boards, a representative of the California Department of Alcohol and Drug Programs, and chaired by the Director of the Department. The SACC was charged with the task of developing uniform standards in sixteen specific areas for use in dealing with substance abusing licensees, whether or not a healing arts board has a formal diversion program. In April 2010, the SACC developed a document named *Uniform Standards Regarding Substance-Abusing Healing Arts Licensees*, which contained the sixteen uniform standards as required by SB 1441. In April 2011, the SACC made revisions to the April 2010 version and finalized the document.

The Dental Board of California (Board) initiated its first rulemaking file to incorporate the uniform standards developed by the SACC into the Board's Disciplinary Guidelines in March 2011. As the Board moved through the formal rulemaking process during 2011 and early 2012, the Board was advised of varying agencies concerns regarding how the Board proposed the incorporation of the uniform standards. During that time, the Board received several legal opinions on its proposed incorporation of the uniform standards.

The Board's first rulemaking file expired in March 2012 and the Board was required to initiate a new rulemaking. The Board worked closely with the Department and Board Legal Counsel to develop new proposed regulatory language to incorporate the uniform standards developed by the SACC. At its May 18, 2012 meeting, the Board approved new proposed regulatory language and directed staff to initiate a new rulemaking. As the rulemaking documents were being prepared, staff became aware of necessary substantive amendments to the proposed language.

Recommended Amendments for Board Consideration:

Staff has prepared revised proposed regulatory language to amend Section 1018 and adopt Section 1018.01 of Article 4.5 of Chapter 1 of Division 10 of Title 16 of the California Code of Regulations for the Board's consideration. Additionally, staff has prepared a revised copy of the document incorporated by reference in proposed Section 1018.01 entitled *Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders, New May 18, 2012*. Staff has enclosed a copy of the proposed language and incorporated documents with the recommended revisions highlighted.

Staff recommends the Board accept the following revisions:

- Revise Section 1018.01 for the purposes of revising the date of the incorporated document entitled *Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders* from "New May 18, 2012" to "New February 28, 2013". This revision is necessary to identify the date the Board approved the most recent version of the incorporated document for the proposed rulemaking.
- Revise the date on the title page of the incorporated document entitled *Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders* from "New May 18, 2012" to "New February 28, 2013". This revision is necessary to identify the date the Board approved the most recent version of the incorporated document for the proposed rulemaking.
- Revise the date on the footer of the incorporated document entitled *Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders* from "New May 18, 2012" to "New February 28, 2013". This revision is necessary to identify the date the Board approved the most recent version of the incorporated document for the proposed rulemaking.
- Revise probation condition (2) Supervised Practice to specify that all costs of supervision shall be "paid" by the Respondent, rather than "borne" by the Respondent. This revision is necessary to maintain consistency, as the term "paid" is used in the remaining conditions in the incorporated document and in the Board's Disciplinary Guidelines.
- Delete the following sentence from probation condition (2) Supervised Practice: "If Respondent is placed on probation due to substance abuse or alcohol abuse, then the supervisor shall meet the following additional requirements:" This revision is necessary because the licensee would have already been determined to be a substance abuser as provided in Section 1018.01 before the probation conditions within the incorporated document were applied. This sentence implies discretion when in fact the supervisor is required to meet all of the conditions listed because the probationer has already been determined to be a substance abuser.

- Revise references to “respondent” to “Respondent”. This revision is necessary to maintain consistency throughout the incorporated document and the Board’s Disciplinary Guidelines. Additionally, this will ensure consistency with the grammar and terminology used in accusations, stipulated settlements, proposed decisions, etc. prepared by the Attorney General’s Office.
- Revise probation condition (5) Facilitated Group Support Meetings to specify that all costs associated with facilitated group support meetings shall be paid by the Respondent. The initial proposed language did not specify the responsible party for the financial costs associated with this probation condition. Current participants in the Board Diversion Program are responsible for the cost of such support meetings. The Board does not have funds allocated for the purposes of bearing the financial responsibility; therefore it is necessary to specify that it is the Respondent’s responsibility.
- Delete the following from probation condition (5) Facilitated Group Support Meetings: “If a facilitated group support meeting is ordered,”. This revision is necessary because the licensee would have already been ordered to comply with this probation condition. Since the probation condition would have already been ordered, the group facilitator is required to meet the specified qualifications and requirements.
- Revise probation condition (7) Drug or Alcohol Abuse Treatment Program to specify that all costs associated with drug or alcohol abuse treatment programs shall be paid by the Respondent. The initial proposed language did not specify the responsible party for the financial costs associated with this probation condition. Current participants in the Board Diversion Program are responsible for the cost of such treatment programs. The Board does not have funds allocated for the purposes of bearing the financial responsibility; therefore it is necessary to specify that it is the Respondent’s responsibility.

Board Action Requested:

Staff requests the Board accept the recommended revised proposed regulatory language relevant to the Uniform Standards for Substance-Abusing Licensees and direct staff to take all steps necessary to initiate the formal rulemaking process including noticing proposed language for 45-day public comment, setting proposed language for public hearing and authorizing the Executive Officer to make any non-substantive changes to the rulemaking package. If, after the close of the 45-day public comment period and public regulatory hearing, no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process and adopt the proposed amendments to §1018 and proposed addition of §1018.01 of Title 16 of the California Code of Regulations.

1 TITLE 16. DENTAL BOARD OF CALIFORNIA
2 DEPARTMENT OF CONSUMER AFFAIRS

3
4 PROPOSED LANGUAGE

5
6 Amend Section 1018 of Article 4.5 of Chapter 1 of Division 10 of Title 16 of the
7 California Code of Regulations to read as follows:

8
9 Article 4.5.
10 Disciplinary Guidelines and
11 Uniform Standards for Substance-Abusing Licensees

12
13 § 1018. Disciplinary Guidelines and Exceptions for Uniform Standards Related to
14 Substance-Abusing Licensees.

15
16 (a) In reaching a decision on a disciplinary action under the Administrative Procedures
17 Act (Government Code Section 11400 et seq.), the Dental Board of California shall
18 consider the disciplinary guidelines entitled "Dental Board of California Disciplinary
19 Guidelines With Model Language", revised 08/30/2010 which are hereby incorporated
20 by reference. Deviation from these guidelines and orders, including the standard terms
21 of probation, is appropriate where the Dental Board of California, in its sole discretion,
22 determines that the facts of the particular case warrant such deviation - for example: the
23 presence of mitigating factors; the age of the case; evidentiary problems.

24 (b) Notwithstanding subsection (a), the Board shall use the uniform standards for
25 substance-abusing licensees as provided in Section 1018.01, without deviation, for
26 each individual determined to be a substance-abusing licensee.

27 Note: Authority cited: Sections 315, 315.2, 315.4, and 1614, Business and Professions
28 Code; and Sections 11400.20 and 11400.21, Government Code. Reference: Sections
29 315, 315.2, and 315.4 of the Business and Professions Code; and Sections 11400.20
30 and 11425.50(e), Government Code.

31
32
33 **Adopt Section 1018.01 of Article 4.5 of Chapter 1 of Division 10 of Title 16 of the**
34 **California Code of Regulations to read as follows:**

35
36 § 1018.01. Uniform Standards for Substance-Abusing Licensees.

37
38 (a) If after notice and hearing conducted in accordance with Chapter 5, Part 1, Division
39 3, Title 2 of the Government Code (commencing with sections 11500 et seq.), the Board
40 finds that the evidence establishes that an individual is a substance-abusing licensee,
41 then the terms and conditions contained in the document entitled "Uniform Standards
42 Related to Substance-Abusing Licensees with Standard Language for Probationary
43 Orders," New ~~May 18, 2012~~ February 28, 2013, which are hereby incorporated by
44 reference, shall be used in any probationary order of the Board affecting that licensee.
45

1 (b) Nothing in this Section shall prohibit the Board from imposing additional terms or
2 conditions of probation that are specific to a particular case or that are derived from the
3 Board's guidelines referenced in Section 1018 in any order that the Board determines
4 would provide greater public protection.

5
6 Note: Authority cited: Sections 315, 315.2, 315.4, and 1614, Business and Professions
7 Code. Reference: Sections 315, 315.2, and 315.4 of the Business and Professions
8 Code; and Sections 11400.20 and 11425.50(e), Government Code.;

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4
5 **UNIFORM STANDARDS RELATED TO**
6 **SUBSTANCE-ABUSING LICENSEES WITH**
7 **STANDARD LANGUAGE FOR PROBATIONARY ORDERS**
8

9
10 **New ~~May 18, 2012~~ February 28, 2013**

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18 Issued By:
19 The Dental Board of California
20 2005 Evergreen Street, Suite 1550
21 Sacramento, California 95815
22 Telephone: (916) 263-2300
23 Fax: (916) 263-2140
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1 **STANDARD LANGUAGE TO BE INCLUDED IN EVERY PROBATIONARY ORDER**
2 **FOR SUBSTANCE-ABUSING LICENSEES**

3
4 Pursuant to Section 315 of the Business and Professions Code, the Dental Board of
5 California is directed to use the standards developed by the Substance Abuse
6 Coordination Committee (SACC) for substance abusing licensees. On April 11, 2011,
7 the SACC developed standards to be used by all healing arts boards. Administrative
8 Law Judges, parties and staff are therefore required to use the language below, which
9 is developed in accordance with those SACC standards.

10
11 To that end, the following probationary terms and conditions shall be used in every case
12 where it has been determined that the individual is a substance-abusing licensee as
13 provided in Section 1018.01 of Title 16 of the California Code of Regulations. For
14 purposes of implementation of these conditions of probation, any reference to the Board
15 also means staff working for the Dental Board of California or its designee. These
16 conditions shall be used in lieu of any similar standard or optional term or condition
17 proposed in the Board's Disciplinary Guidelines, incorporated by reference at Title 16,
18 California Code of Regulations Section 1018. However, the Board's Disciplinary
19 Guidelines should still be used in formulating the penalty and in considering additional
20 terms or conditions of probation appropriate for greater public protection (e.g., other
21 standard or optional terms of probation).

22
23 **ADDITIONAL PROBATIONARY TERMS AND CONDITIONS**

24
25 **(1) NOTIFICATION TO EMPLOYER:** Prior to engaging in the practice of dentistry, the
26 Respondent shall provide a true copy of the Decision and Accusation to his or her
27 employer, supervisor, or contractor, or prospective employer or contractor, and at any
28 other facility where Respondent engages in the practice of dentistry before accepting or
29 continuing employment. Respondent shall submit proof of compliance to the Board or
30 its designee within 15 calendar days.

31
32 This condition shall apply to any change(s) in place of employment.

33
34 The Respondent shall provide to the Board the names, physical addresses, mailing
35 addresses, and telephone numbers of all employers and supervisors, or contractors,
36 and shall inform the Board in writing of the facility or facilities at which the person
37 engages in the practice of dentistry.
38

1 Respondent shall give specific, written consent to the Board and its contractor to allow
2 the Board or its designee to communicate with the employer and supervisor, or
3 contractor regarding the licensee’s work status, performance, and monitoring.

4
5 **Source:** (Uniform Standard #3 of “Uniform Standards Regarding Substance-Abusing
6 Healing Arts Licensees,” revised dated April 2011.)

7 **(2) SUPERVISED PRACTICE:** Within 60 days of the effective date of this decision,
8 Respondent shall submit to the Board, for its prior approval, the name and qualifications
9 of one or more proposed supervisors and a plan for each such supervisor by which
10 Respondent’s practice would be supervised. The Board will advise Respondent within
11 two weeks whether or not the proposed supervisor and plan of supervision are
12 approved. Respondent shall not practice until receiving notification of Board approval of
13 Respondent’s choice of a supervisor and plan of supervision. Respondent shall
14 complete any required consent forms and sign an agreement with the supervisor and
15 the Board regarding the Respondent and the supervisor’s requirements and reporting
16 responsibilities.

17 The plan of supervision shall be *(direct and require the physical presence of the*
18 *supervising dentist in the dental office during the time dental procedures are*
19 *performed.) (general and not require the physical presence of the supervising dentist*
20 *during the time dental procedures are performed but does require an occasional*
21 *random check of the work performed on the patient as well as quarterly monitoring visits*
22 *at the office or place of practice).* Additionally, the supervisor shall have full and random
23 access to all patient records of Respondent. The supervisor may evaluate all aspects of
24 Respondent’s practice regardless of Respondent’s areas of deficiencies.

25
26 Each proposed supervisor shall be a California licensed dentist who shall submit written
27 reports to the Board on a quarterly basis verifying that supervision has taken place as
28 required and include an evaluation of Respondent’s performance. It shall be
29 Respondent’s responsibility to assure that the required reports are filed in a timely
30 manner. Each supervisor shall have been licensed in California for at least five (5)
31 years and not have ever been subject to any disciplinary action by the Board. An
32 administrative citation and fine does not constitute discipline and therefore, in and of
33 itself is not a reason to deny an individual as a supervisor.

34
35 The supervisor shall be independent, with no prior business or professional relationship
36 with Respondent and the supervisor shall not be in a familial relationship with or be an
37 employee, partner or associate of Respondent. If the supervisor terminates or is
38 otherwise no longer available, Respondent shall not practice until a new supervisor has

1 | been approved by the Board. All costs of the supervision shall be **borne-paid** by the
2 Respondent.

3
4 | **If Respondent is placed on probation due to substance or alcohol abuse, then the**
5 **supervisor shall meet the following additional requirements:**

6
7 The supervisor shall sign an affirmation that he or she has reviewed the terms and
8 conditions of the licensee's disciplinary order and agrees to supervise the licensee as
9 set forth by the Board.

10
11 The supervisor shall have face-to-face contact with the licensee in the work
12 environment on a frequent basis as determined by the Board, but at least once per
13 week. The supervisor shall interview other staff in the office regarding the licensee's
14 behavior, if applicable. The supervisor shall review the licensee's work attendance and
15 behavior.

16
17 The supervisor shall orally report any suspected substance abuse to the Board and the
18 licensee's employer within one (1) business day of occurrence. If occurrence is not
19 during the Board's normal business hours the oral report must be within one (1) hour of
20 the next business day. The supervisor shall submit a written report to the Board within
21 48 hours of occurrence.

22
23 The supervisor shall complete and submit a written report monthly or as directed by the
24 board. The report shall include: the licensee's name; license number; supervisor's
25 name and signature; supervisor's license number; worksite location(s); dates licensee
26 had face-to-face contact with supervisor; worksite staff interviewed, if applicable;
27 attendance report; any change in behavior and/or personal habits; any indicators that
28 can lead to suspected substance abuse.

29
30 **Source:** (Uniform Standard #7 of "Uniform Standards Regarding Substance-Abusing
31 Healing Arts Licensees," revised dated April 2011.)

32
33 | **NOTE:** Orthodontic Assistants require, at a minimum, direct supervision to perform
34 licensed functions (Business and Professions Code section 1750.3). Dental Sedation
35 Assistants require, at a minimum, direct supervision to perform licensed functions
36 (Business and Professions Code section 1750.5). Registered Dental Assistants in
37 Extended Functions require, at a minimum, direct supervision to perform certain
38 licensed functions (Business and Professions Code section 1753.5).

1 **(3) DRUG AND ALCOHOL TESTING:** Respondent shall submit to and pay for any
2 random and directed biological fluid or hair sample, breath alcohol or any other mode of
3 testing required by the Board. Though the frequency of testing will be determined by
4 the board or its designee, and shall be designed so as to prevent **respondent**
5 **Respondent** from anticipating testing dates (either randomized testing or unpredictable
6 dates), the frequency of testing shall be at least the following: at least fifty-two (52) test
7 dates during the first year of probation; at least thirty-six (36) test dates during the
8 second, third, fourth, and fifth years of probation; and at least one (1) test per month in
9 each year of probation after the fifth so long as there have been no positive test results
10 during the previous five (5) years. The board or its designee may require less frequent
11 testing if any of the following applies:

- 12
- 13 • Where **respondent Respondent** has previously participated in a treatment or
14 monitoring program requiring testing, the board or its designee may consider that
15 prior testing record in applying the three-tier testing frequency schedule
16 described above;
- 17
- 18 • Where the basis for probation or discipline is a single incident or conviction
19 involving alcohol or drugs, or two incidents or convictions involving alcohol or
20 drugs that were at least seven (7) years apart, that did not occur at work or on
21 the way to or from work, the board or its designee may skip the first-year testing
22 frequency requirement(s);
- 23
- 24 • Where **respondent Respondent** is not employed in any health care field,
25 frequency of testing may be reduced to a minimum of twelve (12) tests per year.
26 If **respondent Respondent** wishes to thereafter return to employment in a health
27 care field, **respondent Respondent** shall be required to test at least once a week
28 for a period of sixty (60) days before commencing such employment, and shall
29 thereafter be required to test at least once a week for a full year, before [he/she]
30 may be reduced to a testing frequency of at least thirty-six (36) tests per year,
31 and so forth;
- 32
- 33 • Respondent's testing requirement may be suspended during any period of tolling
34 of the period of probation;
- 35
- 36 • Where **respondent Respondent** has a demonstrated period of sobriety and/or
37 non-use, the board or its designee may reduce the testing frequency to no less
38 than twenty-four (24) tests per year.
- 39

1 Any detection through testing of alcohol, or of a controlled substance or dangerous drug
2 absent documentation that the detected substance was taken pursuant to a legitimate
3 prescription and a necessary treatment, may cause the board or its designee to
4 increase the frequency of testing, in addition to any other action including but not limited
5 to further disciplinary action.

6
7 Respondent shall have the test performed by a Board-approved laboratory certified and
8 accredited by the U.S. Department of Health and Human Services on the same day that
9 he or she is notified that a test is required. This shall ensure that the test results are
10 sent immediately to the Board. Failure to comply within the time specified shall be
11 considered an admission of a positive drug screen and constitutes a violation of
12 probation. If a test results in a determination that the urine admission was too diluted
13 for testing, the result shall be considered an admission of a positive urine screen and
14 constitutes a violation of probation. If an “out of range result” is obtained, the Board
15 may require Respondent to immediately undergo a physical examination and to
16 complete laboratory or diagnostic testing to determine if any underlying physical
17 condition has contributed to the diluted result and to cease practice. Any such
18 examination or laboratory and testing costs shall be paid by respondent. An
19 “out of range result” is one in which, based on scientific principles, indicates the
20 Respondent attempted to alter the test results in order to either render the test invalid or
21 obtain a negative result when a positive result should have been the outcome. If it is
22 determined that Respondent altered the test results, the result shall be considered an
23 admission of a positive urine screen and constitutes a violation of probation and
24 Respondent must cease practicing. Respondent shall not resume practice until notified
25 by the board. If Respondent tests positive for a banned substance, Respondent shall
26 be ordered by the Board to cease any practice, and may not practice unless and until
27 notified by the Board. All alternative drug testing sites due to vacation or travel outside
28 of California must be approved by the Board prior to the vacation or travel.

29
30 **Source:** (Uniform Standards #4, #8-10 of “Uniform Standards Regarding Substance-
31 Abusing Healing Arts Licensees,” revised dated April 2011 and Section 315.2 of the
32 Business and Professions Code.)

33
34 **(4) ABSTAIN FROM USE OF ALCOHOL, CONTROLLED SUBSTANCES AND**
35 **DANGEROUS DRUGS:** Respondent shall abstain completely from the possession,
36 injection, or consumption of any route, including inhalation, of all psychotropic (mood
37 altering) drugs, including alcohol, and including controlled substances as defined in the
38 California Uniform Controlled Substances Act, dangerous drug as defined by Business
39 and Professions Code Section 4022, and any drugs requiring a prescription. This
40 prohibition does not apply to medications lawfully prescribed by a physician and

1 surgeon, dentist, or nurse practitioner for a bona fide illness or condition. Within fifteen
2 (15) calendar days of receiving any lawful prescription medications, Respondent shall
3 notify the Board in writing of the following: prescriber's name, address, and telephone
4 number; medication name and strength, issuing pharmacy name, address, and
5 telephone number, and specific medical purpose for medication. Respondent shall also
6 provide a current list of prescribed medication with the prescriber's name, address, and
7 telephone number on each quarterly report submitted. Respondent shall provide the
8 Board with a signed and dated medical release covering the entire probation period.

9
10 Respondent shall identify for the Board's approval a single coordinating physician and
11 surgeon who shall be aware of Respondent's history of substance abuse and who will
12 coordinate and monitor any prescriptions for Respondent for dangerous drugs,
13 controlled substances, psychotropic or mood altering drugs. Once a Board-approved
14 physician and surgeon has been identified Respondent shall provide a copy of the
15 accusation and decision to the physician and surgeon. The coordinating physician and
16 surgeon shall report to the Board on a quarterly basis Respondent's compliance with
17 this condition. If any substances considered addictive have been prescribed, the report
18 shall identify a program for the time limited use of such substances.

19
20 The Board may require that only a physician and surgeon who is a specialist in
21 addictive medicine be approved as the coordinating physician and surgeon.

22
23 If Respondent has a positive drug screen for any substance not legally authorized,
24 Respondent shall be ordered by the Board to cease any practice and may not practice
25 unless and until notified by the Board. If the Board files a petition to revoke probation or
26 an accusation based upon the positive drug screen, Respondent shall be automatically
27 suspended from practice pending the final decision on the petition to revoke probation
28 or accusation. This period of suspension will not apply to the reduction of this
29 probationary period.

30
31 **Source:** (Uniform Standards #4, #8 of "Uniform Standards Regarding Substance-
32 Abusing Healing Arts Licensees," revised dated April 2011, and Section 315.2 of the
33 Business and Professions Code..)

34
35 **(5) FACILITATED GROUP SUPPORT MEETINGS:** Within fifteen (15) days from the
36 effective date of the decision, Respondent shall submit to the Board or its designee for
37 prior approval the name of one or more meeting facilitators. Respondent shall
38 participate in facilitated group support meetings within fifteen (15) days after notification
39 of the Board's approval of the meeting facilitator. When determining the type and

1 frequency of required facilitated group support meeting attendance, the Board shall give
2 consideration to the following:

- 3 • The licensee's history;
- 4 • The documented length of sobriety/time that has elapsed since substance abuse;
- 5 • The recommendation of the clinical evaluator;
- 6 • The scope and pattern of use;
- 7 • The licensee's treatment history; and ,
- 8 • The nature, duration, and severity of substance abuse.

9
10 Verified documentation of attendance shall be submitted by Respondent with each
11 quarterly report. Respondent shall continue attendance in such a group for the duration
12 of probation unless notified by the Board that attendance is no longer required. **All costs**
13 **associated with facilitated group support meetings shall be paid by the Respondent.**

14
15 **If a facilitated group support meeting is ordered, t**he group facilitator shall meet the
16 following qualifications and requirements:

- 17
18 1. The group meeting facilitator shall have a minimum of three (3) years experience
19 in the treatment and rehabilitation of substance abuse, and shall be licensed or
20 certified by the state or other nationally certified organizations.
- 21 2. The group meeting facilitator shall not have a financial relationship, personal
22 relationship, or business relationship with the licensee in the last five (5) years.
- 23 3. The group facilitator shall provide to the Board a signed document showing the
24 licensee's name, the group name, the date and location of the meeting, the
25 licensee's attendance, and the licensee's level of participation and progress.
- 26 4. The group meeting facilitator shall report any unexcused absence to the Board
27 within twenty-four (24) hours.

28
29 **Source:** (Uniform Standard #5 of "Uniform Standards Regarding Substance-Abusing
30 Healing Arts Licensees," revised dated April 2011,

31
32 **(6) CLINICAL DIAGNOSTIC EVALUATION:** Upon order of the Board, Respondent
33 shall undergo a clinical diagnostic evaluation. The board or its designee shall select or
34 approve evaluator(s) holding a valid, unrestricted license to practice, with a scope of
35 practice that includes the conduct of clinical diagnostic evaluations and at least three (3)

1 years' experience conducting such evaluations of health professionals with alcohol or
2 substance abuse problems. The evaluator(s) shall not have a financial relationship,
3 | personal relationship, or business relationship with **respondent-Respondent** within the
4 last five (5) years. The evaluator(s) shall provide an objective/ unbiased, and
5 | independent evaluation of **respondent-Respondent**. Respondent shall provide the
6 evaluator with a copy of the Board's Decision prior to the clinical diagnostic evaluation
7 being performed.

8
9 Any time the Respondent is ordered to undergo a clinical diagnostic evaluation,
10 Respondent shall cease practice for a minimum of 30 days pending the results of a
11 clinical diagnostic evaluation and review by the Board. During such time, the
12 Respondent shall submit to random drug testing at least 2 times per week.

13
14 Respondent shall cause the evaluator to submit to the Board a written clinical diagnostic
15 evaluation report within 10 days from the date the evaluation was completed, unless an
16 extension, not to exceed 30 days, is granted to the evaluator by the Board. The cost of
17 such evaluation shall be paid by the Respondent. The evaluation(s) shall be conducted
18 in accordance with acceptable professional standards for alcohol or substance abuse
19 clinical diagnostic evaluations. The written report(s) shall set forth, at least, the opinions
20 | of the evaluator as to: whether **respondent-Respondent** has an alcohol or substance
21 | abuse problem; whether **respondent-Respondent** is a threat to him/herself or others;
22 and recommendations for alcohol or substance abuse treatment, practice restrictions, or
23 | other steps related to **respondent's-Respondent's** rehabilitation and safe practice. If the
24 | evaluator determines during the evaluation process that **respondent-Respondent** is a
25 threat to him/herself or others, the evaluator shall notify the board within twenty-four
26 (24) hours.

27
28 Respondent shall cease practice until the Board determines that he or she is able to
29 safely practice either full-time or part-time and has had at least 30 days of negative drug
30 test results. Respondent shall comply with any restrictions or recommendations made
31 as a result of the clinical diagnostic evaluation.

32
33 **Source:** (Uniform Standards #1, 2 of "Uniform Standards Regarding Substance-
34 Abusing Healing Arts Licensees," revised dated April 2011, and Business and
35 Professions Code section 315.4,)

36
37 **(7) DRUG OR ALCOHOL ABUSE TREATMENT PROGRAM:** Upon order of the
38 Board, Respondent shall successfully complete an inpatient, outpatient or any other
39 type of recovery and relapse prevention treatment program as directed by the Board.

1 When determining if Respondent should be required to participate in inpatient,
2 outpatient or any other type of treatment, the Board shall take into consideration the
3 recommendation of the clinical diagnostic evaluation, license type, licensee's history,
4 length of sobriety, scope and pattern of substance abuse, treatment history, medical
5 history, current medical condition, nature, duration and severity of substance abuse and
6 whether the licensee is a threat to himself or herself or others. All costs associated with
7 completion of a drug or alcohol abuse treatment program shall be paid by the
8 Respondent.
9
10 **Source:** (Uniform Standard #6 of "Uniform Standards Regarding Substance-Abusing
11 Healing Arts Licensees," revised dated April 2011.



MEMORANDUM

DATE	February 5, 2013
TO	Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item 6 : Discussion and Possible Action Regarding the Subcommittee's Review of § 1005 of Title 16 of the California Code of Regulations Relevant to the Minimum Standards for Infection Control Conducted by the Dental Board of California and the Dental Hygiene Committee of California

Background

Business and Professions Code Section 1680(ad) and California Code of Regulation, Title 16, Section 1005(c) require the Dental Board of California (Board) and the Dental Hygiene Committee of California (Committee) to review the regulation relative to the minimum standards for infection control (Section 1005) annually and establish a consensus.

Section 1005 was last amended in 2011 and has been effective since August 20, 2011. In the fall of 2012, the Board and the Committee appointed the following representatives to a subcommittee to conduct the required annual review of Section 1005:

- Huong Le, DDS (Dental Board of California)
- Noel Kelsch, RDHAP (Dental Hygiene Committee of California)
- Denise Romero, RDA (Dental Assisting Council)

These three subcommittee members were selected to represent each of the licensing categories within the dental health care community of California and to establish a consensus on findings to bring forward to the Board and Committee for consideration. Additionally, the Executive Officers of the Board and the Committee have worked to form a consensus on staff recommendations regarding the subcommittee's findings.

While reviewing Section 1005, the subcommittee considered the six legal review standards established in the Administrative Procedure Act when determining findings to be forwarded to the Board and the Committee for consideration. Those six legal review standards are:

- (1) Authority: Has the Legislature delegated the power to adopt this regulation?

- (2) Clarity: Can the regulation be easily understood by those affected?
- (3) Consistency: Does the regulation conflict with other regulations or statutes?
- (4) Necessity: Is there demonstrated evidence that there is a need for the regulation?
- (5) Non-Duplication: Does the regulation duplicate other regulations or statutes?
- (6) Reference: Which statute does the regulation implement, interpret, or make specific?

Additionally, the subcommittee noted that Section 1005 requires all dental health care personnel to comply with infection control precautions and enforce the minimum precautions established in Section 1005 to protect patients and dental health care personnel and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA). Section 1005 does not preclude any of the Board's or the Committee's licensees from complying with laws and regulations governed by other State and Federal agencies (i.e. Cal/OSHA). A copy of Section 1005 is enclosed for reference.

Subcommittee Findings and Staff Recommendations:

The subcommittee met on February 4, 2013 via teleconference to review Section 1005 and established a consensus to bring the following findings forward to the Board and the Committee for review. The Executive Officers of the Board and Committee have worked to form a consensus on staff recommendations regarding the subcommittee's findings.

Finding No. 1:

The subcommittee established a consensus that Section 1005(a)(12)(C), relative to the definition for "Other Potentially Infections Material (OPIM)", may need to be revised to clarify the definition relating to HIV, HBV, and HCV. The subcommittee questioned if the current definition contradicts universal precautions. The subcommittee determined that this finding should be forwarded to the Board and the Committee for consideration.

Staff Recommendation:

According to The Centers for Disease Control and Prevention (CDC) *Guidelines for Infection Control in Dental Health-Care Settings, 2003* OPIM is defined as: "Other potentially infectious materials. OPIM is an OSHA term that refers to 1) body fluids including semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures; any body fluid visibly contaminated with blood; and all body fluids in situations where differentiating between body fluids is difficult or impossible; 2) any unfixed tissue or organ (other than intact skin) from a human (living or dead); and 3) HIV-containing cell or tissue cultures, organ cultures; HIV- or HBV-containing culture medium or other

solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.”

The California Division of Occupational Safety and Health’s (Cal/OSHA) regulations relating to bloodborne pathogens (Cal.Code of Regs., Title 8, Section 5193) defines OPIM as follows:

“OPIM” means other potentially infectious materials.

“Other Potentially Infectious Materials” means:

(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as emergency response;

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

(3) Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV, or HCV:

(A) Cell, tissue, or organ cultures from humans or experimental animals;

(B) Blood, organs, or other tissues from experimental animals; or

(C) Culture medium or other solutions.

The definition currently found in Section 1005(a)(12)(C) was derived from the Cal/OSHA definition to ensure dental offices are in compliance with Cal/OSHA’s regulations.

At this time, staff does not recommend that the Board or the Committee amend the language currently found in Section 1005(a)(12)(C) as this language is consistent with Cal/OSHA’s definition of OPIM. However, should the CDC or Cal/OSHA amend their definitions in the future, the Board and Committee may find it necessary to amend the definition of OPIM found in Section 1005(a)(12)(C) at that time.

Finding No. 2:

The subcommittee established a consensus that Section 1005(b)(8), relative to gloves, may need to be revised to specify that gloves are required to be puncture-resistant. The subcommittee members noted that there have been some instances when dental health care personnel have not utilized puncture resistant gloves when processing sharp instruments, needles, and devices. The subcommittee determined that this finding should be forwarded to the Board and the Committee for consideration.

Staff Recommendation:

Currently, Section 1005(b)(8) specifies that when processing contaminated sharp instruments, needles, and devices, dental health care personnel shall wear heavy-duty utility gloves to prevent puncture wounds.

At this time, staff does not recommend that the Board or the Committee amend the language currently found in Section 1005(b)(8) relating to gloves. Staff does not believe it is necessary to amend the language at this time as the current language is clear that the heavy duty gloves are to be worn to prevent puncture wounds, thus implying the gloves be “puncture-resistant”. Adding the term “puncture-resistant” would be considered duplication. Staff recommends keeping note of this subcommittee finding and include it as part of a future regulatory proposal at a time when the Board and the Committee deem it necessary to amend Section 1005.

Board Action Requested:

The Board may take action to accept or reject staff’s recommendations in response to the subcommittee’s findings of its review of California Code of Regulations, Title 16, Section 1005 relative to the minimum standards of infection control.

If the Board takes action to accept staff’s recommendations, then formal regulatory amendments **would not** be promulgated at this time; however, staff would maintain records of this subcommittee’s review findings for consideration by the Board and the Committee during future annual reviews.

If the Board takes action to reject staff’s recommendations, then formal regulatory amendments **would** be promulgated and staff would need additional subcommittee, Board, and Committee input regarding the proposed language amendments that would be brought forth to the Board to initiate a proposed rulemaking at a future meeting date.

Title 16. Professional and Vocational Regulations
Division 10. Dental Board of California
Chapter 1. General Provisions Applicable to All Licensees
Article 1. General Provisions

§ 1005. Minimum Standards for Infection Control.

(a) Definitions of terms used in this section:

(1) "Standard precautions" are a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene, use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure, and safe handling of sharps. Standard precautions shall be used for care of all patients regardless of their diagnoses or personal infectious status.

(2) "Critical items" confer a high risk for infection if they are contaminated with any microorganism. These include all instruments, devices, and other items used to penetrate soft tissue or bone.

(3) "Semi-critical items" are instruments, devices and other items that are not used to penetrate soft tissue or bone, but contact oral mucous membranes, non-intact skin or other potentially infectious materials (OPIM).

(4) "Non-critical items" are instruments, devices, equipment, and surfaces that come in contact with soil, debris, saliva, blood, OPIM and intact skin, but not oral mucous membranes.

(5) "Low-level disinfection" is the least effective disinfection process. It kills some bacteria, some viruses and fungi, but does not kill bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.

(6) "Intermediate-level disinfection" kills mycobacterium tuberculosis var bovis indicating that many human pathogens are also killed. This process does not necessarily kill spores.

(7) "High-level disinfection" kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.

(8) "Germicide" is a chemical agent that can be used to disinfect items and surfaces based on the level of contamination.

(9) "Sterilization" is a validated process used to render a product free of all forms of viable microorganisms.

(10) "Cleaning" is the removal of visible soil (e.g., organic and inorganic material) debris and OPIM from objects and surfaces and shall be accomplished manually or mechanically using water with detergents or enzymatic products.

(11) "Personal Protective Equipment" (PPE) is specialized clothing or equipment worn or used for protection against a hazard. PPE items may include, but are not limited to, gloves, masks, respiratory devices, protective eyewear and protective attire which are intended to prevent exposure to blood, body fluids, OPIM, and chemicals used for infection control. General work attire such as uniforms, scrubs, pants and shirts, are not considered to be PPE.

(12) "Other Potentially Infectious Materials" (OPIM) means any one of the following:

(A) Human body fluids such as saliva in dental procedures and any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

(B) Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

(C) Any of the following, if known or reasonably likely to contain or be infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV):

1. Cell, tissue, or organ cultures from humans or experimental animals;
2. Blood, organs, or other tissues from experimental animals; or
3. Culture medium or other solutions.

(13) "Dental Healthcare Personnel" (DHCP), are all paid and non-paid personnel in the dental healthcare setting who might be occupationally exposed to infectious materials, including body substances and contaminated supplies, equipment, environmental surfaces, water, or air. DHCP includes dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).

(b) All DHCP shall comply with infection control precautions and enforce the following minimum precautions to protect patients and DHCP and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA).

- (1) Standard precautions shall be practiced in the care of all patients.
- (2) A written protocol shall be developed, maintained, and periodically updated for proper instrument processing, operatory cleanliness, and management of injuries. The protocol shall be made available to all DHCP at the dental office.
- (3) A copy of this regulation shall be conspicuously posted in each dental office.

Personal Protective Equipment:

(4) All DHCP shall wear surgical facemasks in combination with either chin length plastic face shields or protective eyewear whenever there is potential for aerosol spray, splashing or spattering of the following: droplet nuclei, blood, chemical or germicidal agents or OPIM. Chemical-resistant utility gloves and appropriate, task specific PPE shall be worn when handling hazardous chemicals. After each patient treatment, masks shall be changed and disposed. After each patient treatment, face shields and protective eyewear shall be cleaned, disinfected, or disposed.

(5) Protective attire shall be worn for disinfection, sterilization, and housekeeping procedures involving the use of germicides or handling contaminated items. All DHCP shall wear reusable or disposable protective attire whenever there is a potential for aerosol spray, splashing or spattering of blood, OPIM, or chemicals and germicidal agents. Protective attire must be changed daily or between patients if they should become moist or visibly soiled. All PPE used during patient care shall be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal/OSHA Bloodborne Pathogens Standards (Title 8, Cal. Code Regs., section 5193).

Hand Hygiene:

(6) All DHCP shall thoroughly wash their hands with soap and water at the start and end of each workday. DHCP shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated an alcohol based hand rub may be used as an alternative to soap and water. Hands shall be thoroughly dried before donning gloves in order to prevent promotion of bacterial growth and washed again immediately after glove removal. A DHCP shall refrain from providing direct patient care if hand conditions are present that may render DHCP or patients more susceptible to opportunistic infection or exposure.

(7) All DHCP who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves.

Gloves:

(8) Medical exam gloves shall be worn whenever there is contact with mucous membranes, blood, OPIM, and during all pre-clinical, clinical, post-clinical, and laboratory procedures. When processing contaminated sharp instruments, needles, and devices, DHCP shall wear heavy-duty utility gloves to prevent puncture wounds. Gloves must be discarded when torn or punctured, upon completion of treatment, and before leaving laboratories or areas of patient care activities. All DHCP shall perform hand hygiene procedures before donning gloves and after removing and discarding gloves. Gloves shall not be washed before or after use.

Needle and Sharps Safety:

(9) Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal. Disposable needles, syringes, scalpel blades, or other sharp items and instruments shall be placed into sharps containers for disposal as close as possible to the point of use according to all applicable local, state, and federal regulations.

Sterilization and Disinfection:

(10) All germicides must be used in accordance with intended use and label instructions.

(11) Cleaning must precede any disinfection or sterilization process. Products used to clean items or surfaces prior to disinfection procedures shall be used according to all label instructions.

(12) Critical instruments, items and devices shall be discarded or pre-cleaned, packaged or wrapped and sterilized after each use. Methods of sterilization shall include steam under pressure (autoclaving), chemical vapor, and dry heat. If a critical item is heat-sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process. These instruments, items, and devices, shall remain sealed and stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the facility.

(13) Semi-critical instruments, items, and devices shall be pre-cleaned, packaged or wrapped and sterilized after each use. Methods of sterilization include steam under pressure (autoclaving), chemical vapor and dry heat. If a semi-critical item is heat sensitive, it shall, at minimum, be processed with high level disinfection and packaged or wrapped upon completion of the disinfection process. These packages or containers shall remain sealed and shall be stored in a manner so

as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the facility.

(14) Non-critical surfaces and patient care items shall be cleaned and disinfected with a California Environmental Protection Agency (Cal/EPA)-registered hospital disinfectant (low-level disinfectant) labeled effective against HBV and HIV. When the item is visibly contaminated with blood or OPIM, a Cal/EPA-registered hospital intermediate-level disinfectant with a tuberculocidal claim shall be used.

(15) All high-speed dental hand pieces, low-speed hand pieces, rotary components and dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be packaged, labeled and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item.

(16) Single use disposable items such as prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips, and gloves shall be used for one patient only and discarded.

(17) Proper functioning of the sterilization cycle of all sterilization devices shall be verified at least weekly through the use of a biological indicator (such as a spore test). Test results shall be documented and maintained for 12 months.

Irrigation:

(18) Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone. Sterile coolants/irrigants must be delivered using a sterile delivery system.

Facilities:

(19) If non-critical items or surfaces likely to be contaminated are manufactured in a manner preventing cleaning and disinfection, they shall be protected with disposable impervious barriers. Disposable barriers shall be changed when visibly soiled or damaged and between patients.

(20) Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a California Environmental Protection Agency (Cal/EPA) registered, hospital grade low- to intermediate-level germicide after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use disinfectants in accordance with the manufacturer's instructions. Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal/EPA registered, hospital grade disinfectant. Products used to clean items or surfaces prior to disinfection procedures shall be clearly labeled and DHCP shall follow all material safety data sheet (MSDS) handling and storage instructions.

(21) Dental unit water lines shall be anti-retractable. At the beginning of each workday, dental unit lines and devices shall be purged with air or flushed with water for at least two (2) minutes prior to attaching handpieces, scalers, air water syringe tips, or other devices. The dental unit lines and devices shall be flushed between each patient for a minimum of twenty (20) seconds.

(22) Contaminated solid waste shall be disposed of according to applicable local, state, and federal environmental standards.

Lab Areas:

(23) Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a sterilized or new rag-wheel shall be used for each patient. Devices used to polish, trim, or adjust contaminated intraoral devices shall be disinfected or sterilized, properly packaged or wrapped and labeled with the date and the specific sterilizer used if more than one sterilizer is utilized in the facility. If packaging is compromised, the instruments shall be recleaned, packaged in new wrap, and sterilized again. Sterilized items will be stored in a manner so as to prevent contamination.

(24) All intraoral items such as impressions, bite registrations, prosthetic and orthodontic appliances shall be cleaned and disinfected with an intermediate-level disinfectant before manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

(c) The Dental Board of California and Dental Hygiene Committee of California shall review this regulation annually and establish a consensus.

¹Cal/EPA contacts: WEBSITE www.cdpr.ca.gov or Main Information Center (916) 324-0419.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1680, Business and Professions Code.

HISTORY

1. New section filed 6-29-94; operative 7-29-94 (Register 94, No. 26).
2. Repealer and new section filed 7-8-96; operative 8-7-96 (Register 96, No. 28).
3. Repealer of subsection (a)(5) and subsection renumbering, amendment of subsections (b)(7), (b)(10), (b)(18)-(19) and (b)(23) and repealer of subsection (c) and subsection relettering filed 10-23-97; operative 11-22-97 (Register 97, No. 43).
4. Change without regulatory effect amending subsection (b)(4) filed 12-7-98 pursuant to section 100, title 1, California Code of Regulations (Register 98, No. 50).
5. Amendment of subsections (b)(11), (b)(13) and (b)(15) filed 6-30-99; operative 7-30-99 (Register 99, No. 27).
6. Amendment filed 3-1-2005; operative 3-31-2005 (Register 2005, No. 9).
7. Amendment filed 7-21-2011; operative 8-20-2011 (Register 2011, No. 29).



MEMORANDUM

DATE	February 13, 2013
TO	Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item 7 : Discussion and Possible Action Regarding Board Policy Decision to Authorize the Use of All Image Receptors to Capture Radiographs During Radiation Safety Instruction and Certification Provided by Educational Programs and Courses in Compliance with California Code of Regulations, Title 16, Sections 1014 and 1014.1

Background

The California Association of Dental Assisting Teachers (CADAT) submitted proposed regulatory amendments to the California Code of Regulations, Title 16, Sections 1014 and 1014.1 relative to radiation safety courses for the Dental Assisting Council (Council) to review and provide recommendations to the Board to promulgate a formal rulemaking. Those proposed amendments are currently under review by an appointed subcommittee of the Council and will be considered by the full Council at this meeting.

During discussions with representatives of CADAT, it became evident that the current regulatory requirements regarding traditional film and computer digital radiographic equipment found in Sections 1014 and 1014.1 was not conducive to the technologically advanced environment currently used by dental professionals. During the December 2012 Board meeting public comment agenda item, representatives of CADAT raised concerns regarding the current radiographic technology used by programs and courses during instruction in radiation safety as being outside the scope of the currently effective regulatory requirements. Additionally, CADAT submitted a letter to the Board requesting this issue be placed on the February agenda. A copy of CADAT's letter is enclosed for reference.

Existing Law:

Existing law, Section 1014.1(f)(1) requires two full mouth periapical series, consisting of at least 18 radiographs each, 4 of which must be bitewings for the purposes of laboratory instruction during a radiation safety course. This section specifies that no more than one series may be completed using computer digital radiographic equipment.

Existing law, Section 1014.1(g)(1) requires successful completion of a minimum of four full mouth periapical series, consisting of at least 18 radiographs each, 4 of which must

be bitewings for the purposes of clinical instruction during a radiation safety course. This section specifies that traditional film packets must be double film and no more than three series may be completed using computer digital radiographic equipment.

CADAT's Request:

CADAT has requested the Board consider action to authorize the use of all "image receptors" to capture radiographs during radiation safety instruction and certification provided by educational programs and courses. This would allow the programs and courses to decide the type of image receptor (e.g. traditional film, digital device, etc.) to be used to capture the radiographic images needed for completion of instruction in radiation safety. Additionally, this would allow the program and course to determine which radiography equipment would be best suited to reduce patient exposure to radiation in the interest of public protection.

The proposed regulatory amendments to Sections 1014 and 1014.1 that are currently under review by an appointed subcommittee of the Council are consistent with CADAT's requested action. The Board would be unable to enforce the proposed regulatory amendments until the time the proposed amendments were adopted by the Board and became effective in accordance with the Administrative Procedure Act (Government Code Section 11340 *et seq.*).

Board Action Requested By CADAT:

Consider and possibly adopt a formal policy interpretation of California Code of Regulations, Title 16, Sections 1014 and 1014.1 to authorize the use of all "image receptors" (e.g. traditional film, digital device, etc.) to capture radiographs during radiation safety instruction and certification provided by educational programs and courses and deem the use of all "image receptors" in compliance with the laboratory and clinical instruction requirements until the proposed amendments to Sections 1014 and 1014.1 become effective in accordance with the Administrative Procedure Act (Government Code Section 11340 *et seq.*).



February 6, 2013
Ms. Karen Fischer
Interim Executive Director
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

Request for Agenda Item – February 28 – March 1, 2013 Dental Board Meeting

Full Board Agenda Item: *Discussion and Possible Action to Allow for the Use of all Image Receptors to Capture Radiographs during Radiation Safety Instruction and Certification by Educational Courses and Programs - Reference CCR §1014.1 4 (f)(1), (g) (1)*

Dear Ms. Fischer:

During the December 3 – 4, 2012 Dental Board meeting, representatives of the California Association of Dental Assisting Teachers (CADAT) raised concerns regarding the current radiographic technology used by programs and courses during instruction in Radiation Safety as being outside the scope of the current educational regulations. Specifically, the devices used in education today across all dental disciplines is advanced and not in accordance with the current educational regulations.

During the last DBC meeting discussion identified that Dental Schools are not necessarily limiting radiographs to only three digital radiographic exposures on patients as noted in the current regulations under general considerations. It was further noted that Dental Schools would be considered out of compliance with the current regulations since they use digital image receptors for all of the patient exposures and not traditional films.

It was suggested by Dental Board legal counsel to direct the board to consider action allowing for the use of an image receptor for all radiographic exposures, in keeping with current technology. Such action would amend current regulation stating "no more than one series may be completed using computer digital radiographic equipment" during laboratory instruction (CCR §1014.1 (4)(f)(1)) and "no more than three series may be completed using computer digital radiographic equipment" during clinical experiences (CCR §1014.1 (4)(g) (1)). The program or course could decide the type of image receptor (e.g: traditional film, digital device, etc.) to be used to capture the radiographic images for completion of instruction in the subject area.

It should also be noted that institutional accreditation standards for any dental discipline through the American Dental Association, Commission on Dental Accreditation (CODA), does not supersede individual state regulations for education in any specific subject area, including Radiation Safety, and does not specify subject-specific curriculum requirements. Although all Dental Schools, all Hygiene Schools and several Dental Assisting

Schools in California are CODA accredited, such accreditation does not preclude such schools/programs from adhering to existing State educational regulations or statutes.

CADAT has addressed this matter in the proposed regulations currently under review and consideration by the Board. Until such time as the work has concluded on CCR 1014 and 1014.1, we ask that the Board take action to allow for all programs and schools to be considered compliant while using the advanced technology currently made available to the profession.

Respectfully,

A handwritten signature in cursive script that reads "Lorraine Gagliardi".

Dr. Lorraine Gagliardi, CDA, RDA, RDH, Ed.D
Director – Council on Statutory and Regulatory Affairs, CADAT



NOTICE OF PUBLIC MEETING – Notice is hereby given that a public meeting of the Enforcement Committee of the Dental Board of California will be held as follows:

NOTICE OF ENFORCEMENT COMMITTEE MEETING

Thursday, February 28, 2013

Upon Conclusion of Agenda Item 7

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

(619)232-3861 or (916)263-2300

ENFORCEMENT COMMITTEE

Chair – Steven Afriat, Public Member

Vice Chair – Bruce Witcher, DDS

Fran Burton, Public Member

Luis Dominicis, DDS

Suzanne McCormick, DDS

CALL TO ORDER

ROLL CALL AND ESTABLISHMENT OF QUORUM

ENF 1 - Approval of the December 3, 2012 Enforcement Committee Meeting Minutes

ENF 2 - Staff Update Regarding Enforcement Unit Projects and Improvements

ENF 3 - Enforcement Program – Statistics and Status

ENF 4 - Review of Second Quarter Performance Measures from the Department of Consumer Affairs

ENF 5 - Diversion Statistics

ENF 6 - Discussion and Possible Action Regarding Recommendations for the Appointment of a Northern California Diversion Evaluation Committee Member

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

FUTURE AGENDA ITEMS

Stakeholders Are Encouraged to Propose Items for Possible Consideration by the Committee at a Future Meeting.

COMMITTEE MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

ADJOURNMENT

Public comments will be taken on agenda items at the time the specific item is raised. The Committee may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the Committee Chair. For verification of the meeting, call (916) 263-2300 or access the Board's web site at www.dbc.ca.gov. The meeting facilities are accessible to individuals with physical disabilities. Please make any request for accommodations to Karen M. Fischer, Interim Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, no later than one week prior to the day of the meeting.



ENFORCEMENT COMMITTEE
Meeting Minutes
Monday, December 3, 2012
Embassy Suites LAX/South
1440 East Imperial Avenue, El Segundo, CA 90245
DRAFT

Members Present

Rebecca Downing, Public Member - Chair
Huong Le, DDS - Vice Chair
Steven Afriat, Public Member
Suzanne McCormick, DDS
Bruce Whitcher, DDS

Members Absent

Staff Present

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel

ROLL CALL AND ESTABLISHMENT OF QUORUM

Rebecca Downing, Chair, called the Enforcement Committee to order at 9:58 a.m. Roll was called and a quorum established.

ENF 1 – Approval of the August 16, 2012 Enforcement Committee Meeting Minutes

M/S/C (Afriat/McCormick) to approve the minutes of the August 16, 2012 meeting of the Enforcement Committee of the Dental Board of California (Board). The motion passed with one abstention.

ENF 2 – Staff Update Regarding Enforcement Unit Projects and Improvements

Kim Trefry, Enforcement Chief, introduced April Alameda as the new manager of the Dental Assisting unit as well as the Investigative Analysis unit. Ms. Trefry gave an overview of the Enforcement Programs Projects and Improvements including Probation Procedure Training that was conducted in October and November by Supervising Investigator Teri Lane and lead Investigator Steve Nicas using the newly completed Probation Procedure Manual. The training helps insure that all personnel are approaching the Probation tasks consistently

statewide. She reported that in October and November, sworn investigative staff completed both the mandatory Tactical Weapons course and Arrest and Control training. These courses met the POST biennial Perishable Skills training requirement for a certified law enforcement agency. This is the first time in several years that staff met these two requirements. In addition, several of the staff participated in local task forces to network, share information, and maintain awareness of law enforcement trends. These included the Prescription Drug Abuse Task Force (PDATF) attended by Supervising Investigator Vicki Williams, the San Diego Insurance Premium Fraud Task Force attended by Investigator Stephen Nicas, the Consumer Fraud Task Force, and the Prescription Diversion Investigation Network (PDIN). Ms. Trefry also reported on Enforcement efforts, gave a vehicle update and reviewed staffing changes.

ENF 3 – Enforcement Program – Statistics and Status

Kim Trefry, Enforcement Chief, gave an overview of the Enforcement Program Statistics revealing that an average of 302 complaints per month were received over the last 12 months. Each Consumer Services Analyst (CSA) handles an average of 188 cases. Approximately 2,660 complaint files were closed in the last 12 months with an average number of days to closure being 75.

Ms. Trefry also reported there are currently 718 open investigative cases, 311 probation cases and 53 open inspection cases. Investigators handled an average of 35 cases each. The total number of investigation cases closed, filed with the Attorney General's Office or filed with the District/City Attorney during the last 12 months is 996, an average of 83 per month. It took an average of 401 days to complete an investigation.

Dr. Witcher asked if there was any difference, to the licensee, whether a case is closed with merit or closed without merit as there is no discipline imposed in either case. Mr. DeCuir stated that if there are multiple cases closed with merit they will look for a pattern of practice. Dr. McCormick asked if the license holder is notified when a case is closed with merit. Ms. Trefry indicated that circumstances differ therefore notifications are not always sent. Dr. Witcher commented that it might be a good idea to notify the licensee so that they would know when a complaint against them was closed with merit. Mr. DeCuir agreed.

ENF 4 – Review of First Quarter Performance Measures from the Department of Consumer Affairs

Kim Trefry, Enforcement Chief gave an overview of the first quarter performance measures that are compiled by the Department of Consumer Affairs. Data is collected quarterly and reported on the Department's website at: http://www.dca.ca.gov/about_dca/cpei/index.shtml

ENF 5 – Diversion Statistics

Ms. Trefry gave an overview of the Diversion statistics including one probation referral during July, one investigative referral in August and one probation referral in September totaling three for the quarter ending 9/30/2012. She reported that the Diversion Evaluation Committee conducted interviews on November 29, 2012 for the vacant positions on the Committee.

ENF 6 – Update on Implementation of Notice to Consumers of Licensure by the Dental Board (California Code of Regulations, Title 16, § 1065)

Sarah Wallace, Legislative and Regulatory Analyst, reported that in late October the Office of Administrative Law notified staff that the Board's rulemaking requiring dentists to provide

notice to consumers of licensure by the Dental Board was approved and filed with the Secretary of State. The new regulatory requirement became effective on November 28, 2012. The notice is required to be prominently posted in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services. The notice must be in at least 48-point type font and include the following statement and information:

NOTICE TO CONSUMERS
Dentists are licensed and regulated
by the Dental Board of California
(877) 729-7789
www.dbc.ca.gov

To implement this new requirement, Board staff added information to Board's web site notifying all visitors of the new requirement. Additionally staff sent an email blast to all who have signed up to receive email notifications from the Board. As a courtesy, Board staff also provided a printable sign on the Board's web site.

Karen Fischer, Interim Executive Officer stated that a mass mailing will be done notifying all dental licensees about the new regulations regarding the Notice to Consumers and Sponsored Free Health Care Events.

There was no public comment.

The Enforcement Committee adjourned at 10:30 a.m.



MEMORANDUM

DATE	February 8, 2013
TO	Enforcement Committee Dental Board of California
FROM	Kim A. Trefry, Enforcement Chief Dental Board of California
SUBJECT	Agenda Item ENF 2: Enforcement Program Projects and Improvements

Enforcement Efforts

On January 24, 2013, the Southern California Enforcement office served a search warrant in Los Angeles after an investigation uncovered unlicensed dentistry taking place. The search was the culmination of several weeks of investigation efforts and was successful in large part due to the bilingual skills of two of the investigative staff (Monica Ackerson and Carlos Alvarez). At the time investigators entered the converted apartment, there were six patients in the “family room” waiting to be treated.

Staff cited and released the suspect and seized numerous instruments and equipment as evidence. The case will be presented to the District Attorney’s office for filing of Unlicensed Practice of Dentistry and Health and Safety Code violations for Possession of Hypodermic Needles.

Vehicle Update

In January, our sworn investigators were given notice that effective January 31, 2013 their Vehicle Home Storage Permits were being rescinded. Up until February, investigators could travel from their residence to their case assignments throughout the state without reporting to an office on a daily basis. This was intended as an efficiency for staff who may have assignments in their county of residence or nearer than their assigned office.

This change was the culmination of a Department-wide audit of vehicle utilization in response to Executive order B-2-11. The Department of General Services (DGS), who manages the state’s vehicle fleet has issued new criteria that must be met before re-issuing permits will be considered. We believe our sworn investigators meet the intent of the Cost Effective criteria and will be submitting a new request for consideration.

In July we reported the reduction of our fleet by one vehicle. In January we met with DCA and DGS in anticipation of submitting a Department-wide Vehicle Acquisition Plan to purchase replacements for our aging fleet. Currently the Board is requesting approval to purchase five replacement vehicles for those with the highest mileage and/or highest repair costs.

Staffing

An applicant has been placed in the background process to fill the sworn investigator vacancy in the Southern California Enforcement office. We anticipate the background investigation will be completed in the next 30 days.

The non-sworn Investigative Analysis Unit (IAU) has hired a new Associate Government Program Analyst (Bernal Vaba) to replace a vacancy in this unit.

I will be available during the Board meeting to answer any questions or concerns you may have.



MEMORANDUM

DATE	February 8, 2013
TO	Enforcement Committee Dental Board of California
FROM	Kim A. Trefry, Enforcement Chief Dental Board of California
SUBJECT	Agenda Item ENF 3: Enforcement Program Statistics

Attached please find Complaint Intake and Investigation statistics for the previous 12 month period. Below is a summary of some of the program's trends:

Complaint & Compliance Unit

Complaints Received: The total number of complaint files received during the previous 12 months was **3788**, averaging **315** per month (a 5% increase from the previous calendar year period).

Pending Cases (as of 12/30/12): **905**

Average caseload per Consumer Services Analyst (CSA) = **129** cases
 Cases pending assignment = 1

Chart 1 - Case Aging (as of 12/30/12)

0-3 Months	590	59%
4-6 Months	272	27%
7-9 Months	96	9%
10-12 Months	32	3%
1-3 Years	7	>1%

Chart 2 - Cases Closed: The total number of complaint files closed during the same time period was **2800**, an increase of over 7% from last year. The average number of days a complaint took to close within the last 12 months was **75** days (comparable to last year's average of 74 days).

Charts 3 & 4- Allegation Types These charts provide a breakdown of open and closed complaints by allegation type.

Investigations

Current Open Caseload (As of 12/31/12)

There are currently approximately **833** open investigative cases, **308** probation cases, and **68** open inspection cases.

Average caseload per full time Investigator = 37.5 (22.5 in North, 52.5 in South)

Average caseload per Special Investigator/Analyst = 31.5

Chart 5 - Case Aging(As of 12/31/12)

0 – 3 Months	97	12%
3 – 6 Months	93	11%
6 – 12 Months	254	32%
1 – 2 Years	290	35%
2 – 3 Years	64	8%
3+ Years	14	2%

Since our last report (December 2012), the number of cases over 1 year old has increased slightly from 40% - 45%. The number of cases in the oldest category (3 years and older) has increased from 13 to 14.

Chart 6 - Case Closures The total number of investigation cases closed, filed with the Attorney General's Office or filed with the District/City Attorney during the last 12 months is **926**, an average of **77** per month, down slightly from last quarter.

Of the closures, approximately 14% were referred to the AGO for discipline.

The average number of days an investigation took to complete within the last 12 months was **394** days. The average number of days to close a case in 2011 was 389.

Charts 7 & 8 – Allegation Types These charts provide a breakdown of open and closed investigations by allegation type.

Chart 9 – Unassigned Caseload Currently the enforcement program is assigning cases shortly after they have been assigned to investigation from the Complaint unit.

Charts 10 & 11 – Cases Referred for Discipline The total number of cases referred to the Attorney General's Office during the past 12 months was **150** (approximately 12.5 referrals per month). The 12-month average for a disciplinary case to be completed was **890** days.

Investigative Activity Reporting (IAR) Update

The IAR program records investigative time spent performing administrative and criminal casework and probation monitoring tasks, as well as the type of closure when the work is completed. Case hours are provided to the prosecution for cost recovery purposes and can be used as a budgetary tool.

The Case Closure attachment shows the percentage of cases closed within the designated closure categories. These charts include data for the previous 12 month cycle (01/01/2012 – 12/31/2012). The majority (**53%**) of our case time is devoted to cases which are ultimately closed due to *Insufficient Evidence*.¹ This percentage has remained relatively stable.

The Case Category attachment displays the cumulative case hours dedicated to different allegations being investigated or licensees being monitored on probation. This report shows the majority (**35%**) of our investigative efforts are dedicated to *Negligence/Incompetence* cases. The next highest categories of investigative case time were divided between *Criminal Conviction* cases (**12%**) and *Unlicensed Practice* cases (**12%**).

It should be noted that although *Drug Prescribing Violations* are only 3% of our total hours, these cases average approximately 40 hours each; far in excess of any other investigation type.

Probation Monitoring Activity These quarterly tasks require an average of 12 hours per case of investigative time annually. At the time of this report, staff were spending approximately **12%** of their investigative time performing probation monitoring tasks.

Attached are two pie charts to illustrate these percentages.

I will be available during the Board meeting to answer any questions or concerns you may have.

¹Cases are typically closed *Insufficient Evidence* when a complaint alleging negligent or incompetent treatment is reviewed by a Subject Matter Expert, and is found to be a simple departure from the standard of care or does not rise to the level warranting formal discipline.

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITY - DENTAL BOARD OF CALIFORNIA
January 2012 - December 2012

COMPLAINT UNIT														
Initial Pending		593	599	623	704	748	826	741	740	802	824	853	863	
Total Received		304	269	413	320	381	279	275	377	225	368	296	281	3788
Closed in Complaint Unit	2,4	242	235	290	244	203	261	240	239	163	244	242	217	2820
With Merit		117	117	154	134	100	147	115	100	72	106	154	140	1456
w/o merit		125	118	136	110	103	114	125	139	91	138	88	77	1364
Referred for Investigation		59	75	107	66	123	104	74	91	46	48	57	58	908
Pending at end of Period		599	623	704	748	826	741	740	802	824	853	863	905	
Unassigned at end of period		0	0	0	0	0	0	1	1	1	0	0	1	

0

INVESTIGATIONS	Charts	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
Initial Pending	5,7	851	848	844	864	832	865	853	841	832	832	802	816	
Assigned		817	812	835	845	745	783	744	737	711	711	796	809	
Unassigned		34	36	9	19	15	9	25	11	13	7	6	7	
Total Received from Complaint Unit		59	75	107	66	123	104	74	91	46	48	57	58	908
Closed in Current Month	6,8	62	79	87	98	90	116	86	100	46	78	43	41	926
With Merit		49	58	67	72	52	99	66	93	41	57	27	26	707
w/o Merit		13	21	20	26	38	17	20	7	5	21	16	15	219
Referred to AG		9	16	19	16	17	15	6	21	6	17	8	7	136
Referred for Criminal		0	0	3	1	2	2	2	6	1	0	0	0	17
Pending at end of period		848	844	864	832	865	853	841	832	832	802	816	833	
Assigned		812	835	845	745	783	744	737	711	711	796	809	821	
Unassigned	9	36	9	19	15	9	25	11	13	7	6	7	12	

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITY - DENTAL BOARD OF CALIFORNIA
January 2012 - December 2012

ATTORNEY GENERAL	Charts	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
Initial Pending		213	216	224	231	236	236	227	227	219	209	219	211	
Referrals from Investigations		9	16	19	16	17	15	6	21	6	17	8	7	136
Referred to the AG	10	9	16	23	16	21	11	7	9	3	20	5	10	150
Accusations Filed		3	11	5	9	15	6	10	5	10	11	11	4	100
Statement of Issues Filed		2	1	13	2	4	2	3	0	2	4	1	0	34
Petition to Revoke		1	0	2	0	1	1	0	0	1	1	1	0	8
Surrender of License		0	0	0	3	0	0	1	1	1	2	0	0	8
Cases Closed	11	8	6	11	13	17	4	8	14	8	8	5	6	108
Pending at end of period		216	224	231	236	236	227	227	219	209	219	211	208	

**Statistical Summary of Complaint Age
January 2012 - December 2012**

Chart 1 - Open Complaints by Age

Breakdown by Age	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
0 - 3 Months	532	546	576	590	651	564	537	566	573	650	609	590
4-6 Months	101	113	128	123	123	141	153	193	193	178	215	272
7-9 Months	12	14	27	34	37	32	31	24	35	57	89	96
10-12 Months	7	7	3	6	5	7	8	7	10	17	19	32
1-2 Years	0	1	1	3	4	4	4	4	4	5	10	6
2-3 Years	1	1	1	0	0	0	0	1	1	0	0	0
3+ Years	0	0	0	1	1	0	0	0	0	1	1	0
Total*	539	682	536	757	821	748	733	795	816	908	943	997

*Totals will not match **Pending at end of Period** due to coding variations within Open Case Aging reports.

Chart 2 - Closed Complaints by Age

Breakdown by Age	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
0 - 3 Months	174	161	223	169	137	145	129	149	86	139	178	137	1827
3-6 Months	62	62	52	59	51	95	72	62	57	85	42	38	737
6-12 Months	6	11	14	15	15	20	37	25	19	18	21	23	224
1-2 Years	0	0	1	1	0	0	2	2	1	2	0	2	11
2-3 Years	0	0	0	0	0	0	0	0	0	0	0	0	0
3+ Years	0	0	0	0	0	1	0	0	0	0	0	0	1
Total*	242	234	290	244	203	261	240	238	163	244	241	200	2800

**Statistical Summary of Complaint Categories
January 2012 - December 2012**

Chart 3 - Open Complaints by Allegation Type

Allegation	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD Totals
Substance Abuse, Mental/Physical Impairment (A)	1	1	0	0	0	0	1	1	2	2	2	3	13
Drug Related Offenses (D)	2	1	3	4	0	0	0	0	0	0	1	0	11
Unsafe/Unsanitary Conditions (E)	5	5	8	7	6	7	10	10	7	9	6	7	87
Fraud (F)	18	22	29	31	38	42	48	46	55	58	58	54	499
Non-Jurisdictional (J)	23	27	27	27	25	20	10	11	12	12	16	16	226
Incompetence/Negligence (N)	456	463	475	500	511	494	512	560	570	599	587	618	6345
Other (O)	51	44	40	44	43	50	50	57	65	56	68	0	636
Unprofessional Conduct (R)	24	33	35	40	40	38	37	38	32	37	50	75	479
Sexual Misconduct (S)	1	0	0	0	0	0	0	1	0	2	1	1	6
Discipline by Another State (T)	0	2	2	0	1	2	1	1	2	2	2	2	17
Unlicensed/Unregistered (U)	9	18	4	8	5	5	9	12	12	12	15	14	123
Criminal Charges (V)	74	72	115	110	158	95	62	65	67	127	143	145	1233
Total*	664	688	738	771	827	753	740	802	824	916	949	1003	

*Totals will not match **Pending at end of Period** due to coding variations within Open Case Allegation reports.

**Statistical Summary of Complaint Categories
January 2012 - December 2012**

Chart 4 - Closed Complaints by Allegation Type

Allegation	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD Totals
Sub. Abuse, Mental/Physical Impairment (A)	0	0	0	0	0	0	0	0	0	0	0	0	0
Drug Related Offenses (D)	0	0	0	0	1	0	0	0	0	0	0	0	1
Unsafe/Unsanitary Conditions (E)	3	6	12	16	2	10	5	8	7	9	5	7	90
Fraud (F)	7	2	10	4	3	6	9	16	3	9	5	6	80
Non-Jurisdictional (J)	22	19	39	20	23	20	23	9	11	14	16	12	228
Incompetence/Negligence (N)	111	100	108	100	95	116	108	110	77	118	71	67	1181
Other (O)	16	22	14	6	18	13	19	15	20	28	8	38	217
Unprofessional Conduct (R)	8	8	8	11	6	7	13	4	11	5	6	5	92
Sexual Misconduct (S)	0	0	0	0	0	0	0	0	0	1	0	0	1
Discipline by Another State (T)	0	0	1	1	0	0	1	0	0	0	0	0	3
Unlicensed/Unregistered (U)	1	2	5	1	0	2	1	3	0	1	1	0	17
Criminal Charges (V)	74	78	93	85	55	87	61	74	34	59	130	65	895
Total	242	237	290	244	203	261	240	239	163	244	242	200	2805

**Statistical Summary of Investigation Age
January 2012 - December 2012**

Chart 5 - Open Investigations by Age

Breakdown by Age	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
0 - 3 Months	87	68	129	134	175	126	109	92	89	83	73	97
3 - 6 Months	135	129	113	103	100	146	160	164	119	103	97	93
6 - 12 Months	258	253	254	246	247	225	217	212	250	253	256	254
1 - 2 Years	272	272	247	250	236	249	253	256	259	257	273	290
2 - 3 Years	92	86	93	72	63	63	68	61	64	66	70	64
3+ Years	7	10	16	8	22	18	13	10	13	11	15	14
Total	851	818	852	813	843	827	820	795	794	773	784	0

Chart 6 - Closed Investigations by Age

Breakdown by Age	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
0 - 3 Months	4	13	16	14	21	60	27	22	5	19	9	3	213
3 - 6 Months	7	13	7	11	8	6	12	12	4	18	8	7	113
6 - 12 Months	17	16	19	15	22	10	13	22	6	7	11	14	172
1 - 2 Years	24	26	23	28	20	21	21	23	23	19	9	9	246
2 - 3 Years	10	11	22	29	16	14	11	17	8	7	7	6	158
3+ Years	0	0	0	1	3	5	2	4	0	8	0	1	24
Total	62	79	87	98	90	116	86	100	46	78	44	40	926

*Numbers in Chart 5 & 6 may not match the main statistical summary.

Aging reports are captured at the end of each month.

Summary reports are captured at the end of each quarter and may reflect changes to the data.

**Statistical Summary of Investigation Categories
January 2012 - December 2012**

Chart 7 - Open Investigations by Allegation Type

Allegation	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Substance Abuse, Mental/Physical Impairment (A)	7	6	7	7	7	7	8	8	7	9	8	9
Drug Related Offenses (D)	32	30	32	34	32	35	33	28	27	27	27	29
Unsafe/Unsanitary Conditions (E)	4	5	5	4	6	6	6	6	4	4	5	5
Fraud (F)	58	53	50	50	50	49	50	49	46	47	51	56
Non-Jurisdictional (J)	2	2	2	2	3	4	3	3	3	3	2	2
Incompetence/Negligence (N)	307	299	290	285	297	283	281	275	283	259	268	270
Other (O)	42	42	82	90	89	89	84	86	87	96	0	98
Unprofessional Conduct (R)	103	101	103	96	89	85	84	79	79	78	76	82
Sexual Misconduct (S)	10	11	11	8	9	8	7	7	7	6	6	5
Discipline by Another State (T)	30	29	29	20	16	15	16	5	6	7	7	7
Unlicensed/Unregistered (U)	131	131	140	138	141	146	144	139	139	140	147	152
Criminal Charges (V)	125	112	99	85	112	101	106	114	105	89	86	83
Total	851	821	850	819	851	828	822	799	793	765	780	798

Statistical Summary of Investigation Categories
January 2012 - December 2012

Chart 8 - Closed Investigations by Allegation Type

Allegation	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
Substance Abuse, Mental/Physical Impairment (A)	1	1	0	0	0	0	0	0	1	0	1	0
Drug Related Offenses (D)	2	4	1	3	5	2	1	5	1	1	2	2
Unsafe/Unsanitary Conditions (E)	0	0	1	1	0	0	0	1	2	1	0	0
Fraud (F)	1	6	7	2	5	3	3	2	3	3	0	0
Non-Jurisdictional (J)	0	0	0	0	0	0	1	0	0	0	1	0
Incompetence/Negligence (N)	32	25	32	28	15	27	33	17	16	38	13	11
Other (O)	1	5	6	1	7	3	5	4	1	4	4	6
Unprofessional Conduct (R)	7	6	8	13	12	8	9	10	1	4	7	0
Sexual Misconduct (S)	0	0	1	3	1	1	2	0	1	1	1	3
Discipline by Another State (T)	0	1	0	11	5	1	1	11	0	1	0	0
Unlicensed/Unregistered (U)	3	11	12	16	8	6	5	14	6	6	2	4
Criminal Charges (V)	15	18	19	20	32	65	26	35	14	19	12	14
Total	62	77	87	98	90	116	86	99	46	78	43	40

Unassigned Investigations by Case Age
January 2012 - December 2012

Chart 9

Breakdown by Age	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
0 - 3 Months	9	3	11	8	3	10	4	5	1	0	2	4
3 - 6 Months	9	0	2	2	0	1	2	3	3	2	0	1
6 - 12 Months	4	3	3	3	1	2	1	1	1	1	3	4
1 - 2 Years	12	3	2	0	2	1	3	3	1	1	1	2
2 - 3 Years	2	0	1	1	1	1	1	1	1	1	1	1
3 + Years	0	0	0	0	0	0	0	0	0	0	0	0
Total	36	9	19	14	7	15	11	13	7	5	7	12

Disciplinary Referrals by Category
January 2012 - December 2012

Chart 10 - Disciplinary Referrals by Category

Allegation	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
Cases referred to the Attorney Generals Office	9	16	23	16	21	11	7	9	3	20	5	10	150
Accusations Filed	3	11	5	9	15	6	10	5	10	11	11	4	100
Statement of Issues Filed	2	1	13	2	4	2	3	0	2	4	1	0	34
Petition for Reinstatement	0	0	0	0	0	0	0	0	0	0	0	0	0
Petition to Revoke Probation	1	0	2	0	1	1	0	0	1	1	1	0	8
Petition for Early Termination of Probation	0	0	0	1	0	0	0	0	0	0	1	0	2
Petition to Modify Probation	0	0	0	1	0	0	0	0	0	0	0	0	1
Request for Interim Susp Order / PC23 / TRO	0	1	0	1	0	1	1	0	0	0	0	2	6

**Disciplinary Actions Taken
January 2012 - December 2012**

Chart 11 - Disciplinary Actions

Allegation	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	YTD
Probation	5	3	6	6	6	11	1	7	6	3	2	3	59
Suspension	0	0	1	0	0	2	0	0	0	0	0	0	3
Revocation	3	4	4	5	3	2	5	5	2	2	1	1	37
Public Reprimand	1	1	2	1	1	2	2	2	0	1	2	1	16
License Denial	0	0	1	0	0	2	0	0	0	0	1	1	5
License Surrender	0	0	0	3	0	0	1	1	1	2	0	0	8
Interim Suspension Order/PC23	0	1	1	1	0	1	2	0	0	0	0	2	8
Other*	0	0	0	0	0	1	1	0	2	2	0	0	6
No Discipline	1	1	1	0	0	2	1	0	2	1	1	1	11
Accusation Withdrawn	0	1	0	2	0	0	1	1	1	1	1	0	8
Accusation Dismissed	0	0	0	0	0	0	0	0	0	1	0	0	1
Accusation Declined	0	0	0	0	0	0	0	0	0	0	0	0	0

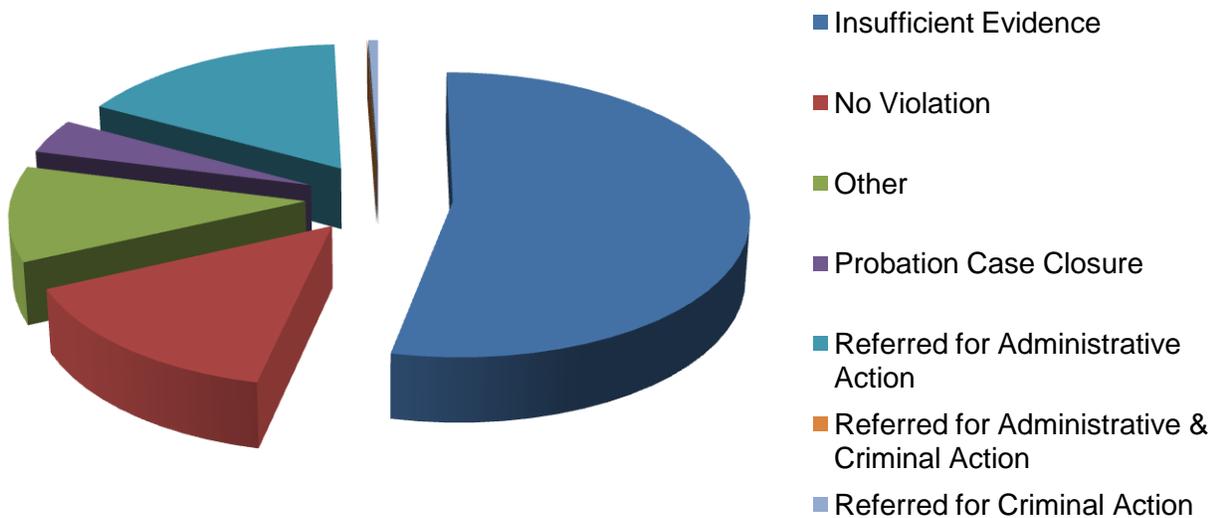
* Represents cases *Opened in Error* & cases rejected for filing by the Executive Officer

Investigator Activity Report Hours Worked by Closure Category

Case Closure Categories	Case Hours	# of Cases	% of Total
Insufficient Evidence	3093	371	53%
No Violation	853	85	15%
Other	628	67	11%
Probation Case Closure	228.5	21	4%
Referred for Administrative Action	953	93	16%
Referred for Administrative & Criminal Action	1	1	0%
Referred for Criminal Action	33	6	1%
Total	5789.5	644	100%

1/1/2012 - 12/31/2012

Hours Worked by Closure Category

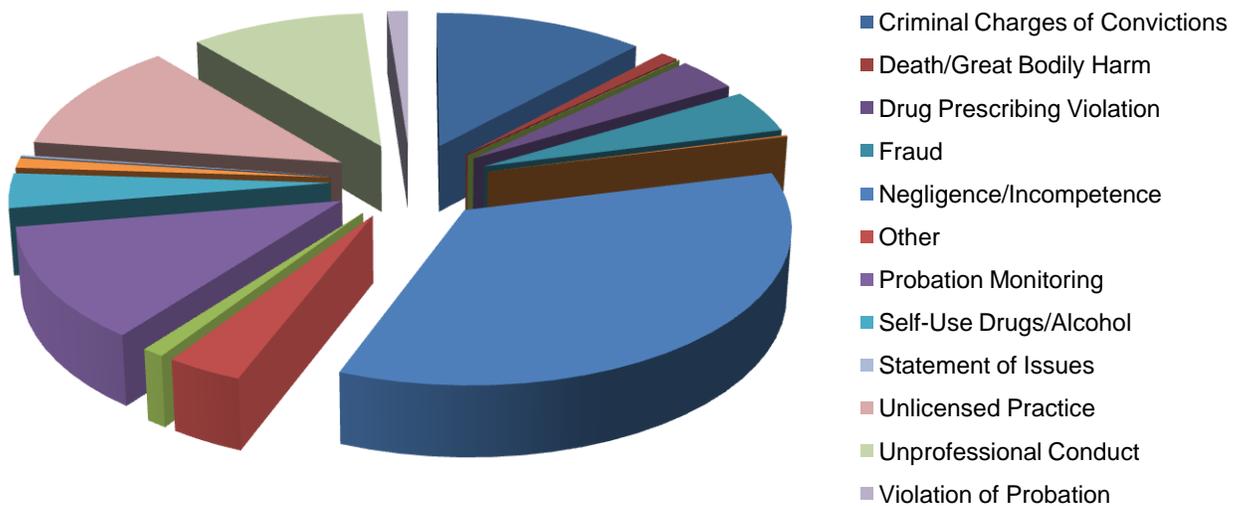


Investigator Activity Reporting System (IAR) Hours Worked by Case Type

Case Categories	Case Hours	# of Cases	% of Total
Aid/Abet Unlicensed Activity	140	21	1%
Criminal Charges of Convictions	2374	355	12%
Death/Great Bodily Harm	205	18	1%
Discipline by Another State	12	3	0%
Drug Prescribing Violation	696	27	3%
Fraud	899	87	4%
Mental/Physical Illness	31	2	0%
Negligence/Incompetence	6940	530	35%
Other	690	96	3%
Patient Abandonment	201	17	1%
Probation Monitoring	2391	194	12%
Self-Use Drugs/Alcohol	724	44	4%
Sexual Misconduct	207	16	1%
Statement of Issues	35	3	0%
Unlicensed Practice	2339	142	12%
Unprofessional Conduct	1969	175	10%
Violation of Probation	235	17	1%
Totals	20,088	1747	100%

1/1/2012 - 12/31/2012

Hours Worked by Case Type



overall time to resolve. Amending an accusation or requesting additional expert opinions can also cause delays in case adjudication. Other matters are outside the control of the Board and include: availability of hearing dates, continuance of hearing dates, changes to opposing party counsel, and requests for a change of venue.

- **Probation Intake – Target: 10 Days** **Q2 Average: 23 Days**
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer; and

Probation Intake measures the time between when the probation monitor is assigned the case file and the date they meet with their assigned probationer to review monitoring terms and conditions. The Board's probation monitors are assigned a case file within a few days of the probationary order being signed. Monitors attempt to schedule their initial meeting on or soon after the effective date of the decision; thereby resulting in a 10 – 20 day intake average. We believe this Q2 average of 23 days is reasonable. It should also be noted that in some cases, probation monitoring may not take place until an applicant has completed all their licensing requirements, or returned to California (if the applicant is out-of-state). These exceptions may skew this average.

- **Probation Violation Response – Target: 10 Days** **Q2 Average: 7 Days**
Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

In general, once a violation is discovered, the decision to take action is made immediately. However, the monitor must collect any supporting evidence (arrest/conviction records, positive drug test results) and write a report documenting the event. Once the report is referred for discipline, "appropriate action" has been initiated and the clock stops. Factors which may affect the turnaround time on this measure include how the violation is reported; (incoming complaints or arrest/conviction reports from the Department of Justice may take several days to be processed) and how quickly the monitor can write up and file the violation.

- **Consumer Satisfaction Survey** The Department provided the Board with survey results for only one month of the second quarter performance measure cycle (October through December 2012). With approximately 240 case closures during this one month period, only five survey responses were received, a 2% response rate.

Dental Board of California

Performance Measures

Q2 Report (October - December 2012)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

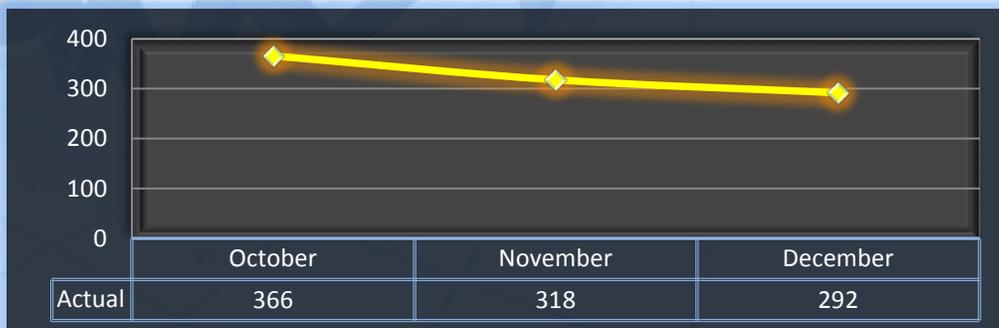
Volume

Number of complaints and convictions received.

Q2 Total: 976

Complaints: 657 Convictions: 319

Q2 Monthly Average: 325

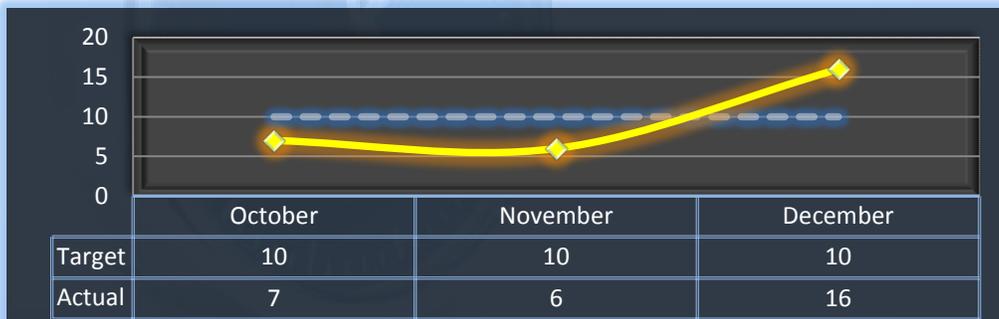


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 10 Days

Q2 Average: 9 Days

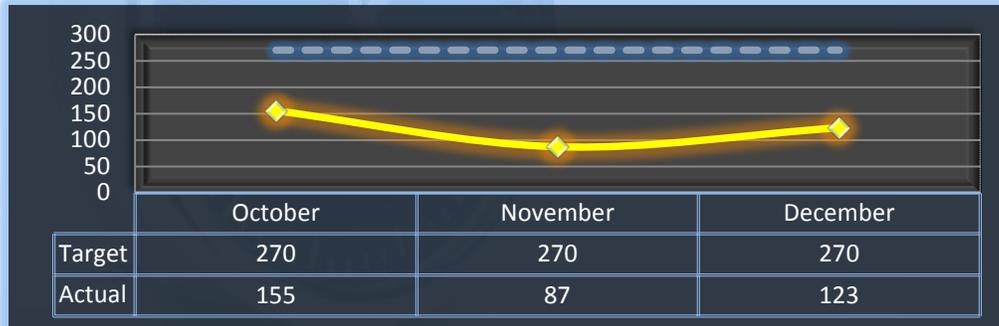


Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 270 Days

Q2 Average: 123 Days



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 540 Days

Q2 Average: 834 Days



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 10 Days

Q2 Average: 23 Days

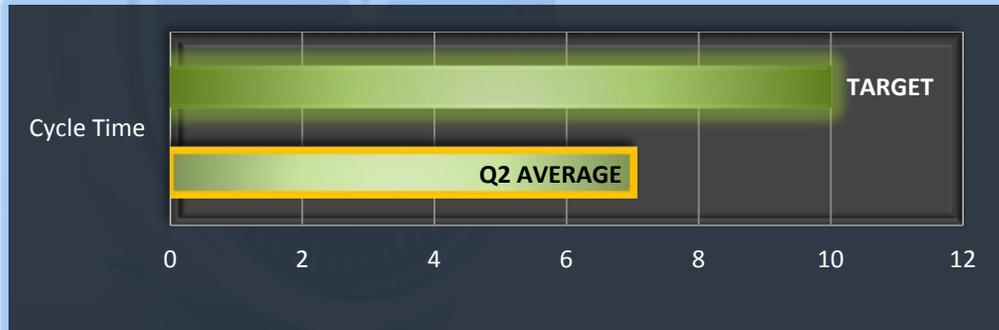


Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 10 Days

Q2 Average: 7 Days





MEMORANDUM

DATE	February 12, 2013
TO	Enforcement Committee Members Dental Board of California
FROM	Lori Reis, Manager Dental Board of California
SUBJECT	Agenda Item ENF 5: Diversion Statistics

Attached are the Diversion Program statistics for quarter ending 12/31/12. These statistics reflect the participant activity in the Diversion (Recovery) Program and are presented for information purposes only.

These statistics are derived from the MAXIMUS reports and are approximated numbers.

NOTE: There was one (1) probation referral into the Diversion Program during the month of October. In November, there was one (1) investigative referral. In December, there were no intakes. For the quarter ending 12/31/12, there was a total of two (2) intakes.

The next DEC meeting is scheduled for March 7th at the Board's Sacramento Office.

**Dental Board of California
Diversion Program
Statistical Summary
As of 12/31/2012**

	Current Quarter	Fiscal Year To Date	Program To Date
I INTAKES INTO PROGRAM			
1. Self Referral	0	0	29
2. Investigative Referral	1	2	65
3. Probation Referral	1	3	61
Group Totals	2	5	155
II APPLICANTS INTERVIEWED BY EACH DEC			
1. DBC Northern CA	2	2	57
2. DBC Southern CA	3	7	80
Group Totals	5	9	137
III APPLICANTS ACCEPTED BY EACH DEC			
1. DBC Northern CA	2	2	52
2. DBC Southern CA	3	6	65
Group Totals	5	8	117
IV STATUS CHANGES IN PROGRAM			
1. Closed	1	NA	NA
V CLOSED CASES			
1. Applicant Not Accepted by DEC	1	1	20
2. Applicant Public Risk	0	0	1
3. Applicant Withdrawn - Pre DEC	0	0	14
4. Clinically Inappropriate - Post DEC	0	0	7
5. Clinically Inappropriate - Pre DEC	0	0	7
6. Completed	1	5	76
7. No Longer Eligible - Post DEC	0	0	2
8. Sent to Board - Pre DEC	0	0	1
9. Terminated - Expired	0	0	3
10. Terminated - Failure to Receive Benefit	0	0	6
11. Terminated - Non Compliant	0	0	17
12. Terminated - Public Risk	0	0	19
13. Withdrawn - Post DEC	1	1	14
Group Totals	3	7	187
VI PARTICIPANT POPULATION TOTALS			
1. Active Participants at Beginning of Quarter	33		
2. Active Participants served this Quarter	34		
3. Active Participants at the End of the Quarter	34		
VII RECIDIVISM, INTAKE OF KNOWN PRIOR PARTICIPANTS			
Intake of Known Prior Participants	1	2	20
VIII GENDER AT INTAKE			
1. Female	0	0	47
2. Male	2	5	106
3. Unknown	0	0	2
Group Totals	2	5	155

	Current Quarter	Fiscal Year To Date	Program To Date
IX AGE CATEGORY AT INTAKE			
1. 20 - 24	0	0	2
2. 25 - 29	0	0	6
3. 30 - 34	0	0	15
4. 35 - 39	0	1	23
5. 40 - 44	0	1	25
6. 45 - 49	0	0	29
7. 50 - 54	2	2	23
8. 55 - 59	0	0	16
9. 60 - 64	0	1	11
10. 65 +	0	0	5
Group Totals	2	5	155
X WORKSITE OF PRACTICE SETTING AT INTAKE			
1. Corporation	0	0	1
3. Dental Private Practice	2	3	77
4. Doctor's Office	0	0	11
5. Group Practice - profit	0	2	5
6. Hospital	0	0	1
7. Lab	0	0	1
8. Other	0	0	4
9. Undetermined	0	0	23
10. Unemployed	0	0	32
Group Totals	2	5	155
XI SPECIALTIES AT INTAKE			
1. General Dentist	2	4	74
2. HMO	0	0	1
3. Medical Surgical	0	0	1
4. Other	0	1	46
5. Undetermined	0	0	33
Group Totals	2	5	155
XII PRESENTING PROBLEM AT INTAKE			
1. Alcohol	2	3	33
2. Alcohol and Mental Illness	0	0	7
3. Alcohol and Mono Drug	0	0	21
4. Alcohol and Poly Drug	0	1	19
5. Alcohol, Mono Drug and Mental Illness	0	0	2
6. Alcohol, Poly Drug and Mental Illness	0	1	6
7. Mental Illness	0	0	2
8. Mono Drug	0	0	33
9. Mono Drug and Mental Illness	0	0	7
10. Poly Drug	0	0	15
11. Poly Drug and Mental Illness	0	0	8
12. Undetermined	0	0	2
Group Totals	2	5	155
XIII SUBSTANCE USED DURING 12 MONTHS PRIOR TO INTAKE			
Collection of statistical information for Substance began September 2004			
1. Coumadin	0	0	1
2. Aciphex	0	0	1
3. Advair Diskus	0	0	1
4. Alcohol	0	1	60
5. Aleve	1	1	13

	Current Quarter	Fiscal Yr To Date	Program To Date
6. Alprazolam (Xanax)	0	0	4
7. ASA	0	0	3
8. Aspirin	0	0	4
9. Atenolol (Tenormin)	0	0	6
10. Ativan	0	0	3
11. Benadryl (Diphenhydramine HCL)	0	0	3
12. Benazepril (Lotensin)	0	1	3
13. Benzodiazepenes Unspecified	0	0	1
14. Butalbital (Fiorinal, Esgic)	0	0	1
15. Celexa	0	0	1
16. Chlordiazepoxide (Librium)	0	0	1
17. Claritin	0	0	3
18. Cocaine	0	0	8
19. Codeine (Various Names)	0	0	2
21. Diazepam (Valium)	0	0	4
22. Folic Acid	0	1	2
23. Hydrocodone (Vicodin / Lortabs / Hycodan)	0	1	12
24. Ibuprofen	1	2	11
25. Lexapro	0	1	3
26. Lorazepam (Ativan)	0	0	1
27. Marijuana	0	2	10
28. Maxalt	0	0	1
29. Methadone and/or Metabolite	0	1	1
30. Methamphetamine	0	1	11
31. Morphine	0	1	2
32. Motrin	0	0	2
33. Nazoril	0	0	1
34. None	1	1	6
35. Norco	0	1	4
36. Other Opiates	0	1	1
37. Oxycodone (Oxycontin)	0	0	2
38. Oxycodone (Percodan, Percocet)	0	0	2
39. Percocet	0	0	1
40. Prevacid	0	0	1
41. Undetermined	0	0	12
42. Wellbutrin	0	0	2
43. Zolpidem Tartrate (Ambien)	0	0	3
XIV MARITAL STATUS AT INTAKE			
1. Divorced	0	0	33
2. Married	1	2	64
3. Remarried	1	1	4
4. Separated	0	1	7
5. Significant Other	0	0	3
6. Single	0	1	41
7. Undetermined	0	0	2
8. Widowed	0	0	1
Group Totals	2	5	155



MEMORANDUM

DATE	January 22, 2013
TO	Enforcement Committee Dental Board of California
FROM	Lori Reis, Manager Dental Board of California
SUBJECT	Agenda Item ENF 6: Discussion and Possible Action Regarding Recommendations for the Appointment of a Northern California Diversion Evaluation Committee Member

The Dental Board of California Diversion Program utilizes two Diversion Evaluation Committees (DECs), one North and one South, consisting of six members each: three licensed dentists, one licensed dental auxiliary, one public member, and one licensed physician or psychologist. The Northern California DEC currently has two dental vacancies and the Southern California DEC has one dental auxiliary vacancy.

In accordance with California Code of Regulations (CCR), Title 16, Section 1020.4,

“(b) Each committee member shall have experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse.

“(c) Each member of the committee shall be appointed by the board and shall serve at the board's pleasure. Members of a committee shall be appointed for a term of four years, and each member shall hold office until the appointment and qualification of his or her successor or until one year shall have elapsed since the expiration of; the term for which he or she was appointed, whichever first occurs. No person shall serve as a member of the committee for more than two terms. “

Two candidates were interviewed by a DEC Panel. The Panel is recommending appointment of Gregory S. Pluckhan, D.D.S. to fill one of the dental vacancies on the Northern California DEC. Dr. Pluckhan has established that he has the experience and knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse. A copy of his resume is attached.

Action Requested:

The Committee may take action to accept or reject the Interview Panel's recommendation to appoint Gregory S. Pluckhan D.D.S. to fill one of the dental vacancies on the Northern California DEC.

Upon acceptance of the recommendation, the Committee will recommend that the full Board appoint Gregory S. Pluckhan D.D.S. to fill the one of the dental vacancies on the Northern California DEC on March 1, 2013.

Curriculum Vitae

Gregory S. Pluckhan, D.D.S.
[REDACTED]

COPY

Education:

Oral and Maxillofacial Surgery Residency, 1990-1994
Martin Luther King/Drew Medical Center, Los Angeles, California

Oral and Maxillofacial Surgery Internship, 1989-1990
Louisiana State University, School of Dentistry, New Orleans, Louisiana

Doctorate of Dental Surgery Degree, 1981-1984
University of the Pacific, School of Dentistry, San Francisco, California

B.A. in Biological Sciences, 1979-1981
University of the Pacific, Stockton, California

Associate of Arts Degree, 1977-1979
West Valley Junior College, Saratoga, California

Work Experience:

Full-time practice as an Oral and Maxillofacial Surgeon, 1994-present
Roseville, California

Full-time practice as a General Dentist, 1984-1989
Milpitas, California

Faculty, Dept. of Oral and Maxillofacial Surgery and Facial Pain Research
Center, University of the Pacific, School of Dentistry, San Francisco, California,
1985-1988

Faculty, Dept. of Oral and Maxillofacial Surgery, University of California School of
Dentistry, San Francisco, California, 1985-1988

Affiliations:

Member of the American Association of Oral and Maxillofacial Surgeons
Member of the California Association of Oral and Maxillofacial Surgeons
Member of the American Dental Association
Member of the California Dental Association
Member of the Sacramento District Dental Society

References available upon request.



NOTICE OF PUBLIC MEETING – Notice is hereby given that a public meeting of the Legislative and Regulatory Committee of the Dental Board of California will be held as follows:

NOTICE OF LEGISLATIVE AND REGULATORY COMMITTEE MEETING

Thursday, February 28, 2013

Upon Conclusion of the Enforcement Committee Meeting

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

(619)232-3861 or (916)263-2300

**LEGISLATIVE & REGULATORY
COMMITTEE**

Chair – Fran Burton, Public Member
Vice Chair – Steve Afriat, Public Member
Stephen Casagrande, DDS
Huong Le, DDS
Steve Morrow, DDS

CALL TO ORDER

ROLL CALL AND ESTABLISHMENT OF QUORUM

LEG 1 - Approval of the December 3, 2012 Legislative and Regulatory Committee Meeting Minutes

LEG 2 - 2013 Tentative Legislative Calendar – Information Only

LEG 3 - Report on Legislative Committee Assignments for the 2013-14 Legislative Session

LEG 4 - Discussion and Possible Action on the Following Legislation:

- Assembly Bill 50 (Pan) Health Care Coverage: Medi-Cal Eligibility
- Assembly Bill 186 (Maienschein) Professions and Vocations: Military Spouses: Licenses
- Assembly Bill 213 (Logue) Healing Arts: Certification: Military Experience
- Assembly Bill 318 (Logue) Dental Care: Telehealth
- Senate Bill 28 (Hernandez) Medi-Cal: Eligibility
- Senate Bill 128 (Emmerson) Health Care Professionals
- Any additional legislation impacting the Board that staff becomes aware of between the time the meeting notice is posted and the Board meeting

LEG 5 - Discussion of Prospective Legislative Proposals:

Stakeholders Are Encouraged to Submit Proposals in Writing to the Board Before or During the Meeting for Possible Consideration by the Board at a Future Meeting

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

FUTURE AGENDA ITEMS

Stakeholders Are Encouraged to Propose Items for Possible Consideration by the Committee at a Future Meeting.

COMMITTEE MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

ADJOURNMENT

Public comments will be taken on agenda items at the time the specific item is raised. The Committee may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the Committee Chair. For verification of the meeting, call (916) 263-2300 or access the Board's web site at **www.dbc.ca.gov**. The meeting facilities are accessible to individuals with physical disabilities. Please make any request for accommodations to Karen M. Fischer, Interim Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, no later than one week prior to the day of the meeting.



LEGISLATIVE AND REGULATORY COMMITTEE
Meeting Minutes
Monday, December 3, 2012
Embassy Suites LAX/South
1440 East Imperial Avenue, El Segundo, CA 90245
DRAFT

Members Present

Chair – Fran Burton, Public Member
Vice Chair – Steve Afriat, Public Member
Stephen Casagrande, DDS
Huong Le, DDS
Steve Morrow, DDS
Thomas Olinger, DDS

Members Absent

Staff Present

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel

ROLL CALL AND ESTABLISHMENT OF QUORUM

Fran Burton, Committee Chair, called the meeting to order at 2:13 p.m. Roll was called and a quorum established.

LEG 1 - Approval of the August 16, 2012 Legislative and Regulatory Committee Meeting Minutes

M/S/C (Afriat/Morrow) to approve the minutes of the August 16, 2012 meeting of the Legislative and Regulatory Committee of the Dental Board of California (Board). The motion passed with one abstention.

LEG 2 - 2013 Tentative Legislative Calendar – Information Only

Sarah Wallace, Legislative and Regulatory Analyst, reported that she has been checking the Assembly, Senate and Legislative Information websites daily but as of this date the 2013 tentative Legislative calendar is not yet available.

LEG 3 – End of 2-Year Legislative Session Summary

Ms. Wallace reported that throughout 2011 and 2012, the Legislative and Regulatory Committee and the Board have been tracking several bills impacting the Dental Board of California, the Administrative Procedure Act, government accountability, and military licensing. Board members and staff have actively partaken in the 2011-12 Legislative Session by attending hearings, communicating with Legislators and their staff, and taking positions on proposed bills. Ms. Wallace stated that she is preparing a summary of these bills that will be posted on the Board's website. Ms. Burton noted that the past 2 years have been very busy and she thanked Ms. Wallace for the overwhelming amount of work that she accomplished to get so much done for the Board.

LEG 4 – Discussion and Possible Action Regarding Omnibus Bill Proposals for 2013

Ms. Wallace reported that the Senate Business, Professions and Economic Development Committee contacted all of the Healing Arts Board's and non-Healing Arts Boards regarding Omnibus Bill proposals for 2013. One bill will be designated for health care board and bureau legislation and the other will be for non-health care board and bureau legislation. The Committee plans to introduce the bills in early January 2013 and has requested that board and bureau proposals be submitted to the Committee on or before December 10th for inclusion in the introduced version of the bill. Omnibus bill proposals should be non-controversial and are intended to be used for clean up.

Ms. Wallace stated that after consultation with Board managers, current Legal Counsel, and past Legal Counsel, staff determined that Business and Professions Code (Code) Section 1613 regarding the Board's Seal should be amended. Currently the provision refers to the "Board of Dental Examiners" when it should refer to the "Dental Board of California". Additionally, the Board may consider amendments that address persons who use the Board's logo without consent. Staff prepared the following amendment options for the Board's consideration:

Code Section 1613 Current Language:

§ 1613. Seal

The board shall have and use a seal bearing the name "Board of Dental Examiners of California."

Proposed Revision Option 1:

§ 1613. Seal

The board shall have and use a seal bearing the name "Board of Dental Examiners Dental Board of California."

Proposed Revision Option 2:

§ 1613. Seal

The board shall have and use a seal bearing the name "Board of Dental Examiners Dental Board of California." It is unlawful for any person, firm, corporation, or association that is a nongovernmental entity to solicit information, or to solicit the purchase of or payment for a product or service, or to solicit the contribution of funds or membership fees, by means of any solicitation, including a mailing, electronic message, or Internet Web site that contains a seal, insignia, trade or brand name, or any other term or symbol that reasonably could be interpreted or construed as implying a connection, approval, or endorsement by the Dental Board of California unless the

following requirement has been met: the nongovernmental entity has an expressed connection with, or the approval or endorsement of, the Dental Board of California, if permitted by other provisions of law.

There was discussion regarding option 2 and its correlation to advertising.

Ms. Wallace explained that Option 2 speaks to using the Dental Board name, a provision that other Boards already have. Dr. Casagrande stated that we need to put this provision into place by going with Option 2.

Spencer Wallace, Senior Legal Counsel recommended that it be broadened to “any seal” under the Department of Consumer Affairs.

Richard DeCuir, Executive Officer, gave some history surrounding the misuse of the name and logo by former Dental Board Examiners.

Ms. Burton recommended the Committee accept Option 1 and have further discussion about Option 2. M/S/C (Burton/Olinger) accept Option 1, direct staff to prepare the proposal for submission to the Committee for inclusion in the 2013 healing arts board omnibus bill and direct the Executive Officer to talk with the Business and Professions Committee about Option 2 and whether or not it is something that fits in an Omnibus bill or should be done separately.

Bill Lewis, California Dental Association (CDA), commented that he is concerned that the term “implying a connection” is too vague and broad in Option 2.

The motion passed unanimously.

LEG 5 – Discussion and Possible Action Regarding the Need for Revision of the Mobile Dental Clinic Registration Form as it Pertains to Mobile Clinics Operated by Dental Schools

Sarah Wallace reported that at the August 2012 meeting, the Board reviewed a proposal from the California Dental Association relative to amending the current regulations regarding mobile dental clinics. At the conclusion of the discussion, Dr. Morrow commented that there was another section within the Board’s regulations relating to mobile dental clinics that may require amendments.

California Code of Regulations, Title 16, Section 1026 provides for the registration of mobile dental clinics operated by an approved dental school for instruction in dentistry. Currently, the Board does not have a unique form used for the purposes of registering mobile dental clinics operated by dental schools. Dental schools must register their mobile dental clinics by submitting an application.

The application does not clearly provide a mechanism for dental schools to register mobile dental clinics with the Board. In the past, staff had required the dental schools to register their mobile dental clinics under the name of a faculty member who holds a valid and active license in the State of California. This created a potential problem in the event the designated faculty member ceased employment with the dental school. Additionally, the designated faculty

member would be liable for the mobile dental clinic should the Board need to seek disciplinary action.

Staff recommended that the Board seek regulatory action to clarify the registration requirements for mobile dental clinics operated by approved dental schools and develop a new form, as part of the regulatory action, which is unique for this purpose.

Staff requested that the Board direct staff to add this issue to the list of needed regulatory actions for the Board's consideration when determining the regulatory priorities for fiscal year 2013/2014.

M/S/C (Morrow/Olinger) to direct staff to add this issue to the list of needed regulatory actions for the Board's consideration when determining the regulatory priorities for fiscal year 2013/2014.

There was discussion surrounding satellite clinics and extra mural sites and their registration processes. Dr. Morrow asked staff to bring back a report on how many mobile dental clinics are registered to schools as applicable in §1026, how they are registered i.e. whose name, and is the named registrant still affiliated with the school.

The motion was tabled to be brought back at a future meeting. The Board directed staff to conduct further research.

LEG 6 - Discussion of Prospective Legislative Proposals:
Stakeholders Are Encouraged to Submit Proposals in Writing to the Board Before or During the Meeting for Possible Consideration by the Board at a Future Meeting

Bill Lewis, CDA, commented on mobile/portable dental clinic issues. He stated that CDA will be discussing the possibility of introducing legislation to clarify the Board's role related to mobile/portable dentistry at their January 2013 meeting. Dr. Morrow mentioned the change coming, no sooner than 2017, to the National Board Dental Examination and asked that we keep this on our list of prospective proposals. Mr. DeCuir stated that Dr. Morrow's suggestion of changing the language related to this examination from "must pass parts one and two..." to "must pass the National Board's written examination(s)" would be appropriate for inclusion in an omnibus bill but is premature at this time.

There was no further public comment.

The committee adjourned at 3:09 p.m.



MEMORANDUM

DATE	February 5, 2013
TO	Legislative and Regulatory Committee Members, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item LEG 2: 2013 Tentative Legislative Calendar – Information Only

The 2013 Tentative Legislative Calendars are enclosed. Please note that there are differing calendars for the Senate and the Assembly.

Action Requested:
No action necessary.



2013 TENTATIVE LEGISLATIVE CALENDAR
 COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE
 November 20, 2012

DEADLINES

JANUARY						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

- Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 7** Legislature Reconvenes (J.R. 51(a)(1)).
- Jan. 10** Budget must be submitted by Governor (Art. IV, Sec. 12(a)).
- Jan. 21** Martin Luther King, Jr. Day.
- Jan. 25** Last day to submit **bill requests** to the Office of Legislative Counsel.

FEBRUARY						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

- Feb. 18** President's Day.
- Feb. 22** Last day for **bills to be introduced** (J.R. 61(a)(1)), (J.R. 54(a)).

MARCH						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

- Mar. 21** Spring Recess begins at end of this day's session (J.R. 51(a)(2)).
- Mar. 29** Cesar Chavez Day.

APRIL						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

- Apr. 1** Legislature Reconvenes from Spring Recess (J.R. 51(a)(2)).

MAY						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

- May 3** Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(a)(2)).
- May 10** Last day for **policy committees** to hear and report to the Floor **non-fiscal bills** introduced in their (J.R. 61(a)(3)).
- May 17** Last day for **policy committees** to meet prior to June 3 (J.R. 61(a)(4)).
- May 24** Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61(a)(5)). Last day for **fiscal committees** to meet prior to June 3 (J.R. 61(a)(6)).
- May 27** Memorial Day.
- May 28-May 31 Floor Session Only.**
No committee may meet for any purpose (J.R. 61(a)(7)).
- May 31** Last day for bills to be **passed out of the house of origin** (J.R. 61(a)(8)).

2013 TENTATIVE LEGISLATIVE CALENDAR
 COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE
 November 20, 2012

JUNE						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Jun. 3 Committee meetings may resume (J.R. 61(a)(9)).

Jun. 15 Budget must be passed by midnight (Art. IV, Sec. 12(c)(3)).

JULY						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Jul. 4 Independence Day.

Jul. 12 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)).
Summer recess begins at the end of this day's session, provided the Budget Bill has been passed (J.R. 51(a)(3)).

AUGUST						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Aug. 12 Legislature Reconvenes from **Summer Recess** (J.R. 51(a)(3)).

Aug. 30 Last day for **Fiscal Committees** to meet and report bills to Floor (J.R. 61(a)(11)).

SEPTEMBER						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Sep. 2 Labor Day.

Sep. 6 Last day to **amend bills on the floor** (J.R. 61(a)(13)).

Sep. 3-13 **Floor Session Only.** No Committees, other than conference committees and Rules committee, may meet for any purpose (J.R. 61(a)(12)).

Sep. 13 Last day for **each house to pass bills** (J.R. 61(a)(14)).
Interim Study Recess begins at the end of this day's session (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM STUDY RECESS

2013

Oct. 13 Last day for Governor to sign or veto bills passed by the Legislature on or before Sep. 13 and in the Governor's possession after Sep. 13 (Art. IV, Sec.10(b)(1)).

2014

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 6 Legislature reconvenes (J.R. 51 (a)(4)).

2013 TENTATIVE LEGISLATIVE CALENDAR
 COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK
 Revised 1-3-13

DEADLINES

JANUARY							
	S	M	T	W	TH	F	S
			1	2	3	4	5
Wk. 1	6	7	8	9	10	11	12
Wk. 2	13	14	15	16	17	18	19
Wk. 3	20	21	22	23	24	25	26
Wk. 4	27	28	29	30	31		

FEBRUARY							
	S	M	T	W	TH	F	S
Wk. 4						1	2
Wk. 1	3	4	5	6	7	8	9
Wk. 2	10	11	12	13	14	15	16
Wk. 3	17	18	19	20	21	22	23
Wk. 4	24	25	26	27	28		

MARCH							
	S	M	T	W	TH	F	S
Wk. 4						1	2
Wk. 1	3	4	5	6	7	8	9
Wk. 2	10	11	12	13	14	15	16
Wk. 3	17	18	19	20	21	22	23
Spring Recess	24	25	26	27	28	29	30
Wk. 4	31						

APRIL							
	S	M	T	W	TH	F	S
Wk. 4		1	2	3	4	5	6
Wk. 1	7	8	9	10	11	12	13
Wk. 2	14	15	16	17	18	19	20
Wk. 3	21	22	23	24	25	26	27
Wk. 4	28	29	30				

MAY							
	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
No Hrgs.	26	27	28	29	30	31	

- Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 7** Legislature reconvenes (J.R. 51(a)(1)).
- Jan. 10** Budget Bill must be submitted by Governor (Art. IV, Sec. 12(a)).
- Jan. 21** Martin Luther King, Jr. Day observed.
- Jan. 25** Last day to submit **bill requests** to the Office of Legislative Counsel.

- Feb. 18** Presidents' Day observed.
- Feb. 22** Last day for bills to be **introduced** (J.R. 61(a)(1), J.R. 54(a)).

- Mar. 21** **Spring Recess** begins upon adjournment (J.R. 51(a)(2)).
- Mar. 29** Cesar Chavez Day observed.

- Apr. 1** Legislature reconvenes from Spring Recess (J.R. 51(a)(2)).

- May 3** Last day for **policy committees** to meet and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(a)(2)).
- May 10** Last day for **policy committees** to meet and report to the floor **non-fiscal bills** introduced in their house (J.R. 61(a)(3)).
- May 17** Last day for **policy committees** to meet prior to June 3 (J.R. 61(a)(4)).
- May 24** Last day for **fiscal committees** to meet and report to the floor bills introduced in their house (J.R. 61(a)(5)). Last day for **fiscal committees** to meet prior to June 3 (J.R. 61(a)(6)).
- May 27** Memorial Day observed.
- May 28-31** **Floor session only.** No committee may meet for any purpose (J.R. 61(a)(7)).
- May 31** Last day for each house to pass bills introduced in that house (J.R. 61(a)(8)).

*Holiday schedule subject to final approval by Rules Committee.

2013 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised 1-3-13

JUNE							
	S	M	T	W	TH	F	S
No Hrgs							1
Wk. 4	2	3	4	5	6	7	8
Wk. 1	9	10	11	12	13	14	15
Wk. 2	16	17	18	19	20	21	22
Wk. 3	23	24	25	26	27	28	29
Wk. 4	30						

June 3 Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)(3)).

JULY							
	S	M	T	W	TH	F	S
Wk. 4		1	2	3	4	5	6
Summer Recess	7	8	9	10	11	12	13
Summer Recess	14	15	16	17	18	19	20
Summer Recess	21	22	23	24	25	26	27
Summer Recess	28	29	30	31			

July 3 **Summer Recess** begins upon adjournment, provided Budget Bill has been passed (J.R. 51(a)(3)).

July 4 Independence Day observed.

AUGUST							
	S	M	T	W	TH	F	S
Summer Recess					1	2	3
Wk. 1	4	5	6	7	8	9	10
Wk. 2	11	12	13	14	15	16	17
Wk. 3	18	19	20	21	22	23	24
Wk. 4	25	26	27	28	29	30	31

Aug. 5 Legislature reconvenes from Summer Recess (J.R. 51(a)(3)).

Aug. 16 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)).

Aug. 30 Last day for **fiscal committees** to meet and report bills (J.R. 61(a)(11)).

SEPTEMBER							
	S	M	T	W	TH	F	S
No Hrgs.	1	2	3	4	5	6	7
No Hrgs.	8	9	10	11	12	13	14
Interim Recess	15	16	17	18	19	20	21
Interim Recess	22	23	24	25	26	27	28
Interim Recess	29	30					

Sept. 2 Labor Day observed.

Sept. 3-13 **Floor session only.** No committees, other than conference committees and Rules Committee, may meet for any purpose (J.R. 61(a)(12)).

Sept. 6 Last day to **amend** bills on the floor (J.R. 61(a)(13)).

Sept. 13 Last day for any bill to be passed (J.R. 61(a)(14)). **Interim Recess** begins upon adjournment (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM RECESS

2013

Oct. 13 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 13 and in the Governor's possession after Sept. 13 (Art. IV, Sec. 10(b)(1)).

2014

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 6 Legislature reconvenes (J.R. 51(a)(4)).

*Holiday schedule subject to final approval by Rules Committee.



MEMORANDUM

DATE	January 15, 2013
TO	Legislative & Regulatory Committee Members, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item LEG 3 : Report on Legislative Committee Assignments for the 2013-14 Legislative Session

The California Legislature convened the 2013-2014 Legislative Session on Monday, January 7th. On that day, Senate President pro Tempore Darrel Steinberg announced Senate Committee assignments and Speaker John A. Pérez announced Assembly Committee assignments. A full listing of the Senate Committee assignments may be found on the Senate's web site at: <http://senate.ca.gov/committees>. A full listing of the Assembly Committee assignments may be found on the Assembly's web site at: <http://assembly.ca.gov/committees>.

Most importantly for the Board, the assignments for the Senate Business, Professions, and Economic Development Committee and the Assembly Business, Professions and Consumer Protection Committee have been announced as follows:

Senate Business, Professions, and Economic Development Committee Members:

Senator Curren D. Price, Jr. (Chair)
Senator Bill Emmerson (Vice Chair)
Senator Ellen M. Corbett
Senator Cathleen Galgiani
Senator Ed Hernandez
Senator Jerry Hill
Senator Alex Padilla
Senator Mark Wyland
Senator Leland Y. Yee

Assembly Business, Professions and Consumer Protection Committee Members:

Assembly Member Richard S. Gordon (Chair)
Assembly Member Brian W. Jones (Vice Chair)
Assembly Member Raul Bocanegra
Assembly Member Nora Campos
Assembly Member Roger Dickinson
Assembly Member Susan Talamantes Eggman

Assembly Member Curt Hagman
Assembly Member Chris R. Holden
Assembly Member Brian Maienschein
Assembly Member Kevin Mullin
Assembly Member Nancy Skinner
Assembly Member Philip Y. Ting
Assembly Member Scott Wilk

Staff will be ordering copies of the 2013 Pocket Directory of the California Legislature for Board Members when they become available for purchase in March. This directory includes information regarding each member of the California Legislature and Committee assignments.



MEMORANDUM

DATE	February 20, 2013
TO	Legislative and Regulatory Committee, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item LEG 4: Discussion and Possible Action on Legislation

Background:

Board staff is currently tracking six (6) bills, pertaining to health care coverage, military licensing, and healing arts boards. Currently, the only bill that will most likely impact the Dental Practice Act is Assembly Bill 318 (Logue) which may provide for a Telehealth Advancement Act for dentistry.

Staff has provided a matrix of the tracked legislation disclosing information regarding each bill's status and location. Staff has also provided copies of each bill, in its most recent version, accompanied by staff analyses.

Staff will be presenting the following bills to the Committee for review and consideration:

- AB 50 (Pan) Health Care Coverage: Medi-Cal Eligibility
- AB 186 (Maienschein) Professions and Vocations: Military Spouses: Licenses
- AB 213 (Logue) Healing Arts: Certification: Military Experience
- AB 318 (Logue) Dental Care: Telehealth
- SB 28 (Hernandez) Medi-Cal: Eligibility
- SB 128 (Emmerson) Health Care Professionals

Action Requested:

The Legislative and Regulatory Committee may recommend the Board take one of the following actions regarding each bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

**DENTAL BOARD OF CALIFORNIA TRACKED BILLS
2013/2014 LEGISLATIVE SESSION**

Bill No.	Author	Title	Date Introduced	Date Last Amended	Status	Location	Board Position
Assembly Bills							
AB 50	Pan	Health Care Coverage: Medi-Cal: Eligibility	12/21/2012		01/14/2013 - Referred to Committee on Health	Assembly Health Committee	
AB 186	Maienschein	Professions and Vocations: Military Spouses: Licenses	1/28/2013		02/07/13 - Referred to Committee on Business, Professions, and Consumer Protection	Assembly Committee on Business, Professions, and Consumer Protection	
AB 213	Logue	Healing Arts: Certification: Military Experience	1/31/2013		02/07/2013 - Referred to Committees on Business, Professions, and Consumer Protection and Veteran Affairs	Assembly Committee on Business, Professions, and Consumer Protection	
AB 318	Logue	Dental Care: Telehealth	2/12/2013		02/13/2013 - From printer. May be heard in committee March 15.	Assembly	
Senate Bills							
SB 28	Hernandez	Medi-Cal: Eligibility	12/3/2012		01/10/2013 - Referred ot Committee on Health	Senate Health Committee	
SB 128	Emmerson	Health Care Professionals	1/22/2013		01/31/13 - Referred to Committee on Rules	Senate Rules Committee	

**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 28 - MARCH 1, 2013 BOARD MEETING**

BILL NUMBER: Assembly Bill 50

AUTHOR: Pan

SPONSOR:

VERSION: Introduced 12/21/2012

INTRODUCED: 12/21/2012

BILL STATUS: 01/14/2013 – To Assembly
Committee on Health

BILL LOCATION: Assembly Health
Committee

SUBJECT: Health Care Coverage: Medi-
Cal: Eligibility

**RELATED
BILLS:**

SUMMARY

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would require the department to establish a process in accordance with federal law to allow a hospital that is a participating Medi-Cal provider to elect to be a qualified entity for purposes of determining whether any individual is eligible for Medi-Cal and providing the individual with medical assistance during the presumptive eligibility period.

Existing law requires an applicant or beneficiary, as specified, who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, to personally attend a presentation at which the applicant or beneficiary is informed of managed care and fee-for-service options for receiving Medi-Cal benefits. Existing law requires the applicant or beneficiary to indicate in writing his or her choice of health care options and provides that if the applicant or beneficiary does not make a choice he or she shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides. Existing law requires the department to develop a program, as specified, to implement these provisions.

This bill would repeal these provisions on January 1, 2015, and would require the department to implement a new process by January 1, 2015, to inform Medi-Cal enrollees of their options with regard to the delivery of Medi-Cal services, including fee-for-service, if available, and all managed care options. The bill would, in this regard, prohibit the department from extending, or exercising any options to extend, the term of any existing contracts under which a nongovernmental entity has responsibility for performing functions under the Medi-Cal Managed Health Care Options program,

including enrolling or informing an applicant or enrollee of managed care plan choices, assigning an applicant or enrollee to a managed care plan, or informing applicants of, or processing applications or requests for, exemptions to enrollment.

Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements.

This bill would require that an applicant or recipient of benefits under a state health subsidy program be given an option, with his or her informed consent, to have an application for renewal form prepopulated or electronically verified in real time, or both, as specified.

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

ANALYSIS

Board staff is tracking this bill because of its potential impact relating to the federal Patient Protection and Affordable Care Act. Staff will continue to monitor this bill and advise the Board of its impact on the practice of dentistry.

REGISTERED SUPPORT/OPPOSITION

To date, there is no registered support or opposition on file.

BOARD POSITION

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

ASSEMBLY BILL

No. 50

Introduced by Assembly Member Pan

December 21, 2012

An act to amend and repeal Sections 14016.5 and 14016.6 of, and to add Sections 14011.66, 14016.54, and 15926.6 to, the Welfare and Institutions Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 50, as introduced, Pan. Health care coverage: Medi-Cal: eligibility: enrollment.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would require the department to establish a process in accordance with federal law to allow a hospital that is a participating Medi-Cal provider to elect to be a qualified entity for purposes of determining whether any individual is eligible for Medi-Cal and providing the individual with medical assistance during the presumptive eligibility period.

Existing law requires an applicant or beneficiary, as specified, who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, to personally attend a presentation at which the applicant or beneficiary is informed of managed care and fee-for-service options for receiving Medi-Cal benefits. Existing law requires the applicant or beneficiary to indicate in writing his or her

choice of health care options and provides that if the applicant or beneficiary does not make a choice he or she shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides. Existing law requires the department to develop a program, as specified, to implement these provisions.

This bill would repeal these provisions on January 1, 2015, and would require the department to implement a new process by January 1, 2015, to inform Medi-Cal enrollees of their options with regard to the delivery of Medi-Cal services, including fee-for-service, if available, and all managed care options. The bill would, in this regard, prohibit the department from extending, or exercising any options to extend, the term of any existing contracts under which a nongovernmental entity has responsibility for performing functions under the Medi-Cal Managed Health Care Options program, including enrolling or informing an applicant or enrollee of managed care plan choices, assigning an applicant or enrollee to a managed care plan, or informing applicants of, or processing applications or requests for, exemptions to enrollment.

Existing law requires the California Health and Human Services Agency, in consultation with specified entities, to establish standardized single, accessible application forms and related renewal procedures for state health subsidy programs, as defined, in accordance with specified requirements.

This bill would require that an applicant or recipient of benefits under a state health subsidy program be given an option, with his or her informed consent, to have an application for renewal form prepopulated or electronically verified in real time, or both, as specified.

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

Vote: $\frac{2}{3}$. 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 14011.66 is added to the Welfare and
- 2 Institutions Code, to read:
- 3 14011.66. The department shall establish a process in
- 4 accordance with Section 1396a(a)(47)(B) of Title 42 of the United
- 5 States Code, effective January 1, 2014, to allow a hospital that is

1 a participating provider under the state plan to elect to be a
2 qualified entity for purposes of determining, on the basis of
3 preliminary information, whether any individual is eligible for
4 Medi-Cal under the state plan or under a federal waiver for
5 purposes of providing the individual with medical assistance during
6 the presumptive eligibility period.

7 SEC. 2. Section 14016.5 of the Welfare and Institutions Code
8 is amended to read:

9 14016.5. (a) At the time of determining or redetermining the
10 eligibility of a Medi-Cal program or Aid to Families with
11 Dependent Children (AFDC) program applicant or beneficiary
12 who resides in an area served by a managed health care plan or
13 pilot program in which beneficiaries may enroll, each applicant
14 or beneficiary shall personally attend a presentation at which the
15 applicant or beneficiary is informed of the managed care and
16 fee-for-service options available regarding methods of receiving
17 Medi-Cal benefits. The county shall ensure that each beneficiary
18 or applicant attends this presentation.

19 (b) The health care options presentation described in subdivision
20 (a) shall include all of the following elements:

21 (1) Each beneficiary or eligible applicant shall be informed that
22 he or she may choose to continue an established patient-provider
23 relationship in the fee-for-service sector.

24 (2) Each beneficiary or eligible applicant shall be provided with
25 the name, address, telephone number, and specialty, if any, of each
26 primary care provider, and each clinic participating in each prepaid
27 managed health care plan, pilot project, or fee-for-service case
28 management provider option. This information shall be provided
29 under geographic area designations, in alphabetical order by the
30 name of the primary care provider and clinic. The name, address,
31 and telephone number of each specialist participating in each
32 prepaid managed health care plan, pilot project, or fee-for-service
33 case management provider option shall be made available by
34 contacting either the health care options contractor or the prepaid
35 managed health care plan, pilot project, or fee-for-service case
36 management provider.

37 (3) Each beneficiary or eligible applicant shall be informed that
38 he or she may choose to continue an established patient-provider
39 relationship in a managed care option, if his or her treating provider
40 is a primary care provider or clinic contracting with any of the

1 prepaid managed health care plans, pilot projects, or fee-for-service
2 case management provider options available, has available capacity,
3 and agrees to continue to treat that beneficiary or applicant.

4 (4) In areas specified by the director, each beneficiary or eligible
5 applicant shall be informed that if he or she fails to make a choice,
6 or does not certify that he or she has an established relationship
7 with a primary care provider or clinic, he or she shall be assigned
8 to, and enrolled in, a prepaid managed health care plan, pilot
9 project, or fee-for-service case management provider.

10 (c) No later than 30 days following the date a Medi-Cal or
11 AFDC beneficiary or applicant is determined eligible, the
12 beneficiary or applicant shall indicate his or her choice in writing,
13 as a condition of coverage for Medi-Cal benefits, of either of the
14 following health care options:

15 (1) To obtain benefits by receiving a Medi-Cal card, which may
16 be used to obtain services from individual providers, that the
17 beneficiary would locate, who choose to provide services to
18 Medi-Cal beneficiaries.

19 The department may require each beneficiary or eligible
20 applicant, as a condition for electing this option, to sign a statement
21 certifying that he or she has an established patient-provider
22 relationship, or in the case of a dependent, the parent or guardian
23 shall make that certification. This certification shall not require
24 the acknowledgment or guarantee of acceptance, by any indicated
25 Medi-Cal provider or health facility, of any beneficiary making a
26 certification under this section.

27 (2) (A) To obtain benefits by enrolling in a prepaid managed
28 health care plan, pilot program, or fee-for-service case management
29 provider that has agreed to make Medi-Cal services readily
30 available to enrolled Medi-Cal beneficiaries.

31 (B) At the time the beneficiary or eligible applicant selects a
32 prepaid managed health care plan, pilot project, or fee-for-service
33 case management provider, the department shall, when applicable,
34 encourage the beneficiary or eligible applicant to also indicate, in
35 writing, his or her choice of primary care provider or clinic
36 contracting with the selected prepaid managed health care plan,
37 pilot project, or fee-for-service case management provider.

38 (d) (1) In areas specified by the director, a Medi-Cal or AFDC
39 beneficiary or eligible applicant who does not make a choice, or
40 who does not certify that he or she has an established relationship

1 with a primary care provider or clinic, shall be assigned to and
2 enrolled in an appropriate Medi-Cal managed care plan, pilot
3 project, or fee-for-service case management provider providing
4 service within the area in which the beneficiary resides.

5 (2) If it is not possible to enroll the beneficiary under a Medi-Cal
6 managed care plan, pilot project, or a fee-for-service case
7 management provider because of a lack of capacity or availability
8 of participating contractors, the beneficiary shall be provided with
9 a Medi-Cal card and informed about fee-for-service primary care
10 providers who do all of the following:

11 (A) The providers agree to accept Medi-Cal patients.

12 (B) The providers provide information about the provider's
13 willingness to accept Medi-Cal patients as described in Section
14 14016.6.

15 (C) The providers provide services within the area in which the
16 beneficiary resides.

17 (e) If a beneficiary or eligible applicant does not choose a
18 primary care provider or clinic, or does not select any primary care
19 provider who is available, the managed health care plan, pilot
20 project, or fee-for-service case management provider that was
21 selected by or assigned to the beneficiary shall ensure that the
22 beneficiary selects a primary care provider or clinic within 30 days
23 after enrollment or is assigned to a primary care provider within
24 40 days after enrollment.

25 (f) (1) The managed care plan shall have a valid Medi-Cal
26 contract, adequate capacity, and appropriate staffing to provide
27 health care services to the beneficiary.

28 (2) The department shall establish standards for all of the
29 following:

30 (A) The maximum distances a beneficiary is required to travel
31 to obtain primary care services from the managed care plan,
32 fee-for-service case management provider, or pilot project in which
33 the beneficiary is enrolled.

34 (B) The conditions under which a primary care service site shall
35 be accessible by public transportation.

36 (C) The conditions under which a managed care plan,
37 fee-for-service case management provider, or pilot project shall
38 provide nonmedical transportation to a primary care service site.

39 (3) In developing the standards required by paragraph (2), the
40 department shall take into account, on a geographic basis, the

1 means of transportation used and distances typically traveled by
2 Medi-Cal beneficiaries to obtain fee-for-service primary care
3 services and the experience of managed care plans in delivering
4 services to Medi-Cal enrollees. The department shall also consider
5 the provider's ability to render culturally and linguistically
6 appropriate services.

7 (g) To the extent possible, the arrangements for carrying out
8 subdivision (d) shall provide for the equitable distribution of
9 Medi-Cal beneficiaries among participating managed care plans,
10 fee-for-service case management providers, and pilot projects.

11 (h) If, under the provisions of subdivision (d), a Medi-Cal
12 beneficiary or applicant does not make a choice or does not certify
13 that he or she has an established relationship with a primary care
14 provider or clinic, the person may, at the option of the department,
15 be provided with a Medi-Cal card or be assigned to and enrolled
16 in a managed care plan providing service within the area in which
17 the beneficiary resides.

18 (i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with
19 the provider or managed care plan, pilot project, or fee-for-service
20 case management provider shall be allowed to select or be assigned
21 to another provider or managed care plan, pilot project, or
22 fee-for-service case management provider.

23 (j) The department or its contractor shall notify a managed care
24 plan, pilot project, or fee-for-service case management provider
25 when it has been selected by or assigned to a beneficiary. The
26 managed care plan, pilot project, or fee-for-service case
27 management provider that has been selected by, or assigned to, a
28 beneficiary, shall notify the primary care provider or clinic that it
29 has been selected or assigned. The managed care plan, pilot project,
30 or fee-for-service case management provider shall also notify the
31 beneficiary of the managed care plan, pilot project, or
32 fee-for-service case management provider or clinic selected or
33 assigned.

34 (k) (1) The department shall ensure that Medi-Cal beneficiaries
35 eligible under Title XVI of the Social Security Act are provided
36 with information about options available regarding methods of
37 receiving Medi-Cal benefits as described in subdivision (c).

38 (2) (A) The director may waive the requirements of subdivisions
39 (c) and (d) until a means is established to directly provide the
40 presentation described in subdivision (a) to beneficiaries who are

1 eligible for the federal Supplemental Security Income for the Aged,
2 Blind, and Disabled Program (Subchapter 16 (commencing with
3 Section 1381) of Chapter 7 of Title 42 of the United States Code).

4 (B) The director may elect not to apply the requirements of
5 subdivisions (c) and (d) to beneficiaries whose eligibility under
6 the Supplemental Security Income program is established before
7 January 1, 1994.

8 (l) In areas where there is no prepaid managed health care plan
9 or pilot program that has contracted with the department to provide
10 services to Medi-Cal beneficiaries, and where no other enrollment
11 requirements have been established by the department, no explicit
12 choice need be made, and the beneficiary or eligible applicant shall
13 receive a Medi-Cal card.

14 (m) The following definitions contained in this subdivision shall
15 control the construction of this section, unless the context requires
16 otherwise:

17 (1) "Applicant," "beneficiary," and "eligible applicant," in the
18 case of a family group, mean any person with legal authority to
19 make a choice on behalf of dependent family members.

20 (2) "Fee-for-service case management provider" means a
21 provider enrolled and certified to participate in the Medi-Cal
22 fee-for-service case management program the department may
23 elect to develop in selected areas of the state with the assistance
24 of and in cooperation with California physician providers and other
25 interested provider groups.

26 (3) "Managed health care plan" and "managed care plan" mean
27 a person or entity operating under a Medi-Cal contract with the
28 department under this chapter or Chapter 8 (commencing with
29 Section 14200) to provide, or arrange for, health care services for
30 Medi-Cal beneficiaries as an alternative to the Medi-Cal
31 fee-for-service program that has a contractual responsibility to
32 manage health care provided to Medi-Cal beneficiaries covered
33 by the contract.

34 (n) (1) Whenever a county welfare department notifies a public
35 assistance recipient or Medi-Cal beneficiary that the recipient or
36 beneficiary is losing Medi-Cal eligibility, the county shall include,
37 in the notice to the recipient or beneficiary, notification that the
38 loss of eligibility shall also result in the recipient's or beneficiary's
39 disenrollment from Medi-Cal managed health care or dental plans,
40 if enrolled.

1 (2) (A) Whenever the department or the county welfare
2 department processes a change in a public assistance recipient's
3 or Medi-Cal beneficiary's residence or aid code that will result in
4 the recipient's or beneficiary's disenrollment from the managed
5 health care or dental plan in which he or she is currently enrolled,
6 a written notice shall be given to the recipient or beneficiary.

7 (B) This paragraph shall become operative and the department
8 shall commence sending the notices required under this paragraph
9 on or before the expiration of 12 months after the effective date
10 of this section.

11 (o) This section shall be implemented in a manner consistent
12 with any federal waiver required to be obtained by the department
13 in order to implement this section.

14 (p) *This section shall remain in effect only until January 1, 2015,*
15 *and as of that date is repealed, unless a later enacted statute, that*
16 *is enacted before January 1, 2015, deletes or extends that date.*

17 SEC. 3. Section 14016.54 is added to the Welfare and
18 Institutions Code, to read:

19 14016.54. (a) On or before January 1, 2015, the department
20 shall implement a new process to inform Medi-Cal enrollees of
21 their options with regard to the delivery of Medi-Cal services,
22 including fee-for-service, if available, and all managed care options.
23 The process shall include a mechanism to allow enrollees to make
24 an informed choice and to pick a health plan and a primary care
25 provider. In developing the process, the department shall convene
26 public meetings to allow for input from stakeholders and other
27 members of the public, consult with counties and the Legislature,
28 and coordinate with the California Health Benefit Exchange.

29 (b) For purposes of implementing subdivision (a), the
30 department shall not extend, or exercise any options to extend the
31 term of any existing contracts under which a nongovernmental
32 entity has responsibility for performing functions under the
33 Medi-Cal Managed Health Care Options program, including
34 enrolling or informing an applicant or enrollee of managed care
35 plan choices, assigning an applicant or enrollee to a managed care
36 plan, or informing applicants of, or processing applications or
37 requests for, exemptions to enrollment.

38 SEC. 4. Section 14016.6 of the Welfare and Institutions Code
39 is amended to read:

1 14016.6. The State Department of Health *Care* Services shall
2 develop a program to implement Section 14016.5 and to provide
3 information and assistance to enable Medi-Cal beneficiaries to
4 understand and successfully use the services of the Medi-Cal
5 managed care plans in which they enroll. The program shall
6 include, but not be limited to, the following components:

7 (a) (1) Development of a method to inform beneficiaries and
8 applicants of all of the following:

9 (A) Their choices for receiving Medi-Cal benefits including the
10 use of fee-for-service sector managed health care plans, or pilot
11 programs.

12 (B) The availability of staff and information resources to
13 Medi-Cal managed health care plan enrollees described in
14 subdivision (f).

15 (2) (A) Marketing and informational materials including printed
16 materials, films, and exhibits, to be provided to Medi-Cal
17 beneficiaries and applicants when choosing methods of receiving
18 health care benefits.

19 (B) The department shall not be responsible for the costs of
20 developing material required by subparagraph (A).

21 (C) (i) The department may prescribe the format and edit the
22 informational materials for factual accuracy, objectivity and
23 comprehensibility .

24 (ii) The department shall use the edited materials in informing
25 beneficiaries and applicants of their choices for receiving Medi-Cal
26 benefits.

27 (b) Provision of information that is necessary to implement this
28 program in a manner that fairly and objectively explains to
29 beneficiaries and applicants their choices for methods of receiving
30 Medi-Cal benefits, including information prepared by the
31 department emphasizing the benefits and limitations to
32 beneficiaries of enrolling in managed health care plans and pilot
33 projects as opposed to the fee-for-service system.

34 (c) Provision of information about providers who will provide
35 services to Medi-Cal beneficiaries. This may be information about
36 provider referral services of a local provider professional
37 organization. The information shall be made available to Medi-Cal
38 beneficiaries and applicants at the same time the beneficiary or
39 applicant is being informed of the options available for receiving
40 care.

1 (d) Training of specialized county employees to carry out the
2 program.

3 (e) Monitoring the implementation of the program in those
4 county welfare offices where choices are made available in order
5 to assure that beneficiaries and applicants may make a
6 well-informed choice, without duress.

7 (f) Staff and information resources dedicated to directly assist
8 Medi-Cal managed health care plan enrollees to understand how
9 to effectively use the services of, and resolve problems or
10 complaints involving, their managed health care plans.

11 (g) The responsibilities outlined in this section shall, at the
12 option of the department, be carried out by a specially trained
13 county or state employee or by an independent contractor paid by
14 the department. If a county sponsored prepaid health plan or pilot
15 program is offered, the responsibilities outlined in this section shall
16 be carried out either by a specially trained state employee or by
17 an independent contractor paid by the department.

18 (h) The department shall adopt any regulations as are necessary
19 to ensure that the informing of beneficiaries of their health care
20 options is a part of the eligibility determination process.

21 *(i) This section shall remain in effect only until January 1, 2015,*
22 *and as of that date is repealed, unless a later enacted statute, that*
23 *is enacted before January 1, 2015, deletes or extends that date.*

24 SEC. 5. Section 15926.6 is added to the Welfare and
25 Institutions Code, to read:

26 15926.6. (a) An applicant or recipient of benefits under a state
27 health subsidy program shall be given the option, with his or her
28 informed consent, to have an application for renewal form
29 prepopulated or electronically verified in real time, or both, using
30 personal information from his or her own state health subsidy
31 program or other public benefits case file, a case file of that
32 individual's parent or child, or other electronic databases required
33 by the PPACA.

34 (1) An applicant or recipient who chooses to have an application
35 for renewal form prepopulated shall be given an opportunity, before
36 the application for renewal form is submitted to the entity
37 authorized to make eligibility determinations, to provide additional
38 eligibility information and to correct any information retrieved
39 from a database.

1 (2) An applicant or recipient who chooses to have an application
2 for renewal form electronically verified in real time shall be given
3 an opportunity, before or after a final eligibility determination is
4 made, to provide additional eligibility information and to correct
5 information retrieved from a database. An applicant or recipient
6 shall not be denied eligibility for any state health subsidy program
7 without being given a reasonable opportunity, of at least the kind
8 provided for under the Medi-Cal program for citizenship
9 documentation, to resolve discrepancies concerning any
10 information provided by a verifying entity. Applicants or recipients
11 shall receive the benefits for which they would otherwise qualify
12 pending this reasonable-opportunity period.

13 (b) Renewal procedures shall be coordinated across all state
14 health subsidy programs and among entities that accept and make
15 eligibility determinations so that all relevant information already
16 included in the individual's Medi-Cal or other public benefits case
17 file, his or her California Health Benefit Exchange case file, a case
18 file of the individual's parent or child, or other electronic databases
19 authorized for data sharing under the PPACA can be used to renew
20 benefits or transfer eligible recipients between programs without
21 a break in coverage and without requiring a recipient to provide
22 redundant information. Renewal procedures shall be as simple,
23 user-friendly, and accessible as possible, shall require recipients
24 to provide only the information that has changed, if any, and shall
25 use all available methods for reporting renewal information,
26 including, but not limited to, face-to-face, telephone, and online
27 renewal. Families shall be able to renew coverage at the same time
28 for all family members enrolled in any state health subsidy
29 program, including if family members are enrolled in more than
30 one state health subsidy program. A recipient shall be permitted
31 to update his or her eligibility information at any time.

32 SEC. 6. This act is an urgency statute necessary for the
33 immediate preservation of the public peace, health, or safety within
34 the meaning of Article IV of the Constitution and shall go into
35 immediate effect. The facts constituting the necessity are:

36 In order to implement provisions of the federal Patient Protection
37 and Affordable Care Act (Public Law 111-148), as amended by
38 the federal Health Care and Education Reconciliation Act of 2010

- 1 (Public Law 111-152), it is necessary that this act take effect
- 2 immediately.

O

**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 28 - MARCH 1, 2013 BOARD MEETING**

BILL NUMBER: Assembly Bill 186

AUTHOR: Maienschein

SPONSOR:

VERSION: Introduced 01/28/2013

INTRODUCED: 01/28/2013

BILL STATUS: 02/07/13 - Referred to
Committee on Business,
Professions, and Consumer
Protection

BILL LOCATION: Assembly
Committee on
Business,
Professions, and
Consumer
Protection

SUBJECT: Professions and Vocations:
Military Spouses:
Temporary Licenses

RELATED BILLS: AB 1904 (Block,
Chapter 399,
Statutes of 2012)

SUMMARY

Existing law, Business and Professions Code Section 115.5 (AB 1904, Chapter 399, Statutes of 2012), became effective on January 1, 2013 and requires boards within the Department of Consumer Affairs (Department) to expedite the licensure process for an applicant who holds a license in the same profession or vocation in another state, district, or territory of the United States and is married to, or in a legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

This bill would authorize boards within the Department to issue a provisional license to an applicant who qualifies for an expedited license pursuant to Business and Professions Code Section 115.5. This bill specifies that the provisional license would expire after eighteen (18) months.

ANALYSIS

At this time, the potential impact of this bill upon the Dental Board of California (Board) is unknown. Staff is in the process of implementing the provisions of AB 1904 (Block, Chapter 399, Statutes of 2012) and have not encountered applications from military spouses as a result of the expedited licensure process. The Board does not currently issue temporary or provisional licenses to applicants. To ensure public protection, the Board issues licenses to practice to qualified applicants who meet all of the application requirements.

REGISTERED SUPPORT/OPPOSITION

To date, there is no registered support or opposition on file.

BOARD POSITION

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

ASSEMBLY BILL

No. 186

**Introduced by Assembly Member Maienschein
(Principal coauthor: Assembly Member Hagman)**

January 28, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would authorize a board within the department to issue a provisional license to an applicant who qualifies for an expedited license

pursuant to the above-described provision. The bill would require the provisional license to expire after 18 months.

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 115.5 of the Business and Professions
- 2 Code is amended to read:
- 3 115.5. (a) A board within the department shall expedite the
- 4 licensure process for an applicant who meets both of the following
- 5 requirements:
- 6 (1) Supplies evidence satisfactory to the board that the applicant
- 7 is married to, or in a domestic partnership or other legal union
- 8 with, an active duty member of the Armed Forces of the United
- 9 States who is assigned to a duty station in this state under official
- 10 active duty military orders.
- 11 (2) Holds a current license in another state, district, or territory
- 12 of the United States in the profession or vocation for which he or
- 13 she seeks a license from the board.
- 14 (b) *For each applicant who is eligible for an expedited license*
- 15 *pursuant to subdivision (a), the board may provide a provisional*
- 16 *license while the board processes the application for licensure.*
- 17 *The provisional license shall expire 18 months after issuance.*
- 18 ~~(b)~~
- 19 (c) A board may adopt regulations necessary to administer this
- 20 section.

**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 28 - MARCH 1, 2013 BOARD MEETING**

BILL NUMBER: Assembly Bill 213

AUTHOR: Logue
Principal Coauthor: Pan

SPONSOR:

VERSION: Introduced 01/31/2013

INTRODUCED: 01/31/2013

BILL STATUS: 02/07/2013 – Referred to
Assembly Committees on
Business, Professions &
Consumer Protection and
Veterans Affairs

BILL LOCATION: Assembly
Committee on
Business,
Professions &
Consumer
Protection

SUBJECT: Healing Arts: Certification:
Military Experience

**RELATED
BILLS:**

SUMMARY

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs (Department). The rules and regulations of these healing arts boards provide for methods of evaluating education, training, and experience obtained in military service if such training is applicable to the requirements of the particular profession or vocation regulated by the board.

Existing law provides for other healing arts professions to be licensed or certified and regulated by the State Department of Public Health. In some instances, a board with the Department of Consumer Affairs or the State Department of Public Health (DPH) approves schools offering educational course credit for meeting licensing or certification qualifications and requirements.

This bill would require a healing arts board within the Department and the DPH, upon the presentation of evidence by an applicant for licensure or certification, to accept education, training, and practical experience completed by an applicant in military service toward the qualifications and requirements to receive a license or certificate if that education, training, or experience is equivalent to the standards of the board or department. If a board or the DPH accredits or otherwise approves schools offering educational course credit for meeting licensing and certification qualifications and requirements, the bill would, not later than July 1, 2014, require those schools seeking accreditation or approval to have procedures in place to evaluate an applicant's military

education, training, and practical experience toward the completion of an educational program that would qualify a person to apply for licensure or certification, as specified.

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

ANALYSIS

The potential impact of this bill upon the Dental Board of California is unknown at this time. Staff will need to conduct more research regarding the education, training, and practical experience that a potential applicant for a Board-issued license may obtain as part of military service and how it would be applicable to the Board's standards.

REGISTERED SUPPORT/OPPOSITION

To date, there is no registered support or opposition on file.

BOARD POSITION

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

ASSEMBLY BILL

No. 213

**Introduced by Assembly Member Logue
(Principal coauthor: Assembly Member Pan)**

January 31, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would require a healing arts board within the Department of Consumer Affairs and the State Department of Public Health, upon the presentation of evidence by an applicant for licensure or certification, to accept education, training, and practical experience completed by an applicant in military service toward the qualifications and requirements

to receive a license or certificate if that education, training, or experience is equivalent to the standards of the board or department. If a board or the State Department of Public Health accredits or otherwise approves schools offering educational course credit for meeting licensing and certification qualifications and requirements, the bill would, not later than July 1, 2014, require those schools seeking accreditation or approval to have procedures in place to evaluate an applicant’s military education, training, and practical experience toward the completion of an educational program that would qualify a person to apply for licensure or certification, as specified.

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

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

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

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

- 1 SECTION 1. This act shall be known and may be cited as the
- 2 Veterans Health Care Workforce Act of 2012.
- 3 SEC. 2. (a) The Legislature finds and declares all of the
- 4 following:
- 5 (1) Lack of health care providers continues to be a significant
- 6 barrier to access to health care services in medically underserved
- 7 urban and rural areas of California.
- 8 (2) Veterans of the United States Armed Forces and the
- 9 California National Guard gain invaluable education, training, and
- 10 practical experience through their military service.

1 (3) According to the federal Department of Defense, as of June
2 2011, one million veterans were unemployed nationally and the
3 jobless rate for post-9/11 veterans was 13.3 percent, with young
4 male veterans 18 to 24 years of age experiencing an unemployment
5 rate of 21.9 percent.

6 (4) According to the federal Department of Defense, during the
7 2011 federal fiscal year, 8,854 enlisted service members with
8 medical classifications separated from active duty.

9 (5) According to the federal Department of Defense, during the
10 2011 federal fiscal year, 16,777 service members who separated
11 from active duty listed California as their state of residence.

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

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

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

27 712. (a) Notwithstanding any other provision of law, a board
28 under this division shall, upon the presentation of satisfactory
29 evidence by an applicant for licensure, accept the education,
30 training, and practical experience completed by the applicant as a
31 member of the United States Armed Forces or Military Reserves
32 of the United States, the national guard of any state, the military
33 reserves of any state, or the naval militia of any state, toward the
34 qualifications and requirements for licensure by that board if the
35 board determines that the education, training, or practical
36 experience is equivalent to the standards of the board.

37 (b) Not later than July 1, 2014, if a board under this division
38 accredits or otherwise approves schools offering educational course
39 credit for meeting licensing qualifications and requirements, the
40 board shall require a school seeking accreditation or approval to

1 submit to the board proof that the school has procedures in place
2 to evaluate, upon presentation of satisfactory evidence by the
3 applicant, the applicant's military education, training, and practical
4 experience toward the completion of an educational program that
5 would qualify a person to apply for licensure if the school
6 determines that the education, training, or practical experience is
7 equivalent to the standards of the board. A board that requires a
8 school to be accredited by a national organization shall not impose
9 requirements on the school that conflict with the standards of the
10 national organization.

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

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

22 131136. (a) Notwithstanding any other provision of law, the
23 department shall, upon the presentation of satisfactory evidence
24 by an applicant for licensure or certification in one of the
25 professions described in subdivision (b), accept the education,
26 training, and practical experience completed by the applicant as a
27 member of the United States Armed Forces or Military Reserves
28 of the United States, the national guard of any state, the military
29 reserves of any state, or the naval militia of any state, toward the
30 qualifications and requirements for licensure by the department if
31 the department determines that the education, training, or practical
32 experience is equivalent to the standards of the department.

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

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

36 (2) Clinical laboratory scientist as described in Section 1262 of
37 the Business and Professions Code.

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

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

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

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

6 (7) Certified hemodialysis technician as described in Article
7 3.5 (commencing with Section 1247) of Chapter 3 of Division 2
8 of the Business and Professions Code.

9 (8) Nursing home administrator as described in Chapter 2.35
10 (commencing with Section 1416) of Division 2.

11 (c) Not later than July 1, 2014, if the department accredits or
12 otherwise approves schools offering educational course credit for
13 meeting licensing and certification qualifications and requirements,
14 the department shall require a school seeking accreditation or
15 approval to submit to the board proof that the school has procedures
16 in place to fully accept an applicant's military education, training,
17 and practical experience toward the completion of an educational
18 program that would qualify a person to apply for licensure or
19 certification if the school determines that the education, training,
20 or practical experience is equivalent to the standards of the
21 department. If the department requires a school to be accredited
22 by a national organization, the requirement of the department shall
23 not, in any way, conflict with standards set by the national
24 organization.

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

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**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 28 - MARCH 1, 2013 BOARD MEETING**

BILL NUMBER: Assembly Bill 318

AUTHOR: Assembly Member Logue

SPONSOR:

VERSION: Introduced 02/12/2013

INTRODUCED: 02/12/2013

BILL STATUS: 02/13/2013 - From printer.
May be heard in committee
March 15.

BILL LOCATION: Assembly

SUBJECT: Dental Care: Telehealth

**RELATED
BILLS:** AB 415 (Logue,
Chapter 547,
Statutes of 2011)

SUMMARY

The Dental Practice Act (Act) provides for the licensure and regulation by the Dental Board of California of those engaged in the practice of dentistry.

This bill would declare the intent of the Legislature to enact legislation that would promote the advancement of telehealth in dental care.

ANALYSIS

Board staff has been advised that this is a spot bill at this time but amendments are anticipated in the near future. According to the author's office, Assembly Member Logue is interested in establishing a Telehealth Advancement Act for dentistry that would be similar to the Telehealth Advancement Act for medicine (Logue, AB 415, Chapter 547, Statutes of 2011). A copy of AB 415 is enclosed for reference.

REGISTERED SUPPORT/OPPOSITION

To date, there is no registered support or opposition on file.

BOARD POSITION

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

ASSEMBLY BILL

No. 318

Introduced by Assembly Member Logue

February 12, 2013

An act relating to dental care.

LEGISLATIVE COUNSEL'S DIGEST

AB 318, as introduced, Logue. Dental care: telehealth.

Existing law, the Dental Practice Act, provides for the licensure and regulation by the Dental Board of California of those engaged in the practice of dentistry. Existing law provides that a person practices dentistry if the person, among other things, manages or conducts as manager, proprietor, conductor, lessor, or otherwise, in any place where dental operations are performed.

This bill would declare the intent of the Legislature to enact legislation that would promote the advancement of telehealth in dental care.

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. It is the intent of the Legislature to enact
- 2 legislation to promote the advancement of telehealth in dental care.

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Assembly Bill No. 415

CHAPTER 547

An act to repeal and add Section 2290.5 of the Business and Professions Code, to repeal and add Section 1374.13 of the Health and Safety Code, to repeal and add Section 10123.85 of the Insurance Code, and to amend Sections 14132.72 and 14132.725 of the Welfare and Institutions Code, relating to telehealth.

[Approved by Governor October 7, 2011. Filed with
Secretary of State October 7, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

AB 415, Logue. Healing arts: telehealth.

(1) Existing law provides for the licensure and regulation of various healing arts professions by various boards within the Department of Consumer Affairs. A violation of specified provisions is a crime. Existing law defines telemedicine, for the purpose of its regulation, to mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Existing law requires a health care practitioner, as defined, to obtain verbal and written informed consent from the patient or the patient's legal representative before telemedicine is delivered. Existing law also imposes various requirements with regard to the provision of telemedicine by health care service plans, health insurers, or under the Medi-Cal program, including a prohibition on requiring face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to certain contracts or policies. Existing federal regulations, for the purposes of participation in the Medicare and Medicaid programs, authorize the governing body of a hospital whose patients are receiving telemedicine services to grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital. Existing state regulations require medical staff, appointed by the governing body of a hospital, to adopt procedures for the evaluation of staff applications for credentials and privileges. Existing law provides that health care service plans and health insurers shall not be required to pay for consultations provided by telephone or facsimile machines. Existing law provides that a willful violation of the provisions governing health care service plans is a crime.

This bill would delete the provisions of state law regarding telemedicine as described above, and would instead set forth provisions relating to telehealth, as defined. This bill would require a health care provider, as defined, prior to the delivery of health care via telehealth, to verbally inform the patient that telehealth may be used and obtain verbal consent from the

patient. This bill would provide that failure to comply with this provision constitutes unprofessional conduct. This bill would, subject to contract terms and conditions, also preclude health care service plans and health insurers from imposing prior to payment, certain requirements regarding the manner of service delivery. This bill would establish procedures for granting privileges to, and verifying and approving credentials for, providers of telehealth services. By changing the definition of a crime applicable to health care service plans, the bill would impose a state-mandated local program.

(2) Existing law prohibits a requirement of face-to-face contact between a health care provider and a patient under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine.

This bill would, instead, prohibit a requirement of in-person contact between a health care provider and patient under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is appropriately provided by telehealth, as defined, and would make related changes.

(3) Existing law, until January 1, 2013, and to the extent that federal financial participation is available, authorizes, under the Medi-Cal program, teleophthalmology and teledermatology by store and forward, as defined.

This bill would delete the repeal of the above-described authorization.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. This act shall be known, and may be cited, as the Telehealth Advancement Act of 2011.

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

(a) Lack of primary care providers, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas.

(b) Parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care.

(c) Many health care providers in medically underserved areas are isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally.

(d) It is the intent of the Legislature to create a parity of telehealth with other health care delivery modes, to actively promote telehealth as a tool to

advance stakeholders' goals regarding health status and health system improvement, and to create opportunities and flexibility for telehealth to be used in new models of care and system improvements.

(e) Telehealth is a mode of delivering health care services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.

(f) Telehealth is part of a multifaceted approach to address the problem of inadequate provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations, and other forms of support.

(g) The use of information and telecommunication technologies to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care, particularly in rural and other medically underserved areas.

(h) Telehealth will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of medical care in the local area, strengthening the health infrastructure, and preserving health care-related jobs.

(i) Consumers of health care will benefit from telehealth in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

(j) It is the intent of the Legislature that the fundamental health care provider-patient relationship cannot only be preserved, but can also be augmented and enhanced, through the use of telehealth as a tool to be integrated into practices.

(k) Without the assurance of payment and the resolution of legal and policy barriers, the full potential of telehealth will not be realized.

SEC. 3. Section 2290.5 of the Business and Professions Code is repealed.

SEC. 4. Section 2290.5 is added to the Business and Professions Code, to read:

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

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

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

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

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

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

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

(b) Prior to the delivery of health care via telehealth, the health care provider at the originating site shall verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent shall be documented in the patient’s medical record.

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

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

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

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

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

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

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

SEC. 5. Section 1374.13 of the Health and Safety Code is repealed.

SEC. 6. Section 1374.13 is added to the Health and Safety Code, to read: 1374.13. (a) For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care

services from a health care provider without in-person contact with the health care provider.

(c) No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

(d) No health care service plan shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

(e) The requirements of this subdivision shall also be operative for health care service plan contracts with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(f) Notwithstanding any other provision, this section shall not be interpreted to authorize a health care service plan to require the use of telehealth when the health care provider has determined that it is not appropriate.

SEC. 7. Section 10123.85 of the Insurance Code is repealed.

SEC. 8. Section 10123.85 is added to the Insurance Code, to read:

10123.85. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) No health insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups.

(d) No health insurer shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract between the policyholder or contract holder and the insurer, and between the insurer and its participating providers or provider groups.

(e) Notwithstanding any other provision, this section shall not be interpreted to authorize a health insurer to require the use of telehealth when the health care provider has determined that it is not appropriate.

SEC. 9. Section 14132.72 of the Welfare and Institutions Code is amended to read:

14132.72. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.

(c) In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. Nothing in this section or the Telehealth Advancement Act of 2011 shall be construed to conflict with or supersede the provisions of Section 14091.3 of this code or any other existing state laws or regulations related to reimbursement for services provided by a noncontracted provider.

(d) The department shall not require a health care provider to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.

(e) For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

(f) Nothing in this section shall be interpreted to authorize the department to require the use of telehealth when the health care provider has determined that it is not appropriate.

(g) 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, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

SEC. 10. Section 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, “teleophthalmology and teledermatology by store and forward” means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with

Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) 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, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

(d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.

SEC. 11. 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.

**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 28 - MARCH 1, 2013 BOARD MEETING**

BILL NUMBER: Senate Bill 28

AUTHOR: Hernandez

SPONSOR:

VERSION: Introduced 12/03/2012

INTRODUCED: 12/03/2012

BILL STATUS: 01/10/2013 – To Senate
Committee on Health

BILL LOCATION: Senate Health
Committee

SUBJECT: Medi-Cal: Eligibility

**RELATED
BILLS:**

SUMMARY

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. The bill would also add, commencing January 1, 2014, benefits, services, and coverage included in the essential health benefits package, as adopted by the state and approved by the United States Secretary of Health and Human Services, to the schedule of Medi-Cal benefits.

Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

ANALYSIS

Board staff is tracking this bill because of its potential impact relating to the federal Patient Protection and Affordable Care Act. Staff will continue to monitor this bill and advise the Board of its impact on the practice of dentistry.

REGISTERED SUPPORT/OPPOSITION

To date, there is no registered support or opposition on file.

BOARD POSITION

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Introduced by Senators Hernandez and Steinberg

December 3, 2012

An act to amend Section 12698.30 of the Insurance Code, and to amend Sections 14005.31, 14005.32, 14132, and 15926 of, to amend and repeal Sections 14008.85, 14011.16, and 14011.17 of, to amend, repeal, and add Sections 14005.18, 14005.28, 14005.30, 14005.37, and 14012 of, to add Sections 14005.60, 14005.62, 14005.63, 14005.64, 14132.02, and 15926.2 to, the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 28, as introduced, Hernandez. Medi-Cal: eligibility.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

This bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. The bill would also add, commencing January 1, 2014, benefits, services, and coverage included in the essential health benefits package, as adopted by the state and approved by the United States

Secretary of Health and Human Services, to the schedule of Medi-Cal benefits.

Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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) The United States is the only industrialized country in the
- 4 world without a universal health insurance system.
- 5 (b) (1) In 2006, the United States Census reported that 46
- 6 million Americans did not have health insurance.
- 7 (2) In California in 2009, according to the UCLA Center for
- 8 Health Policy Research’s “The State of Health Insurance in
- 9 California: Findings from the 2009 California Health Interview
- 10 Survey,” 7.1 million Californians were uninsured in 2009,
- 11 amounting to 21.1 percent of nonelderly Californians who had no
- 12 health insurance coverage for all or some of 2009, up nearly 2
- 13 percentage points from 2007.
- 14 (c) On March 23, 2010, President Obama signed the Patient
- 15 Protection and Affordable Care Act (Public Law 111-148), which
- 16 was amended by the Health Care and Education Reconciliation
- 17 Act of 2010 (Public Law 111-152), and together are referred to as
- 18 the Affordable Care Act of 2010 (Affordable Care Act).
- 19 (d) The Affordable Care Act is the culmination of decades of
- 20 movement toward health reform, and is the most fundamental
- 21 legislative transformation of the United States health care system
- 22 in 40 years.

1 (e) As a result of the enactment of the Affordable Care Act,
2 according to estimates by the UCLA Center for Health Policy
3 Research and the UC Berkeley Labor Center, using the California
4 Simulation of Insurance Markets, in 2019, after the Affordable
5 Care Act is fully implemented:

6 (1) Between 89 and 92 percent of Californians under 65 years
7 of age will have health coverage.

8 (2) Between 1.2 and 1.6 million individuals will be newly
9 enrolled in Medi-Cal.

10 (f) It is the intent of the Legislature to ensure full implementation
11 of the Affordable Care Act, including the Medi-Cal expansion for
12 individuals with incomes below 133 percent of the federal poverty
13 level, so that millions of uninsured Californians can receive health
14 care coverage.

15 SEC. 2. Section 12698.30 of the Insurance Code is amended
16 to read:

17 12698.30. (a) ~~At~~(1) *Subject to paragraph (2), at a minimum,*
18 *coverage shall be provided to subscribers during one pregnancy,*
19 *and for 60 days thereafter, and to children less than two years of*
20 *age who were born of a pregnancy covered under this program to*
21 *a woman enrolled in the program before July 1, 2004.*

22 (2) *Commencing January 1, 2014, at a minimum, coverage shall*
23 *be provided to subscribers during one pregnancy, and until the*
24 *end of the month in which the 60th day thereafter occurs, and to*
25 *children less than two years of age who were born of a pregnancy*
26 *covered under this program to a woman enrolled in the program*
27 *before July 1, 2004.*

28 (b) Coverage provided pursuant to this part shall include, at a
29 minimum, those services required to be provided by health care
30 service plans approved by the *United States* Secretary of Health
31 and Human Services as a federally qualified health care service
32 plan pursuant to Section 417.101 of Title 42 of the Code of Federal
33 Regulations.

34 (c) Coverage shall include health education services related to
35 tobacco use.

36 (d) Medically necessary prescription drugs shall be a required
37 benefit in the coverage provided under this part.

38 SEC. 3. Section 14005.18 of the Welfare and Institutions Code
39 is amended to read:

1 14005.18. (a) A woman is eligible, to the extent required by
2 federal law, as though she were pregnant, for all pregnancy-related
3 and postpartum services for a 60-day period beginning on the last
4 day of pregnancy.

5 For purposes of this section, “postpartum services” means those
6 services provided after childbirth, child delivery, or miscarriage.

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

10 SEC. 4. Section 14005.18 is added to the Welfare and
11 Institutions Code, to read:

12 14005.18. (a) To help prevent premature delivery and low
13 birthweights, the leading causes of infant and maternal morbidity
14 and mortality, and to promote women’s overall health, well-being,
15 and financial security and that of their families, it is imperative
16 that pregnant women enrolled in Medi-Cal be provided with all
17 medically necessary services. Therefore, a woman is eligible, to
18 the extent required by federal law, as though she were pregnant,
19 for all pregnancy-related and postpartum services for a 60-day
20 period beginning on the last day of pregnancy and continuing until
21 the end of the month in which the 60th day of postpartum occurs.

22 (b) For purposes of this section, the following definitions shall
23 apply:

24 (1) “Pregnancy-related services” means, at a minimum, all
25 services required under the state plan unless federal approval is
26 granted after January 1, 2014, pursuant to the procedure under the
27 Preamble to the Final Rule at page 17149 of volume 77 of the
28 Federal Register (March 23, 2012) to provide fewer benefits during
29 pregnancy.

30 (2) “Postpartum services” means those services provided after
31 child birth, child delivery, or miscarriage.

32 (c) This section shall become operative January 1, 2014.

33 SEC. 5. Section 14005.28 of the Welfare and Institutions Code
34 is amended to read:

35 14005.28. (a) To the extent federal financial participation is
36 available pursuant to an approved state plan amendment, the
37 department shall exercise its option under Section
38 ~~1902(a)(10)(A)(XV)~~ *1902(a)(10)(A)(ii)(XVII)* of the federal Social
39 Security Act (42 U.S.C. Sec. ~~1396a(a)(10)(A)(XV)~~
40 *1396a(a)(10)(A)(ii)(XVII)*) to extend Medi-Cal benefits to

1 independent foster care adolescents, as defined in Section
2 ~~1905(v)(1)~~1905(w)(1) of the federal Social Security Act (42 U.S.C.
3 ~~Sec. 1396d(v)(1)~~ 1396(w)(1)).

4 (b) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 and if the state plan amendment described in subdivision (a) is
7 approved by the federal Health Care Financing Administration,
8 the department may implement subdivision (a) without taking any
9 regulatory action and by means of all-county letters or similar
10 instructions. Thereafter, the department shall adopt regulations in
11 accordance with the requirements of Chapter 3.5 (commencing
12 with Section 11340) of Part 1 of Division 3 of Title 2 of the
13 Government Code.

14 (c) The department shall implement subdivision (a) on October
15 1, 2000, but only if, and to the extent that, the department has
16 obtained all necessary federal approvals.

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

20 SEC. 6. Section 14005.28 is added to the Welfare and
21 Institutions Code, to read:

22 14005.28. (a) Commencing January 1, 2014, and to the extent
23 federal financial participation is available pursuant to an approved
24 state plan amendment, the department shall implement Section
25 1902(a)(10)(A)(i)(IX) of the federal Social Security Act (42 U.S.C.
26 Sec. 1396a(a)(10)(A)(i)(IX)) to extend Medi-Cal benefits to a
27 foster care adolescent, until his or her 26th birthday.

28 (1) A foster care adolescent who is in foster care on his or her
29 18th birthday shall be deemed eligible for the benefits extended
30 pursuant to this section and shall be enrolled to receive these
31 benefits until his or her 26th birthday without any interruption in
32 coverage and without requiring a new application.

33 (2) The department shall develop and implement a simplified
34 redetermination form for this program. A recipient qualifying for
35 the benefits extended pursuant to this section shall fill out and
36 return this form only if information previously reported to the
37 department is no longer accurate. Failure to return the form alone
38 will not constitute a basis for termination of Medi-Cal. If the form
39 is returned as undeliverable and the county is otherwise unable to
40 establish contact, the recipient shall remain eligible for

1 fee-for-service Medi-Cal until such time as contact is reestablished
2 or ineligibility is established, and to the extent federal financial
3 participation is available. The department may terminate eligibility
4 if it determines that the recipient is no longer eligible only after
5 ineligibility is established and all due process requirements are
6 met in accordance with state and federal law.

7 (3) This section shall be implemented to the extent that federal
8 financial participation is available, and any necessary federal
9 approvals are obtained.

10 (b) Notwithstanding Chapter 3.5 (commencing with Section
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
12 and if the state plan amendment described in subdivision (a) is
13 approved by the federal Centers for Medicare and Medicaid
14 Services, the department may implement this section without taking
15 any regulatory action and by means of all-county letters or similar
16 instructions. Thereafter, the department shall adopt regulations in
17 accordance with the requirements of Chapter 3.5 (commencing
18 with Section 11340) of Part 1 of Division 3 of Title 2 of the
19 Government Code.

20 (c) This section shall become operative January 1, 2014.

21 SEC. 7. Section 14005.30 of the Welfare and Institutions Code
22 is amended to read:

23 14005.30. (a) (1) To the extent that federal financial
24 participation is available, Medi-Cal benefits under this chapter
25 shall be provided to individuals eligible for services under Section
26 1396u-1 of Title 42 of the United States Code, including any
27 options under Section 1396u-1(b)(2)(C) made available to and
28 exercised by the state.

29 (2) The department shall exercise its option under Section
30 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
31 less restrictive income and resource eligibility standards and
32 methodologies to the extent necessary to allow all recipients of
33 benefits under Chapter 2 (commencing with Section 11200) to be
34 eligible for Medi-Cal under paragraph (1).

35 (3) To the extent federal financial participation is available, the
36 department shall exercise its option under Section 1396u-1(b)(2)(C)
37 of Title 42 of the United States Code authorizing the state to
38 disregard all changes in income or assets of a beneficiary until the
39 next annual redetermination under Section 14012. The department
40 shall implement this paragraph only if, and to the extent ~~that~~ that,

1 the State Child Health Insurance Program waiver described in
2 Section 12693.755 of the Insurance Code extending Healthy
3 Families Program eligibility to parents and certain other adults is
4 approved and implemented.

5 (b) To the extent that federal financial participation is available,
6 the department shall exercise its option under Section
7 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
8 to expand eligibility for Medi-Cal under subdivision (a) by
9 establishing the amount of countable resources individuals or
10 families are allowed to retain at the same amount medically needy
11 individuals and families are allowed to retain, except that a family
12 of one shall be allowed to retain countable resources in the amount
13 of three thousand dollars (\$3,000).

14 (c) To the extent federal financial participation is available, the
15 department shall, commencing March 1, 2000, adopt an income
16 disregard for applicants equal to the difference between the income
17 standard under the program adopted pursuant to Section 1931(b)
18 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and
19 the amount equal to 100 percent of the federal poverty level
20 applicable to the size of the family. A recipient shall be entitled
21 to the same disregard, but only to the extent it is more beneficial
22 than, and is substituted for, the earned income disregard available
23 to recipients.

24 (d) For purposes of calculating income under this section during
25 any calendar year, increases in social security benefit payments
26 under Title II of the federal Social Security Act (42 U.S.C. Sec.
27 401 and following) arising from cost-of-living adjustments shall
28 be disregarded commencing in the month that these social security
29 benefit payments are increased by the cost-of-living adjustment
30 through the month before the month in which a change in the
31 federal poverty level requires the department to modify the income
32 disregard pursuant to subdivision (c) and in which new income
33 limits for the program established by this section are adopted by
34 the department.

35 (e) Subdivision (b) shall be applied retroactively to January 1,
36 1998.

37 (f) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department shall implement, without taking regulatory action,
40 subdivisions (a) and (b) of this section by means of an all county

1 letter or similar instruction. Thereafter, the department shall adopt
2 regulations in accordance with the requirements of Chapter 3.5
3 (commencing with Section 11340) of Part 1 of Division 3 of Title
4 2 of the Government Code.

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

8 SEC. 8. Section 14005.30 is added to the Welfare and
9 Institutions Code, to read:

10 14005.30. (a) (1) To the extent that federal financial
11 participation is available, Medi-Cal benefits under this chapter
12 shall be provided to individuals eligible for services under Section
13 1396u-1 of Title 42 of the United States Code, known as the
14 Section 1931(b) program, including any options under Section
15 1396u-1(b)(2)(C) made available to and exercised by the state.

16 (2) The department shall exercise its option under Section
17 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
18 less restrictive income and resource eligibility standards and
19 methodologies to the extent necessary to allow all recipients of
20 benefits under Chapter 2 (commencing with Section 11200) to be
21 eligible for Medi-Cal under paragraph (1).

22 (b) Commencing January 1, 2014, pursuant to Section
23 1396a(e)(14)(C) of Title 42 of the United States Code, there shall
24 be no assets test and no deprivation test for any individual under
25 this section.

26 (c) For purposes of calculating income under this section during
27 any calendar year, increases in social security benefit payments
28 under Title II of the federal Social Security Act (42 U.S.C. Sec.
29 401 et seq.) arising from cost-of-living adjustments shall be
30 disregarded commencing in the month that these social security
31 benefit payments are increased by the cost-of-living adjustment
32 through the month before the month in which a change in the
33 federal poverty level requires the department to modify the income
34 disregard pursuant to subdivision (c) and in which new income
35 limits for the program established by this section are adopted by
36 the department.

37 (d) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department shall implement, without taking regulatory action,
40 this section by means of an all-county letter or similar instruction.

1 Thereafter, the department shall adopt regulations in accordance
2 with the requirements of Chapter 3.5 (commencing with Section
3 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
4 Beginning six months after the effective date of this section, the
5 department shall provide a status report to the Legislature on a
6 semiannual basis until regulations have been adopted.

7 (e) This section shall become operative January 1, 2014.

8 SEC. 9. Section 14005.31 of the Welfare and Institutions Code
9 is amended to read:

10 14005.31. (a) (1) Subject to paragraph (2), for any person
11 whose eligibility for benefits under Section 14005.30 has been
12 determined with a concurrent determination of eligibility for cash
13 aid under Chapter 2 (commencing with Section 11200), loss of
14 eligibility or termination of cash aid under Chapter 2 (commencing
15 with Section 11200) shall not result in a loss of eligibility or
16 termination of benefits under Section 14005.30 absent the existence
17 of a factor that would result in loss of eligibility for benefits under
18 Section 14005.30 for a person whose eligibility under Section
19 14005.30 was determined without a concurrent determination of
20 eligibility for benefits under Chapter 2 (commencing with Section
21 11200).

22 (2) Notwithstanding paragraph (1), a person whose eligibility
23 would otherwise be terminated pursuant to that paragraph shall
24 not have his or her eligibility terminated until the transfer
25 procedures set forth in Section 14005.32 or the redetermination
26 procedures set forth in Section 14005.37 and all due process
27 requirements have been met.

28 (b) The department, in consultation with the counties and
29 representatives of consumers, managed care plans, and Medi-Cal
30 providers, shall prepare a simple, clear, consumer-friendly notice
31 to be used by the counties, to inform Medi-Cal beneficiaries whose
32 eligibility for cash aid under Chapter 2 (commencing with Section
33 11200) has ended, but whose eligibility for benefits under Section
34 14005.30 continues pursuant to subdivision (a), that their benefits
35 will continue. To the extent feasible, the notice shall be sent out
36 at the same time as the notice of discontinuation of cash aid, and
37 shall include all of the following:

38 (1) A statement that Medi-Cal benefits will continue even though
39 cash aid under the CalWORKs program has been terminated.

1 (2) A statement that continued receipt of Medi-Cal benefits will
2 not be counted against any time limits in existence for receipt of
3 cash aid under the CalWORKs program.

4 (3) (A) A statement that the Medi-Cal beneficiary does not
5 need to fill out monthly status reports in order to remain eligible
6 for Medi-Cal, but ~~shall~~ *may* be required to submit a semiannual
7 status report and annual reaffirmation forms. The notice shall
8 remind individuals whose cash aid ended under the CalWORKs
9 program as a result of not submitting a status report that he or she
10 should review his or her circumstances to determine if changes
11 have occurred that should be reported to the Medi-Cal eligibility
12 worker.

13 (B) *Commencing January 1, 2014, the semiannual status report*
14 *requirement shall not be included in the statement described in*
15 *subparagraph (A).*

16 (4) A statement describing the responsibility of the Medi-Cal
17 beneficiary to report to the county, within 10 days, significant
18 changes that may affect eligibility.

19 (5) A telephone number to call for more information.

20 (6) A statement that the Medi-Cal beneficiary's eligibility
21 worker will not change, or, if the case has been reassigned, the
22 new worker's name, address, and telephone number, and the hours
23 during which the county's eligibility workers can be contacted.

24 (c) This section shall be implemented on or before July 1, 2001,
25 but only to the extent that federal financial participation under
26 Title XIX of the federal Social Security Act (~~Title 42 (42 U.S.C.~~
27 ~~Sec. 1396 and following) et seq.~~) is available.

28 (d) Notwithstanding Chapter 3.5 (commencing with Section
29 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
30 the department shall, without taking any regulatory action,
31 implement this section by means of all county letters or similar
32 instructions. Thereafter, the department shall adopt regulations in
33 accordance with the requirements of Chapter 3.5 (commencing
34 with Section 11340) of Part 1 of Division 3 of Title 2 of the
35 Government Code. Comprehensive implementing instructions
36 shall be issued to the counties no later than March 1, 2001.

37 SEC. 10. Section 14005.32 of the Welfare and Institutions
38 Code is amended to read:

39 14005.32. (a) (1) If the county has evidence clearly
40 demonstrating that a beneficiary is not eligible for benefits under

1 this chapter pursuant to Section 14005.30, but is eligible for
2 benefits under this chapter pursuant to other provisions of law, the
3 county shall transfer the individual to the corresponding Medi-Cal
4 program. Eligibility under Section 14005.30 shall continue until
5 the transfer is complete.

6 (2) The department, in consultation with the counties and
7 representatives of consumers, managed care plans, and Medi-Cal
8 providers, shall prepare a simple, clear, consumer-friendly notice
9 to be used by the counties, to inform beneficiaries that their
10 Medi-Cal benefits have been transferred pursuant to paragraph (1)
11 and to inform them about the program to which they have been
12 transferred. To the extent feasible, the notice shall be issued with
13 the notice of discontinuance from cash aid, and shall include all
14 of the following:

15 (A) A statement that Medi-Cal benefits will continue under
16 another program, even though aid under Chapter 2 (commencing
17 with Section 11200) has been terminated.

18 (B) The name of the program under which benefits will continue,
19 and an explanation of that program.

20 (C) A statement that continued receipt of Medi-Cal benefits will
21 not be counted against any time limits in existence for receipt of
22 cash aid under the CalWORKs program.

23 (D) (i) A statement that the Medi-Cal beneficiary does not need
24 to fill out monthly status reports in order to remain eligible for
25 Medi-Cal, but ~~shall~~ *may* be required to submit a semiannual status
26 report and annual reaffirmation forms. In addition, if the person
27 or persons to whom the notice is directed has been found eligible
28 for transitional Medi-Cal as described in Section 14005.8 ;
29 ~~14005.81~~, or 14005.85, the statement shall explain the reporting
30 requirements and duration of benefits under those programs, and
31 shall further explain that, at the end of the duration of these
32 benefits, a redetermination, as provided for in Section 14005.37
33 shall be conducted to determine whether benefits are available
34 under any other provision of law.

35 (ii) *Commencing January 1, 2014, the semiannual status report*
36 *requirement shall not be included in the statement described in*
37 *clause (i).*

38 (E) A statement describing the beneficiary's responsibility to
39 report to the county, within 10 days, significant changes that may
40 affect eligibility or share of cost.

1 (F) A telephone number to call for more information.

2 (G) A statement that the beneficiary's eligibility worker will
3 not change, or, if the case has been reassigned, the new worker's
4 name, address, and telephone number, and the hours during which
5 the county's Medi-Cal eligibility workers can be contacted.

6 (b) No later than September 1, 2001, the department shall submit
7 a federal waiver application seeking authority to eliminate the
8 reporting requirements imposed by transitional medicaid under
9 Section 1925 of the federal Social Security Act (Title 42 U.S.C.
10 Sec. 1396r-6).

11 (c) This section shall be implemented on or before July 1, 2001,
12 but only to the extent that federal financial participation under
13 Title XIX of the federal Social Security Act (~~Title 42~~ (42 U.S.C.
14 Sec. 1396 and following) *et seq.*) is available.

15 (d) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department shall, without taking any regulatory action,
18 implement this section by means of all county letters or similar
19 instructions. Thereafter, the department shall adopt regulations in
20 accordance with the requirements of Chapter 3.5 (commencing
21 with Section 11340) of Part 1 of Division 3 of Title 2 of the
22 Government Code. Comprehensive implementing instructions
23 shall be issued to the counties no later than March 1, 2001.

24 SEC. 11. Section 14005.37 of the Welfare and Institutions
25 Code is amended to read:

26 14005.37. (a) Except as provided in Section 14005.39,
27 whenever a county receives information about changes in a
28 beneficiary's circumstances that may affect eligibility for Medi-Cal
29 benefits, the county shall promptly redetermine eligibility. The
30 procedures for redetermining Medi-Cal eligibility described in this
31 section shall apply to all Medi-Cal beneficiaries.

32 (b) Loss of eligibility for cash aid under that program shall not
33 result in a redetermination under this section unless the reason for
34 the loss of eligibility is one that would result in the need for a
35 redetermination for a person whose eligibility for Medi-Cal under
36 Section 14005.30 was determined without a concurrent
37 determination of eligibility for cash aid under the CalWORKs
38 program.

39 (c) A loss of contact, as evidenced by the return of mail marked
40 in such a way as to indicate that it could not be delivered to the

1 intended recipient or that there was no forwarding address, shall
2 require a prompt redetermination according to the procedures set
3 forth in this section.

4 (d) Except as otherwise provided in this section, Medi-Cal
5 eligibility shall continue during the redetermination process
6 described in this section. A Medi-Cal beneficiary's eligibility shall
7 not be terminated under this section until the county makes a
8 specific determination based on facts clearly demonstrating that
9 the beneficiary is no longer eligible for Medi-Cal under any basis
10 and due process rights guaranteed under this division have been
11 met.

12 (e) For purposes of acquiring information necessary to conduct
13 the eligibility determinations described in subdivisions (a) to (d),
14 inclusive, a county shall make every reasonable effort to gather
15 information available to the county that is relevant to the
16 beneficiary's Medi-Cal eligibility prior to contacting the
17 beneficiary. Sources for these efforts shall include, but are not
18 limited to, Medi-Cal, CalWORKs, and CalFresh case files of the
19 beneficiary or of any of his or her immediate family members,
20 which are open or were closed within the last 45 days, and
21 wherever feasible, other sources of relevant information reasonably
22 available to the counties.

23 (f) If a county cannot obtain information necessary to
24 redetermine eligibility pursuant to subdivision (e), the county shall
25 attempt to reach the beneficiary by telephone in order to obtain
26 this information, either directly or in collaboration with
27 community-based organizations so long as confidentiality is
28 protected.

29 (g) If a county's efforts pursuant to subdivisions (e) and (f) to
30 obtain the information necessary to redetermine eligibility have
31 failed, the county shall send to the beneficiary a form, which shall
32 highlight the information needed to complete the eligibility
33 determination. The county shall not request information or
34 documentation that has been previously provided by the
35 beneficiary, that is not absolutely necessary to complete the
36 eligibility determination, or that is not subject to change. The form
37 shall be accompanied by a simple, clear, consumer-friendly cover
38 letter, which shall explain why the form is necessary, the fact that
39 it is not necessary to be receiving CalWORKs benefits to be
40 receiving Medi-Cal benefits, the fact that receipt of Medi-Cal

1 benefits does not count toward any time limits imposed by the
2 CalWORKs program, the various bases for Medi-Cal eligibility,
3 including disability, and the fact that even persons who are
4 employed can receive Medi-Cal benefits. The cover letter shall
5 include a telephone number to call in order to obtain more
6 information. The form and the cover letter shall be developed by
7 the department in consultation with the counties and representatives
8 of consumers, managed care plans, and Medi-Cal providers. A
9 Medi-Cal beneficiary shall have no less than 20 days from the date
10 the form is mailed pursuant to this subdivision to respond. Except
11 as provided in subdivision (h), failure to respond prior to the end
12 of this 20-day period shall not impact his or her Medi-Cal
13 eligibility.

14 (h) If the purpose for a redetermination under this section is a
15 loss of contact with the Medi-Cal beneficiary, as evidenced by the
16 return of mail marked in such a way as to indicate that it could not
17 be delivered to the intended recipient or that there was no
18 forwarding address, a return of the form described in subdivision
19 (g) marked as undeliverable shall result in an immediate notice of
20 action terminating Medi-Cal eligibility.

21 (i) If, within 20 days of the date of mailing of a form to the
22 Medi-Cal beneficiary pursuant to subdivision (g), a beneficiary
23 does not submit the completed form to the county, the county shall
24 send the beneficiary a written notice of action stating that his or
25 her eligibility shall be terminated 10 days from the date of the
26 notice and the reasons for that determination, unless the beneficiary
27 submits a completed form prior to the end of the 10-day period.

28 (j) If, within 20 days of the date of mailing of a form to the
29 Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary
30 submits an incomplete form, the county shall attempt to contact
31 the beneficiary by telephone and in writing to request the necessary
32 information. If the beneficiary does not supply the necessary
33 information to the county within 10 days from the date the county
34 contacts the beneficiary in regard to the incomplete form, a 10-day
35 notice of termination of Medi-Cal eligibility shall be sent.

36 (k) If, within 30 days of termination of a Medi-Cal beneficiary's
37 eligibility pursuant to subdivision (h), (i), or (j), the beneficiary
38 submits to the county a completed form, eligibility shall be
39 determined as though the form was submitted in a timely manner

1 and if a beneficiary is found eligible, the termination under
2 subdivision (h), ~~(I);~~(i), or (j) shall be rescinded.

3 (l) If the information reasonably available to the county pursuant
4 to the redetermination procedures of subdivisions (d), (e), (g), and
5 (m) does not indicate a basis of eligibility, Medi-Cal benefits may
6 be terminated so long as due process requirements have otherwise
7 been met.

8 (m) The department shall, with the counties and representatives
9 of consumers, including those with disabilities, and Medi-Cal
10 providers, develop a timeframe for redetermination of Medi-Cal
11 eligibility based upon disability, including ex parte review, the
12 redetermination form described in subdivision (g), timeframes for
13 responding to county or state requests for additional information,
14 and the forms and procedures to be used. The forms and procedures
15 shall be as consumer-friendly as possible for people with
16 disabilities. The timeframe shall provide a reasonable and adequate
17 opportunity for the Medi-Cal beneficiary to obtain and submit
18 medical records and other information needed to establish
19 eligibility for Medi-Cal based upon disability.

20 (n) This section shall be implemented on or before July 1, 2001,
21 but only to the extent that federal financial participation under
22 Title XIX of the federal Social Security Act ~~(Title 42 (42 U.S.C.~~
23 ~~Sec. 1396 and following)~~ *et seq.*) is available.

24 (o) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department shall, without taking any regulatory action,
27 implement this section by means of all county letters or similar
28 instructions. Thereafter, the department shall adopt regulations in
29 accordance with the requirements of Chapter 3.5 (commencing
30 with Section 11340) of Part 1 of Division 3 of Title 2 of the
31 Government Code. Comprehensive implementing instructions
32 shall be issued to the counties no later than March 1, 2001.

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

36 SEC. 12. Section 14005.37 is added to the Welfare and
37 Institutions Code, to read:

38 14005.37. (a) Except as provided in Section 14005.39,
39 whenever a county receives information about changes in a
40 beneficiary's circumstances that may affect eligibility for Medi-Cal

1 benefits, the county shall promptly redetermine eligibility. The
2 procedures for redetermining Medi-Cal eligibility described in this
3 section shall apply to all Medi-Cal beneficiaries.

4 (b) Loss of eligibility for cash aid under that program shall not
5 result in a redetermination under this section unless the reason for
6 the loss of eligibility is one that would result in the need for a
7 redetermination for a person whose eligibility for Medi-Cal under
8 Section 14005.30 was determined without a concurrent
9 determination of eligibility for cash aid under the CalWORKs
10 program.

11 (c) A loss of contact, as evidenced by the return of mail marked
12 in such a way as to indicate that it could not be delivered to the
13 intended recipient or that there was no forwarding address, shall
14 require a prompt redetermination according to the procedures set
15 forth in this section.

16 (d) Except as otherwise provided in this section, Medi-Cal
17 eligibility shall continue during the redetermination process
18 described in this section. A Medi-Cal beneficiary's eligibility shall
19 not be terminated under this section until the county makes a
20 specific determination based on facts clearly demonstrating that
21 the beneficiary is no longer eligible for Medi-Cal under any basis
22 and due process rights guaranteed under this division have been
23 met.

24 (e) (1) For purposes of acquiring information necessary to
25 conduct the eligibility determinations described in subdivisions
26 (a) to (d), inclusive, a county shall gather information available to
27 the county that is relevant to the beneficiary's Medi-Cal eligibility
28 prior to contacting the beneficiary. Sources for these efforts shall
29 include, but are not limited to, Medi-Cal, CalWORKs, and
30 CalFresh case files of the beneficiary or of any of his or her
31 immediate family members, which are open or were closed within
32 the last 45 days, information accessed through any databases
33 accessed by the agency under Sections 435.948, 435.949, and
34 435.956 of Title 42 of the Code of Federal Regulations, and
35 wherever feasible, other sources of relevant information reasonably
36 available to the counties.

37 (2) If the county is able to renew eligibility based on such
38 information, the county shall notify the individual of both of the
39 following:

40 (A) The eligibility determination and basis.

1 (B) That the individual is required to inform the county via the
2 Internet, by telephone, by mail, in person, or through other
3 commonly available electronic means, in counties where such
4 electronic communication is available, if any information contained
5 in the notice is inaccurate but that the individual is not required to
6 sign and return the notice if all information provided on the notice
7 is accurate.

8 (3) The county shall make all reasonable efforts not to send
9 multiple notices during the same time period about eligibility. The
10 notice of eligibility renewal shall contain other related information
11 such as if the individual is in a new Medi-Cal program.

12 (f) If a county cannot obtain information necessary to
13 redetermine eligibility pursuant to subdivision (e), the county shall
14 attempt to reach the beneficiary by telephone and other commonly
15 available electronic means, in counties where such electronic
16 communication is available, in order to obtain this information,
17 either directly or in collaboration with community-based
18 organizations so long as confidentiality is protected.

19 (g) If a county's efforts pursuant to subdivisions (e) and (f) to
20 obtain the information necessary to redetermine eligibility have
21 failed, the county shall send to the beneficiary a form containing
22 information available to the county needed to renew eligibility.
23 The county shall not request information or documentation that
24 has been previously provided by the beneficiary, that is not
25 absolutely necessary to complete the eligibility determination, or
26 that is not subject to change. The county shall not request
27 information for nonapplicants necessary to make an eligibility
28 determination. The form shall be accompanied by a simple, clear,
29 consumer-friendly cover letter, that shall explain why the form is
30 necessary, the fact that it is not necessary to be receiving
31 CalWORKs benefits to be receiving Medi-Cal benefits, the fact
32 that receipt of Medi-Cal benefits does not count toward any time
33 limits imposed by the CalWORKs program, the various bases for
34 Medi-Cal eligibility, including disability, and the fact that even
35 persons who are employed can receive Medi-Cal benefits. The
36 form shall advise the individual to provide any necessary
37 information to the county via the Internet, by telephone, by mail,
38 in person, or through other commonly available electronic means
39 and to sign the renewal form. The cover letter shall include a
40 telephone number to call in order to obtain more information. The

1 form and the cover letter shall be developed by the department in
2 consultation with the counties and representatives of consumers,
3 managed care plans, and Medi-Cal providers. A Medi-Cal
4 beneficiary shall have no less than 20 days from the date the form
5 is mailed pursuant to this subdivision to respond. Except as
6 provided in subdivision (h), failure to respond prior to the end of
7 this 20-day period shall not impact his or her Medi-Cal eligibility.

8 (h) If the purpose for a redetermination under this section is a
9 loss of contact with the Medi-Cal beneficiary, as evidenced by the
10 return of mail marked in such a way as to indicate that it could not
11 be delivered to the intended recipient or that there was no
12 forwarding address, a return of the form described in subdivision
13 (g) marked as undeliverable shall result in an immediate notice of
14 action terminating Medi-Cal eligibility.

15 (i) If, within 20 days of the date of mailing of a form to the
16 Medi-Cal beneficiary pursuant to subdivision (g), a beneficiary
17 does not submit the completed form to the county, the county shall
18 send the beneficiary a written notice of action stating that his or
19 her eligibility shall be terminated 10 days from the date of the
20 notice and the reasons for that determination, unless the beneficiary
21 submits a completed form prior to the end of the 10-day period.

22 (j) If, within 20 days of the date of mailing of a form to the
23 Medi-Cal beneficiary pursuant to subdivision (g), the beneficiary
24 submits an incomplete form, the county shall attempt to contact
25 the beneficiary by telephone, in writing, and other commonly
26 available electronic means, in counties where such electronic
27 communication is available, to request the necessary information.
28 If the beneficiary does not supply the necessary information to the
29 county within 10 days from the date the county contacts the
30 beneficiary in regard to the incomplete form, a 10-day notice of
31 termination of Medi-Cal eligibility shall be sent.

32 (k) (1) Subject to paragraph (2), if within 30 days of termination
33 of a Medi-Cal beneficiary's eligibility pursuant to subdivision (h),
34 (i), or (j), the beneficiary submits to the county a completed form,
35 eligibility shall be determined as though the form was submitted
36 in a timely manner and if a beneficiary is found eligible, the
37 termination under subdivision (h), (i), or (j) shall be rescinded.

38 (2) Commencing January 1, 2014, if within 90 days of
39 termination of a Medi-Cal beneficiary's eligibility pursuant to
40 subdivision (h), (i), or (j), the beneficiary submits to the county a

1 completed form, eligibility shall be determined as though the form
2 was submitted in a timely manner and if a beneficiary is found
3 eligible, the termination under subdivision (h), (i), or (j) shall be
4 rescinded.

5 (l) If the information available to the county pursuant to the
6 redetermination procedures of subdivisions (d), (e), (g), and (m)
7 does not indicate a basis of eligibility, Medi-Cal benefits may be
8 terminated so long as due process requirements have otherwise
9 been met.

10 (m) The department shall, with the counties and representatives
11 of consumers, including those with disabilities, and Medi-Cal
12 providers, develop a timeframe for redetermination of Medi-Cal
13 eligibility based upon disability, including ex parte review, the
14 redetermination form described in subdivision (g), timeframes for
15 responding to county or state requests for additional information,
16 and the forms and procedures to be used. The forms and procedures
17 shall be as consumer-friendly as possible for people with
18 disabilities. The timeframe shall provide a reasonable and adequate
19 opportunity for the Medi-Cal beneficiary to obtain and submit
20 medical records and other information needed to establish
21 eligibility for Medi-Cal based upon disability.

22 (n) The county shall consider blindness as continuing until the
23 reviewing physician determines that a beneficiary's vision has
24 improved beyond the definition of blindness contained in the plan.

25 (o) The county shall consider disability as continuing until the
26 review team determines that a beneficiary's disability no longer
27 meets the definition of disability contained in the plan.

28 (p) If a county has enough information available to it to renew
29 eligibility with respect to all eligibility criteria, the county shall
30 begin a new 12-month eligibility period.

31 (q) For individuals determined ineligible for Medi-Cal, the
32 county shall determine eligibility for other state health subsidy
33 programs and comply with the procedures in Section 15926.

34 (r) Any renewal form or notice shall be accessible to persons
35 who are limited English proficient and persons with disabilities
36 consistent with all federal and state requirements.

37 (s) This section shall become operative January 1, 2014.

38 SEC. 13. Section 14005.60 is added to the Welfare and
39 Institutions Code, to read:

1 14005.60. (a) Commencing January 1, 2014, the department
2 shall provide eligibility for Medi-Cal benefits for any person who
3 meets the eligibility requirements of Section
4 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security
5 Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)).

6 (b) Persons who qualify under subdivision (a) and are currently
7 enrolled in a Low Income Health Program (LIHP) under
8 California's Bridge to Reform Section 1115(a) Medicaid
9 Demonstration shall be transitioned to the Medi-Cal program under
10 this section in accordance with the transition plan as approved by
11 the federal Centers for Medicare and Medicaid Services. With
12 respect to plan enrollment, a LIHP enrollee shall be all of the
13 following:

14 (1) Notified which Medi-Cal health plan or plans contain his or
15 her existing medical home provider.

16 (2) Notified that he or she can select a health plan that contains
17 his or her existing medical home provider.

18 (3) Provided the opportunity to choose a different health plan
19 if there is more than one plan available in the county where he or
20 she resides.

21 (4) Informed that if he or she does not affirmatively choose a
22 plan or there is only one plan in the county where he or she resides,
23 he or she shall be enrolled into the Medi-Cal managed care plan
24 that contains his or her LIHP medical home provider.

25 (c) In order to ensure that no persons lose health care coverage
26 in the course of the transition, the department shall require that
27 notices of the January 1, 2014, change be sent to LIHP enrollees
28 upon their LIHP redetermination in 2013 and again at least 90 days
29 prior to the transition. Pursuant to Section 1902(k)(1) and Section
30 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec.
31 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department
32 shall seek approval from the United States Secretary of Health and
33 Human Services to establish a benchmark benefit package that
34 includes the same benefits, services, and coverage that are provided
35 to all other full-scope Medi-Cal enrollees, supplemented by any
36 benefits, services, and coverage included in the essential health
37 benefits package adopted by the state and approved by the United
38 States Secretary of Health and Human Services under Section
39 18022 of Title 42 of the United States Code.

1 SEC. 14. Section 14005.62 is added to the Welfare and
2 Institutions Code, to read:

3 14005.62. Commencing January 1, 2014, the department shall
4 accept an individual's attestation of information and verify
5 information pursuant to Section 15926.2.

6 SEC. 15. Section 14005.63 is added to the Welfare and
7 Institutions Code, to read:

8 14005.63. (a) Commencing January 1, 2014, a person who
9 wishes to apply for a state health subsidy program, as defined in
10 subdivision (a) of Section 15926, shall be allowed to file an
11 application on his or her own behalf or on behalf of his or her
12 family. The individual also has the right to be accompanied,
13 assisted, and represented in the application and renewal process
14 by an individual or organization of his or her own choice. If the
15 individual for any reason is unable to apply or renew on his or her
16 own behalf, any of the following persons may file the application
17 for the applicant:

18 (1) The individual's guardian, conservator, or executor.

19 (2) A public agency representative.

20 (3) The individual's legal counsel, relative, friend, or other
21 spokesperson of his or her choice.

22 (b) A person who wishes to challenge a decision concerning his
23 or her eligibility for or receipt of benefits from a state health
24 subsidy program has the right to represent himself or herself or
25 use legal counsel, a relative, a friend, or other spokesperson of his
26 or her choice.

27 SEC. 16. Section 14005.64 is added to the Welfare and
28 Institutions Code, to read:

29 14005.64. (a) This section implements Section 1902(e)(14)(C)
30 of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(14)(C))
31 and Section 435.603(g) of Title 42 of the Code of Federal
32 Regulations, which prohibits the use of an assets test for individuals
33 whose income eligibility is determined based on modified adjusted
34 gross income (MAGI), and Section 2002 of the federal Patient
35 Protection and Affordable Care Act (Affordable Care Act) (42
36 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of Title 42
37 of the Code of Federal Regulations, which requires a 5-percent
38 income disregard for individuals whose income eligibility is
39 determined based on MAGI.

1 (b) In the case of individuals whose financial eligibility for
2 Medi-Cal is determined based on the application of MAGI pursuant
3 to Section 435.603 of Title 42 of the Code of Federal Regulations,
4 the eligibility determination shall not include any assets or
5 resources test.

6 (c) The department shall implement the 5-percent income
7 disregard for individuals whose income eligibility is determined
8 based on MAGI in Section 2002 of the Affordable Care Act (42
9 U.S.C. Sec. 1396a(e)(14)(I)) and Section 435.603(d) of the Title
10 42 of the Code of Federal Regulations.

11 (d) The department shall adopt an equivalent income level for
12 each eligibility group whose income level will be converted to
13 MAGI. The equivalent income level shall not be less than the dollar
14 amount of all income exemptions, exclusions, deductions, and
15 disregards in effect on March 23, 2010, plus the existing income
16 level expressed as a percent of the federal poverty level for each
17 eligibility group so as to ensure that the use of MAGI income
18 methodology does not result in populations who would have been
19 eligible under this chapter and Part 6.3 (commencing with Section
20 12695) of Division 2 of the Insurance Code losing coverage.

21 (e) This section shall become operative on January 1, 2014.

22 SEC. 17. Section 14008.85 of the Welfare and Institutions
23 Code is amended to read:

24 14008.85. (a) To the extent federal financial participation is
25 available, a parent who is the principal wage earner shall be
26 considered an unemployed parent for purposes of establishing
27 eligibility based upon deprivation of a child where any of the
28 following applies:

29 (1) The parent works less than 100 hours per month as
30 determined pursuant to the rules of the Aid to Families with
31 Dependent Children program as it existed on July 16, 1996,
32 including the rule allowing a temporary excess of hours due to
33 intermittent work.

34 (2) The total net nonexempt earned income for the family is not
35 more than 100 percent of the federal poverty level as most recently
36 calculated by the federal government. The department may adopt
37 additional deductions to be taken from a family's income.

38 (3) The parent is considered unemployed under the terms of an
39 existing federal waiver of the 100-hour rule for recipients under

1 the program established by Section 1931(b) of the federal Social
2 Security Act (42 U.S.C. Sec. 1396u-1).

3 (b) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the department shall implement this section by means of an all
6 county letter or similar instruction without taking regulatory action.
7 Thereafter, the department shall adopt regulations in accordance
8 with the requirements of Chapter 3.5 (commencing with Section
9 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

10 ~~(e) This section shall become operative March 1, 2000.~~

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

14 SEC. 18. Section 14011.16 of the Welfare and Institutions
15 Code is amended to read:

16 14011.16. (a) Commencing August 1, 2003, the department
17 shall implement a requirement for beneficiaries to file semiannual
18 status reports as part of the department's procedures to ensure that
19 beneficiaries make timely and accurate reports of any change in
20 circumstance that may affect their eligibility. The department shall
21 develop a simplified form to be used for this purpose. The
22 department shall explore the feasibility of using a form that allows
23 a beneficiary who has not had any changes to so indicate by
24 checking a box and signing and returning the form.

25 (b) Beneficiaries who have been granted continuous eligibility
26 under Section 14005.25 shall not be required to submit semiannual
27 status reports. To the extent federal financial participation is
28 available, all children under 19 years of age shall be exempt from
29 the requirement to submit semiannual status reports.

30 (c) For any period of time that the continuous eligibility period
31 described in paragraph (1) of subdivision (a) of Section 14005.25
32 is reduced to six months, subdivision (b) shall become inoperative,
33 and all children under 19 years of age shall be required to file
34 semiannual status reports.

35 (d) Beneficiaries whose eligibility is based on a determination
36 of disability or on their status as aged or blind shall be exempt
37 from the semiannual status report requirement described in
38 subdivision (a). The department may exempt other groups from
39 the semiannual status report requirement as necessary for simplicity
40 of administration.

1 (e) When a beneficiary has completed, signed, and filed a
2 semiannual status report that indicated a change in circumstance,
3 eligibility shall be redetermined.

4 (f) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department shall implement this section by means of all-county
7 letters or similar instructions without taking regulatory action.
8 Thereafter, the department shall adopt regulations in accordance
9 with the requirements of Chapter 3.5 (commencing with Section
10 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

11 (g) This section shall be implemented only if and to the extent
12 federal financial participation is available.

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

16 SEC. 19. Section 14011.17 of the Welfare and Institutions
17 Code is amended to read:

18 14011.17. The following persons shall be exempt from the
19 semiannual reporting requirements described in Section 14011.16:

20 (a) Pregnant women whose eligibility is based on pregnancy.

21 (b) Beneficiaries receiving Medi-Cal through Aid for Adoption
22 of Children Program.

23 (c) Beneficiaries who have a public guardian.

24 (d) Medically indigent children who are not living with a parent
25 or relative and who have a public agency assuming their financial
26 responsibility.

27 (e) Individuals receiving minor consent services.

28 (f) Beneficiaries in the Breast and Cervical Cancer Treatment
29 Program.

30 (g) Beneficiaries who are CalWORKs recipients and custodial
31 parents whose children are CalWORKs recipients.

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

35 SEC. 20. Section 14012 of the Welfare and Institutions Code
36 is amended to read:

37 14012. (a) Reaffirmation shall be filed annually and may be
38 required at other times in accordance with general standards
39 established by the department.

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

4 SEC. 21. Section 14012 is added to the Welfare and Institutions
5 Code, to read:

6 14012. (a) This section implements Section 435.916(a)(1) of
7 Title 42 of the Code of Federal Regulations, which applies to the
8 eligibility of Medi-Cal beneficiaries whose financial eligibility is
9 determined using modified adjusted gross income (MAGI) based
10 income.

11 (b) To the extent required by federal law or regulations, the
12 eligibility of Medi-Cal beneficiaries whose financial eligibility is
13 determined using a MAGI-based income shall be renewed once
14 every 12 months, and no more frequently than every 12 months.

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

16 SEC. 22. Section 14132 of the Welfare and Institutions Code
17 is amended to read:

18 14132. The following is the schedule of benefits under this
19 chapter:

20 (a) Outpatient services are covered as follows:

21 Physician, hospital or clinic outpatient, surgical center,
22 respiratory care, optometric, chiropractic, psychology, podiatric,
23 occupational therapy, physical therapy, speech therapy, audiology,
24 acupuncture to the extent federal matching funds are provided for
25 acupuncture, and services of persons rendering treatment by prayer
26 or healing by spiritual means in the practice of any church or
27 religious denomination insofar as these can be encompassed by
28 federal participation under an approved plan, subject to utilization
29 controls.

30 (b) (1) Inpatient hospital services, including, but not limited
31 to, physician and podiatric services, physical therapy and
32 occupational therapy, are covered subject to utilization controls.

33 (2) For Medi-Cal fee-for-service beneficiaries, emergency
34 services and care that are necessary for the treatment of an
35 emergency medical condition and medical care directly related to
36 the emergency medical condition. This paragraph shall not be
37 construed to change the obligation of Medi-Cal managed care
38 plans to provide emergency services and care. For the purposes of
39 this paragraph, “emergency services and care” and “emergency

1 medical condition” shall have the same meanings as those terms
2 are defined in Section 1317.1 of the Health and Safety Code.

3 (c) Nursing facility services, subacute care services, and services
4 provided by any category of intermediate care facility for the
5 developmentally disabled, including podiatry, physician, nurse
6 practitioner services, and prescribed drugs, as described in
7 subdivision (d), are covered subject to utilization controls.
8 Respiratory care, physical therapy, occupational therapy, speech
9 therapy, and audiology services for patients in nursing facilities
10 and any category of intermediate care facility for the
11 developmentally disabled are covered subject to utilization controls.

12 (d) (1) Purchase of prescribed drugs is covered subject to the
13 Medi-Cal List of Contract Drugs and utilization controls.

14 (2) Purchase of drugs used to treat erectile dysfunction or any
15 off-label uses of those drugs are covered only to the extent that
16 federal financial participation is available.

17 (3) (A) To the extent required by federal law, the purchase of
18 outpatient prescribed drugs, for which the prescription is executed
19 by a prescriber in written, nonelectronic form on or after April 1,
20 2008, is covered only when executed on a tamper resistant
21 prescription form. The implementation of this paragraph shall
22 conform to the guidance issued by the federal Centers of Medicare
23 and Medicaid Services but shall not conflict with state statutes on
24 the characteristics of tamper resistant prescriptions for controlled
25 substances, including Section 11162.1 of the Health and Safety
26 Code. The department shall provide providers and beneficiaries
27 with as much flexibility in implementing these rules as allowed
28 by the federal government. The department shall notify and consult
29 with appropriate stakeholders in implementing, interpreting, or
30 making specific this paragraph.

31 (B) Notwithstanding Chapter 3.5 (commencing with Section
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
33 the department may take the actions specified in subparagraph (A)
34 by means of a provider bulletin or notice, policy letter, or other
35 similar instructions without taking regulatory action.

36 (4) (A) (i) For the purposes of this paragraph, nonlegend has
37 the same meaning as defined in subdivision (a) of Section
38 14105.45.

1 (ii) Nonlegend acetaminophen-containing products, with the
2 exception of children’s acetaminophen-containing products,
3 selected by the department are not covered benefits.

4 (iii) Nonlegend cough and cold products selected by the
5 department are not covered benefits. This clause shall be
6 implemented on the first day of the first calendar month following
7 90 days after the effective date of the act that added this clause,
8 or on the first day of the first calendar month following 60 days
9 after the date the department secures all necessary federal approvals
10 to implement this section, whichever is later.

11 (iv) Beneficiaries under the Early and Periodic Screening,
12 Diagnosis, and Treatment Program shall be exempt from clauses
13 (ii) and (iii).

14 (B) Notwithstanding Chapter 3.5 (commencing with Section
15 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
16 the department may take the actions specified in subparagraph (A)
17 by means of a provider bulletin or notice, policy letter, or other
18 similar instruction without taking regulatory action.

19 (e) Outpatient dialysis services and home hemodialysis services,
20 including physician services, medical supplies, drugs and
21 equipment required for dialysis, are covered, subject to utilization
22 controls.

23 (f) Anesthesiologist services when provided as part of an
24 outpatient medical procedure, nurse anesthetist services when
25 rendered in an inpatient or outpatient setting under conditions set
26 forth by the director, outpatient laboratory services, and X-ray
27 services are covered, subject to utilization controls. Nothing in
28 this subdivision shall be construed to require prior authorization
29 for anesthesiologist services provided as part of an outpatient
30 medical procedure or for portable X-ray services in a nursing
31 facility or any category of intermediate care facility for the
32 developmentally disabled.

33 (g) Blood and blood derivatives are covered.

34 (h) (1) Emergency and essential diagnostic and restorative
35 dental services, except for orthodontic, fixed bridgework, and
36 partial dentures that are not necessary for balance of a complete
37 artificial denture, are covered, subject to utilization controls. The
38 utilization controls shall allow emergency and essential diagnostic
39 and restorative dental services and prostheses that are necessary
40 to prevent a significant disability or to replace previously furnished

1 prostheses which are lost or destroyed due to circumstances beyond
2 the beneficiary's control. Notwithstanding the foregoing, the
3 director may by regulation provide for certain fixed artificial
4 dentures necessary for obtaining employment or for medical
5 conditions that preclude the use of removable dental prostheses,
6 and for orthodontic services in cleft palate deformities administered
7 by the department's California Children Services Program.

8 (2) For persons 21 years of age or older, the services specified
9 in paragraph (1) shall be provided subject to the following
10 conditions:

11 (A) Periodontal treatment is not a benefit.

12 (B) Endodontic therapy is not a benefit except for vital
13 pulpotomy.

14 (C) Laboratory processed crowns are not a benefit.

15 (D) Removable prosthetics shall be a benefit only for patients
16 as a requirement for employment.

17 (E) The director may, by regulation, provide for the provision
18 of fixed artificial dentures that are necessary for medical conditions
19 that preclude the use of removable dental prostheses.

20 (F) Notwithstanding the conditions specified in subparagraphs
21 (A) to (E), inclusive, the department may approve services for
22 persons with special medical disorders subject to utilization review.

23 (3) Paragraph (2) shall become inoperative July 1, 1995.

24 (i) Medical transportation is covered, subject to utilization
25 controls.

26 (j) Home health care services are covered, subject to utilization
27 controls.

28 (k) Prosthetic and orthotic devices and eyeglasses are covered,
29 subject to utilization controls. Utilization controls shall allow
30 replacement of prosthetic and orthotic devices and eyeglasses
31 necessary because of loss or destruction due to circumstances
32 beyond the beneficiary's control. Frame styles for eyeglasses
33 replaced pursuant to this subdivision shall not change more than
34 once every two years, unless the department so directs.

35 Orthopedic and conventional shoes are covered when provided
36 by a prosthetic and orthotic supplier on the prescription of a
37 physician and when at least one of the shoes will be attached to a
38 prosthesis or brace, subject to utilization controls. Modification
39 of stock conventional or orthopedic shoes when medically
40 indicated, is covered subject to utilization controls. When there is

1 a clearly established medical need that cannot be satisfied by the
2 modification of stock conventional or orthopedic shoes,
3 custom-made orthopedic shoes are covered, subject to utilization
4 controls.

5 Therapeutic shoes and inserts are covered when provided to
6 beneficiaries with a diagnosis of diabetes, subject to utilization
7 controls, to the extent that federal financial participation is
8 available.

9 (l) Hearing aids are covered, subject to utilization controls.
10 Utilization controls shall allow replacement of hearing aids
11 necessary because of loss or destruction due to circumstances
12 beyond the beneficiary's control.

13 (m) Durable medical equipment and medical supplies are
14 covered, subject to utilization controls. The utilization controls
15 shall allow the replacement of durable medical equipment and
16 medical supplies when necessary because of loss or destruction
17 due to circumstances beyond the beneficiary's control. The
18 utilization controls shall allow authorization of durable medical
19 equipment needed to assist a disabled beneficiary in caring for a
20 child for whom the disabled beneficiary is a parent, stepparent,
21 foster parent, or legal guardian, subject to the availability of federal
22 financial participation. The department shall adopt emergency
23 regulations to define and establish criteria for assistive durable
24 medical equipment in accordance with the rulemaking provisions
25 of the Administrative Procedure Act (Chapter 3.5 (commencing
26 with Section 11340) of Part 1 of Division 3 of Title 2 of the
27 Government Code).

28 (n) Family planning services are covered, subject to utilization
29 controls.

30 (o) Inpatient intensive rehabilitation hospital services, including
31 respiratory rehabilitation services, in a general acute care hospital
32 are covered, subject to utilization controls, when either of the
33 following criteria are met:

34 (1) A patient with a permanent disability or severe impairment
35 requires an inpatient intensive rehabilitation hospital program as
36 described in Section 14064 to develop function beyond the limited
37 amount that would occur in the normal course of recovery.

38 (2) A patient with a chronic or progressive disease requires an
39 inpatient intensive rehabilitation hospital program as described in

1 Section 14064 to maintain the patient’s present functional level as
2 long as possible.

3 (p) (1) Adult day health care is covered in accordance with
4 Chapter 8.7 (commencing with Section 14520).

5 (2) Commencing 30 days after the effective date of the act that
6 added this paragraph, and notwithstanding the number of days
7 previously approved through a treatment authorization request,
8 adult day health care is covered for a maximum of three days per
9 week.

10 (3) As provided in accordance with paragraph (4), adult day
11 health care is covered for a maximum of five days per week.

12 (4) As of the date that the director makes the declaration
13 described in subdivision (g) of Section 14525.1, paragraph (2)
14 shall become inoperative and paragraph (3) shall become operative.

15 (q) (1) Application of fluoride, or other appropriate fluoride
16 treatment as defined by the department, other prophylaxis treatment
17 for children 17 years of age and under, are covered.

18 (2) All dental hygiene services provided by a registered dental
19 hygienist in alternative practice pursuant to Sections 1768 and
20 1770 of the Business and Professions Code may be covered as
21 long as they are within the scope of Denti-Cal benefits and they
22 are necessary services provided by a registered dental hygienist
23 in alternative practice.

24 (r) (1) Paramedic services performed by a city, county, or
25 special district, or pursuant to a contract with a city, county, or
26 special district, and pursuant to a program established under Article
27 3 (commencing with Section 1480) of Chapter 2.5 of Division 2
28 of the Health and Safety Code by a paramedic certified pursuant
29 to that article, and consisting of defibrillation and those services
30 specified in subdivision (3) of Section 1482 of the article.

31 (2) All providers enrolled under this subdivision shall satisfy
32 all applicable statutory and regulatory requirements for becoming
33 a Medi-Cal provider.

34 (3) This subdivision shall be implemented only to the extent
35 funding is available under Section 14106.6.

36 (s) In-home medical care services are covered when medically
37 appropriate and subject to utilization controls, for beneficiaries
38 who would otherwise require care for an extended period of time
39 in an acute care hospital at a cost higher than in-home medical
40 care services. The director shall have the authority under this

1 section to contract with organizations qualified to provide in-home
2 medical care services to those persons. These services may be
3 provided to patients placed in shared or congregate living
4 arrangements, if a home setting is not medically appropriate or
5 available to the beneficiary. As used in this section, “in-home
6 medical care service” includes utility bills directly attributable to
7 continuous, 24-hour operation of life-sustaining medical equipment,
8 to the extent that federal financial participation is available.

9 As used in this subdivision, in-home medical care services,
10 include, but are not limited to:

- 11 (1) Level of care and cost of care evaluations.
- 12 (2) Expenses, directly attributable to home care activities, for
13 materials.
- 14 (3) Physician fees for home visits.
- 15 (4) Expenses directly attributable to home care activities for
16 shelter and modification to shelter.
- 17 (5) Expenses directly attributable to additional costs of special
18 diets, including tube feeding.
- 19 (6) Medically related personal services.
- 20 (7) Home nursing education.
- 21 (8) Emergency maintenance repair.
- 22 (9) Home health agency personnel benefits which permit
23 coverage of care during periods when regular personnel are on
24 vacation or using sick leave.
- 25 (10) All services needed to maintain antiseptic conditions at
26 stoma or shunt sites on the body.
- 27 (11) Emergency and nonemergency medical transportation.
- 28 (12) Medical supplies.
- 29 (13) Medical equipment, including, but not limited to, scales,
30 gurneys, and equipment racks suitable for paralyzed patients.
- 31 (14) Utility use directly attributable to the requirements of home
32 care activities which are in addition to normal utility use.
- 33 (15) Special drugs and medications.
- 34 (16) Home health agency supervision of visiting staff which is
35 medically necessary, but not included in the home health agency
36 rate.
- 37 (17) Therapy services.
- 38 (18) Household appliances and household utensil costs directly
39 attributable to home care activities.
- 40 (19) Modification of medical equipment for home use.

1 (20) Training and orientation for use of life-support systems,
2 including, but not limited to, support of respiratory functions.

3 (21) Respiratory care practitioner services as defined in Sections
4 3702 and 3703 of the Business and Professions Code, subject to
5 prescription by a physician and surgeon.

6 Beneficiaries receiving in-home medical care services are entitled
7 to the full range of services within the Medi-Cal scope of benefits
8 as defined by this section, subject to medical necessity and
9 applicable utilization control. Services provided pursuant to this
10 subdivision, which are not otherwise included in the Medi-Cal
11 schedule of benefits, shall be available only to the extent that
12 federal financial participation for these services is available in
13 accordance with a home- and community-based services waiver.

14 (t) Home- and community-based services approved by the
15 United States Department of Health and Human Services may be
16 covered to the extent that federal financial participation is available
17 for those services under waivers granted in accordance with Section
18 1396n of Title 42 of the United States Code. The director may
19 seek waivers for any or all home- and community-based services
20 approvable under Section 1396n of Title 42 of the United States
21 Code. Coverage for those services shall be limited by the terms,
22 conditions, and duration of the federal waivers.

23 (u) Comprehensive perinatal services, as provided through an
24 agreement with a health care provider designated in Section
25 14134.5 and meeting the standards developed by the department
26 pursuant to Section 14134.5, subject to utilization controls.

27 The department shall seek any federal waivers necessary to
28 implement the provisions of this subdivision. The provisions for
29 which appropriate federal waivers cannot be obtained shall not be
30 implemented. Provisions for which waivers are obtained or for
31 which waivers are not required shall be implemented
32 notwithstanding any inability to obtain federal waivers for the
33 other provisions. No provision of this subdivision shall be
34 implemented unless matching funds from Subchapter XIX
35 (commencing with Section 1396) of Chapter 7 of Title 42 of the
36 United States Code are available.

37 (v) Early and periodic screening, diagnosis, and treatment for
38 any individual under 21 years of age is covered, consistent with
39 the requirements of Subchapter XIX (commencing with Section
40 1396) of Chapter 7 of Title 42 of the United States Code.

1 (w) Hospice service which is Medicare-certified hospice service
2 is covered, subject to utilization controls. Coverage shall be
3 available only to the extent that no additional net program costs
4 are incurred.

5 (x) When a claim for treatment provided to a beneficiary
6 includes both services which are authorized and reimbursable
7 under this chapter, and services which are not reimbursable under
8 this chapter, that portion of the claim for the treatment and services
9 authorized and reimbursable under this chapter shall be payable.

10 (y) Home- and community-based services approved by the
11 United States Department of Health and Human Services for
12 beneficiaries with a diagnosis of AIDS or ARC, who require
13 intermediate care or a higher level of care.

14 Services provided pursuant to a waiver obtained from the
15 Secretary of the United States Department of Health and Human
16 Services pursuant to this subdivision, and which are not otherwise
17 included in the Medi-Cal schedule of benefits, shall be available
18 only to the extent that federal financial participation for these
19 services is available in accordance with the waiver, and subject to
20 the terms, conditions, and duration of the waiver. These services
21 shall be provided to individual beneficiaries in accordance with
22 the client's needs as identified in the plan of care, and subject to
23 medical necessity and applicable utilization control.

24 The director may under this section contract with organizations
25 qualified to provide, directly or by subcontract, services provided
26 for in this subdivision to eligible beneficiaries. Contracts or
27 agreements entered into pursuant to this division shall not be
28 subject to the Public Contract Code.

29 (z) Respiratory care when provided in organized health care
30 systems as defined in Section 3701 of the Business and Professions
31 Code, and as an in-home medical service as outlined in subdivision
32 (s).

33 (aa) (1) There is hereby established in the department, a
34 program to provide comprehensive clinical family planning
35 services to any person who has a family income at or below 200
36 percent of the federal poverty level, as revised annually, and who
37 is eligible to receive these services pursuant to the waiver identified
38 in paragraph (2). This program shall be known as the Family
39 Planning, Access, Care, and Treatment (Family PACT) Program.

1 (2) The department shall seek a waiver in accordance with
2 Section 1315 of Title 42 of the United States Code, or a state plan
3 amendment adopted in accordance with Section
4 ~~1396a(a)(10)(A)(ii)(XXI)(ii)(2)~~ *1396a(a)(10)(A)(ii)(XXI)* of Title
5 42 of the United States Code, which was added to Section 1396a
6 of Title 42 of the United States Code by Section 2303(a)(2) of the
7 federal Patient Protection and Affordable Care Act (PPACA)
8 (Public Law 111-148), for a program to provide comprehensive
9 clinical family planning services as described in paragraph (8).
10 Under the waiver, the program shall be operated only in accordance
11 with the waiver and the statutes and regulations in paragraph (4)
12 and subject to the terms, conditions, and duration of the waiver.
13 Under the state plan amendment, which shall replace the waiver
14 and shall be known as the Family PACT successor state plan
15 amendment, the program shall be operated only in accordance with
16 this subdivision and the statutes and regulations in paragraph (4).
17 The state shall use the standards and processes imposed by the
18 state on January 1, 2007, including the application of an eligibility
19 discount factor to the extent required by the federal Centers for
20 Medicare and Medicaid Services, for purposes of determining
21 eligibility as permitted under Section
22 ~~1396a(a)(10)(A)(ii)(XXI)(ii)(2)~~ *1396a(a)(10)(A)(ii)(XXI)* of Title
23 42 of the United States Code. To the extent that federal financial
24 participation is available, the program shall continue to conduct
25 education, outreach, enrollment, service delivery, and evaluation
26 services as specified under the waiver. The services shall be
27 provided under the program only if the waiver and, when
28 applicable, the successor state plan amendment are approved by
29 the federal Centers for Medicare and Medicaid Services and only
30 to the extent that federal financial participation is available for the
31 services. Nothing in this section shall prohibit the department from
32 seeking the Family PACT successor state plan amendment during
33 the operation of the waiver.

34 (3) Solely for the purposes of the waiver or Family PACT
35 successor state plan amendment and notwithstanding any other
36 provision of law, the collection and use of an individual's social
37 security number shall be necessary only to the extent required by
38 federal law.

39 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
40 and 24013, and any regulations adopted under these statutes shall

1 apply to the program provided for under this subdivision. No other
2 provision of law under the Medi-Cal program or the State-Only
3 Family Planning Program shall apply to the program provided for
4 under this subdivision.

5 (5) Notwithstanding Chapter 3.5 (commencing with Section
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
7 the department may implement, without taking regulatory action,
8 the provisions of the waiver after its approval by the federal Health
9 Care Financing Administration and the provisions of this section
10 by means of an all-county letter or similar instruction to providers.
11 Thereafter, the department shall adopt regulations to implement
12 this section and the approved waiver in accordance with the
13 requirements of Chapter 3.5 (commencing with Section 11340) of
14 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
15 six months after the effective date of the act adding this
16 subdivision, the department shall provide a status report to the
17 Legislature on a semiannual basis until regulations have been
18 adopted.

19 (6) In the event that the Department of Finance determines that
20 the program operated under the authority of the waiver described
21 in paragraph (2) or the Family PACT successor state plan
22 amendment is no longer cost effective, this subdivision shall
23 become inoperative on the first day of the first month following
24 the issuance of a 30-day notification of that determination in
25 writing by the Department of Finance to the chairperson in each
26 house that considers appropriations, the chairpersons of the
27 committees, and the appropriate subcommittees in each house that
28 considers the State Budget, and the Chairperson of the Joint
29 Legislative Budget Committee.

30 (7) If this subdivision ceases to be operative, all persons who
31 have received or are eligible to receive comprehensive clinical
32 family planning services pursuant to the waiver described in
33 paragraph (2) shall receive family planning services under the
34 Medi-Cal program pursuant to subdivision (n) if they are otherwise
35 eligible for Medi-Cal with no share of cost, or shall receive
36 comprehensive clinical family planning services under the program
37 established in Division 24 (commencing with Section 24000) either
38 if they are eligible for Medi-Cal with a share of cost or if they are
39 otherwise eligible under Section 24003.

1 (8) For purposes of this subdivision, “comprehensive clinical
2 family planning services” means the process of establishing
3 objectives for the number and spacing of children, and selecting
4 the means by which those objectives may be achieved. These
5 means include a broad range of acceptable and effective methods
6 and services to limit or enhance fertility, including contraceptive
7 methods, federal Food and Drug Administration approved
8 contraceptive drugs, devices, and supplies, natural family planning,
9 abstinence methods, and basic, limited fertility management.
10 Comprehensive clinical family planning services include, but are
11 not limited to, preconception counseling, maternal and fetal health
12 counseling, general reproductive health care, including diagnosis
13 and treatment of infections and conditions, including cancer, that
14 threaten reproductive capability, medical family planning treatment
15 and procedures, including supplies and followup, and
16 informational, counseling, and educational services.
17 Comprehensive clinical family planning services shall not include
18 abortion, pregnancy testing solely for the purposes of referral for
19 abortion or services ancillary to abortions, or pregnancy care that
20 is not incident to the diagnosis of pregnancy. Comprehensive
21 clinical family planning services shall be subject to utilization
22 control and include all of the following:

23 (A) Family planning related services and male and female
24 sterilization. Family planning services for men and women shall
25 include emergency services and services for complications directly
26 related to the contraceptive method, federal Food and Drug
27 Administration approved contraceptive drugs, devices, and
28 supplies, and followup, consultation, and referral services, as
29 indicated, which may require treatment authorization requests.

30 (B) All United States Department of Agriculture, federal Food
31 and Drug Administration approved contraceptive drugs, devices,
32 and supplies that are in keeping with current standards of practice
33 and from which the individual may choose.

34 (C) Culturally and linguistically appropriate health education
35 and counseling services, including informed consent, that include
36 all of the following:

- 37 (i) Psychosocial and medical aspects of contraception.
- 38 (ii) Sexuality.
- 39 (iii) Fertility.
- 40 (iv) Pregnancy.

- 1 (v) Parenthood.
- 2 (vi) Infertility.
- 3 (vii) Reproductive health care.
- 4 (viii) Preconception and nutrition counseling.
- 5 (ix) Prevention and treatment of sexually transmitted infection.
- 6 (x) Use of contraceptive methods, federal Food and Drug
- 7 Administration approved contraceptive drugs, devices, and
- 8 supplies.
- 9 (xi) Possible contraceptive consequences and followup.
- 10 (xii) Interpersonal communication and negotiation of
- 11 relationships to assist individuals and couples in effective
- 12 contraceptive method use and planning families.
- 13 (D) A comprehensive health history, updated at the next periodic
- 14 visit (between 11 and 24 months after initial examination) that
- 15 includes a complete obstetrical history, gynecological history,
- 16 contraceptive history, personal medical history, health risk factors,
- 17 and family health history, including genetic or hereditary
- 18 conditions.
- 19 (E) A complete physical examination on initial and subsequent
- 20 periodic visits.
- 21 (F) Services, drugs, devices, and supplies deemed by the federal
- 22 Centers for Medicare and Medicaid Services to be appropriate for
- 23 inclusion in the program.
- 24 (9) In order to maximize the availability of federal financial
- 25 participation under this subdivision, the director shall have the
- 26 discretion to implement the Family PACT successor state plan
- 27 amendment retroactively to July 1, 2010.
- 28 (ab) (1) Purchase of prescribed enteral nutrition products is
- 29 covered, subject to the Medi-Cal list of enteral nutrition products
- 30 and utilization controls.
- 31 (2) Purchase of enteral nutrition products is limited to those
- 32 products to be administered through a feeding tube, including, but
- 33 not limited to, a gastric, nasogastric, or jejunostomy tube.
- 34 Beneficiaries under the Early and Periodic Screening, Diagnosis,
- 35 and Treatment Program shall be exempt from this paragraph.
- 36 (3) Notwithstanding paragraph (2), the department may deem
- 37 an enteral nutrition product, not administered through a feeding
- 38 tube, including, but not limited to, a gastric, nasogastric, or
- 39 jejunostomy tube, a benefit for patients with diagnoses, including,
- 40 but not limited to, malabsorption and inborn errors of metabolism,

1 if the product has been shown to be neither investigational nor
2 experimental when used as part of a therapeutic regimen to prevent
3 serious disability or death.

4 (4) Notwithstanding Chapter 3.5 (commencing with Section
5 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
6 the department may implement the amendments to this subdivision
7 made by the act that added this paragraph by means of all-county
8 letters, provider bulletins, or similar instructions, without taking
9 regulatory action.

10 (5) The amendments made to this subdivision by the act that
11 added this paragraph shall be implemented June 1, 2011, or on the
12 first day of the first calendar month following 60 days after the
13 date the department secures all necessary federal approvals to
14 implement this section, whichever is later.

15 (ac) Diabetic testing supplies are covered when provided by a
16 pharmacy, subject to utilization controls.

17 (ad) *Commencing January 1, 2014, any benefits, services, and*
18 *coverage not otherwise described in this section that are included*
19 *in the essential health benefits package adopted by the state and*
20 *approved by the United States Secretary of Health and Human*
21 *Services under Section 18022 of Title 42 of the United States Code.*

22 SEC. 23. Section 14132.02 is added to the Welfare and
23 Institutions Code, to read:

24 14132.02. (a) Pursuant to Sections 1902(k)(1) and
25 1937(b)(1)(D) of the federal Social Security Act (42 U.S.C. Sec.
26 1396a(k)(1); 42 U.S.C. Sec. 1396u-7(b)(1)(D)), the department
27 shall seek approval from the United States Secretary of Health and
28 Human Services to establish a benchmark benefit package that
29 includes the same benefits, services, and coverage as is provided
30 to all other full-scope Medi-Cal enrollees, supplemented by any
31 benefits, services, and coverage included in the essential health
32 benefits package adopted by the state and approved by the secretary
33 under Section 18022 of Title 42 of the United States Code.

34 (b) This section shall become operative January 1, 2014.

35 SEC. 24. Section 15926 of the Welfare and Institutions Code
36 is amended to read:

37 15926. (a) The following definitions apply for purposes of
38 this part:

1 (1) “Accessible” means in compliance with Section 11135 of
2 the Government Code, Section 1557 of the PPACA, and regulations
3 or guidance adopted pursuant to these statutes.

4 (2) “Limited-English-proficient” means not speaking English
5 as one’s primary language and having a limited ability to read,
6 speak, write, or understand English.

7 (3) “State health subsidy programs” means the programs
8 described in Section 1413(e) of the PPACA.

9 (b) An individual shall have the option to apply for state health
10 subsidy programs in person, by mail, online, by telephone, or by
11 other commonly available electronic means.

12 (c) (1) A single, accessible, standardized paper, electronic, and
13 telephone application for state health subsidy programs shall be
14 developed by the department in consultation with MRMIB and
15 the board governing the Exchange as part of the stakeholder process
16 described in subdivision (b) of Section 15925. The application
17 shall be used by all entities authorized to make an eligibility
18 determination for any of the state health subsidy programs and by
19 their agents.

20 (2) The application shall be tested and operational by the date
21 as required by the federal Secretary of Health and Human Services.

22 (3) The application form shall, to the extent not inconsistent
23 with federal statutes, regulations, and guidance, satisfy all of the
24 following criteria:

25 (A) The form shall include simple, user-friendly language and
26 instructions.

27 (B) The form may not ask for information related to a
28 nonapplicant that is not necessary to determine eligibility in the
29 applicant’s particular circumstances.

30 (C) The form may require only information necessary to support
31 the eligibility and enrollment processes for state health subsidy
32 programs.

33 (D) The form may be used for, but shall not be limited to,
34 screening.

35 (E) The form may ask, or be used otherwise to identify, if the
36 mother of an infant applicant under one year of age had coverage
37 through a state health subsidy program for the infant’s birth, for
38 the purpose of automatically enrolling the infant into the applicable
39 program without the family having to complete the application
40 process for the infant.

1 (F) The form may include questions that are voluntary for
2 applicants to answer regarding demographic data categories,
3 including race, ethnicity, primary language, disability status, and
4 other categories recognized by the federal Secretary of Health and
5 Human Services under Section 4302 of the PPACA.

6 (d) Nothing in this section shall preclude the use of a
7 provider-based application form or enrollment procedures for state
8 health subsidy programs or other health programs that differs from
9 the application form described in subdivision (c), and related
10 enrollment procedures.

11 (e) The entity making the eligibility determination shall grant
12 eligibility immediately whenever possible and with the consent of
13 the applicant in accordance with the state and federal rules
14 governing state health subsidy programs.

15 (f) (1) If the eligibility, enrollment, and retention system has
16 the ability to prepopulate an application form for insurance
17 affordability programs with personal information from available
18 electronic databases, an applicant shall be given the option, with
19 his or her informed consent, to have the application form
20 prepopulated. Before a prepopulated renewal form or, if available,
21 prepopulated application is submitted to the entity authorized to
22 make eligibility determinations, the individual shall be given the
23 opportunity to provide additional eligibility information and to
24 correct any information retrieved from a database.

25 (2) All state health subsidy programs ~~may~~ shall accept
26 self-attestation, instead of requiring an individual to produce a
27 document, ~~with respect to all information~~ for age, date of birth,
28 family size, household income, state residence, pregnancy, and
29 any other applicable criteria needed to determine the eligibility
30 of an applicant or recipient, to the extent permitted by state and
31 federal law.

32 (3) An applicant or recipient shall have his or her information
33 electronically verified in the manner required by the PPACA and
34 implementing federal regulations and guidance.

35 (4) Before an eligibility determination is made, the individual
36 shall be given the opportunity to provide additional eligibility
37 information and to correct information.

38 (5) The eligibility of an applicant shall not be delayed or denied
39 for any state health subsidy program unless the applicant is given
40 a reasonable opportunity, of at least the kind provided for under

1 the Medi-Cal program pursuant to Section 14007.5 and paragraph
2 (7) of subdivision (e) of Section 14011.2, to resolve discrepancies
3 concerning any information provided by a verifying entity.

4 (6) To the extent federal financial participation is available, an
5 applicant shall be provided benefits in accordance with the rules
6 of the state health subsidy program, as implemented in federal
7 regulations and guidance, for which he or she otherwise qualifies
8 until a determination is made that he or she is not eligible and all
9 applicable notices have been provided. Nothing in this section
10 shall be interpreted to grant presumptive eligibility if it is not
11 otherwise required by state law, and, if so required, then only to
12 the extent permitted by federal law.

13 (g) The eligibility, enrollment, and retention system shall offer
14 an applicant and recipient assistance with his or her application or
15 renewal for a state health subsidy program in person, over the
16 telephone, and online, and in a manner that is accessible to
17 individuals with disabilities and those who are limited English
18 proficient.

19 (h) (1) During the processing of an application, renewal, or a
20 transition due to a change in circumstances, an entity making
21 eligibility determinations for a state health subsidy program shall
22 ensure that an eligible applicant and recipient of state health
23 subsidy programs that meets all program eligibility requirements
24 and complies with all necessary requests for information moves
25 between programs without any breaks in coverage and without
26 being required to provide any forms, documents, or other
27 information or undergo verification that is duplicative or otherwise
28 unnecessary. The individual shall be informed about how to obtain
29 information about the status of his or her application, renewal, or
30 transfer to another program at any time, and the information shall
31 be promptly provided when requested.

32 (2) The application or case of an individual screened as not
33 eligible for Medi-Cal on the basis of Modified Adjusted Gross
34 Income (MAGI) household income but who may be eligible on
35 the basis of being 65 years of age or older, or on the basis of
36 blindness or disability, shall be forwarded to the Medi-Cal program
37 for an eligibility determination. During the period this application
38 or case is processed for a non-MAGI Medi-Cal eligibility
39 determination, if the applicant or recipient is otherwise eligible

1 for a state health subsidy program, he or she shall be determined
2 eligible for that program.

3 (3) Renewal procedures shall include all available methods for
4 reporting renewal information, including, but not limited to,
5 face-to-face, telephone, and online renewal.

6 (4) An applicant who is not eligible for a state health subsidy
7 program for a reason other than income eligibility, or for any reason
8 in the case of applicants and recipients residing in a county that
9 offers a health coverage program for individuals with income above
10 the maximum allowed for the Exchange premium tax credits, shall
11 be referred to the county health coverage program in his or her
12 county of residence.

13 (i) Notwithstanding subdivisions (e), (f), and (j), before an online
14 applicant who appears to be eligible for the Exchange with a
15 premium tax credit or reduction in cost sharing, or both, may be
16 enrolled in the Exchange, both of the following shall occur:

17 (1) The applicant shall be informed of the overpayment penalties
18 under the federal Comprehensive 1099 Taxpayer Protection and
19 Repayment of Exchange Subsidy Overpayments Act of 2011
20 (Public Law 112-9), if the individual’s annual family income
21 increases by a specified amount or more, calculated on the basis
22 of the individual’s current family size and current income, and that
23 penalties are avoided by prompt reporting of income increases
24 throughout the year.

25 (2) The applicant shall be informed of the penalty for failure to
26 have minimum essential health coverage.

27 (j) The department shall, in coordination with MRMIB and the
28 Exchange board, streamline and coordinate all eligibility rules and
29 requirements among state health subsidy programs using the least
30 restrictive rules and requirements permitted by federal and state
31 law. This process shall include the consideration of methodologies
32 for determining income levels, assets, rules for household size,
33 citizenship and immigration status, and self-attestation and
34 verification requirements.

35 (k) (1) Forms and notices developed pursuant to this section
36 shall be accessible and standardized, as appropriate, and shall
37 comply with federal and state laws, regulations, and guidance
38 prohibiting discrimination.

39 (2) Forms and notices developed pursuant to this section shall
40 be developed using plain language and shall be provided in a

1 manner that affords meaningful access to limited-English-proficient
2 individuals, in accordance with applicable state and federal law,
3 and at a minimum, provided in the same threshold languages as
4 required for Medi-Cal managed care plans.

5 (l) The department, the California Health and Human Services
6 Agency, MRMIB, and the Exchange board shall establish a process
7 for receiving and acting on stakeholder suggestions regarding the
8 functionality of the eligibility systems supporting the Exchange,
9 including the activities of all entities providing eligibility screening
10 to ensure the correct eligibility rules and requirements are being
11 used. This process shall include consumers and their advocates,
12 be conducted no less than quarterly, and include the recording,
13 review, and analysis of potential defects or enhancements of the
14 eligibility systems. The process shall also include regular updates
15 on the work to analyze, prioritize, and implement corrections to
16 confirmed defects and proposed enhancements, and to monitor
17 screening.

18 (m) In designing and implementing the eligibility, enrollment,
19 and retention system, the department, MRMIB, and the Exchange
20 board shall ensure that all privacy and confidentiality rights under
21 the PPACA and other federal and state laws are incorporated and
22 followed, including responses to security breaches.

23 (n) Except as otherwise specified, this section shall be operative
24 on and after January 1, 2014.

25 SEC. 25. Section 15926.2 is added to the Welfare and
26 Institutions Code, to read:

27 15926.2. In accordance with paragraph (2) of subdivision (f)
28 of Section 15926 and Sections 435.945(a) and 435.956 of Title 42
29 of the Code of Federal Regulations, state health subsidy programs
30 shall accept an individual's attestation, without further
31 documentation from the individual, for age, date of birth, family
32 size, household income, state residence, pregnancy, and any other
33 applicable eligibility criteria for which attestation is permitted by
34 federal law.

35 SEC. 26. If the Commission on State Mandates determines
36 that this act contains costs mandated by the state, reimbursement
37 to local agencies and school districts for those costs shall be made

- 1 pursuant to Part 7 (commencing with Section 17500) of Division
- 2 4 of Title 2 of the Government Code.

O

**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 28 - MARCH 1, 2013 BOARD MEETING**

BILL NUMBER: Senate Bill 128

AUTHOR: Emmerson

SPONSOR:

VERSION: Introduced 01/22/2013

INTRODUCED: 01/22/2013

BILL STATUS: 01/31/13 - Referred to
Committee on Rules

BILL LOCATION: Senate Rules
Committee

SUBJECT: Health Care Professionals

**RELATED
BILLS:**

SUMMARY

Business and Professions Code Sections 920 through 922 is known as the Health Care Professional Disaster Response Act (Act). This Act states findings of the Legislature regarding the shortage of qualified health care practitioners during times of national or state disasters, and allows a physician and surgeon, whose license has been expired for less than 5 years and who meets specified criteria, to obtain a license without paying fees.

This bill would make a technical, non-substantive change to those provisions.

ANALYSIS

Board staff has been advised by the author's office that this is only a spot bill, and specific statutory revisions have not been specified for this bill at this time.

REGISTERED SUPPORT/OPPOSITION

To date, there is no registered support or opposition on file.

BOARD POSITION

The Board has not taken a position on the bill. The Committee may consider recommending the Board take one of the following actions regarding this bill:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

Introduced by Senator Emmerson

January 22, 2013

An act to amend Section 921 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 128, as introduced, Emmerson. Health care professionals.

Existing law, the Health Care Professional Disaster Response Act, states findings of the Legislature regarding the shortage of qualified health care practitioners during times of national or state disasters, and allows a physician and surgeon, whose license has been expired for less than 5 years and who meets specified criteria, to obtain a license without paying fees.

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

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. Section 921 of the Business and Professions Code
- 2 is amended to read:
- 3 921. (a) The Legislature finds and declares the following:
- 4 (1) In times of national or state disasters, a shortage of qualified
- 5 health care practitioners may exist in areas throughout the state
- 6 where they are desperately required to respond to public health
- 7 emergencies.
- 8 (2) Health care practitioners with lapsed or inactive licenses
- 9 could potentially serve in those areas where a shortage of qualified

1 health care practitioners exists, if licensing requirements were
2 streamlined and fees curtailed.
3 (b) ~~It is, therefore,~~ *Therefore, it is* the intent of the Legislature
4 to address these matters through the provisions of the Health Care
5 Professional Disaster Response Act.



MEMORANDUM

DATE	January 17, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	LEG 5: Discussion of Prospective Legislative Proposals

Stakeholders are encouraged to submit proposals in writing to the Board before or during the meeting for possible consideration by the Board at a future Board meeting.



NOTICE OF PUBLIC MEETING – Notice is hereby given that meeting of the Examination Committee of the Dental Board of California will be held as follows:

NOTICE OF EXAMINATION COMMITTEE MEETING

Thursday, February 28, 2013

Upon Conclusion of the Legislative and Regulatory Committee Meeting

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

(619)232-3861 or (916)263-2300

EXAMINATION COMMITTEE

Chair – Stephen Casagrande, DDS

Vice Chair – Steven Morrow, DDS

Fran Burton, Public Member

Luis Dominicis, DDS

Huong Le, DDS

Suzanne McCormick, DDS

Thomas Olinger, DDS

CALL TO ORDER

ROLL CALL AND ESTABLISHMENT OF QUORUM

EX 1 - Approval of the December 3, 2012 Examination Committee Meeting Minutes

EX 2 – Update on Office of Professional Examination Services (OPES) Occupational Analysis of the Western Regional Examining Board (WREB) Examination

EX 3 – Update on Western Regional Examining Board (WREB) Activities

EX 4 - Update on the Portfolio Licensure Examination for Dentistry

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

FUTURE AGENDA ITEMS

Stakeholders Are Encouraged to Propose Items for Possible Consideration by the Committee at a Future Meeting.

COMMITTEE MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

ADJOURNMENT

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**EXAMINATION COMMITTEE
Meeting Minutes**

Monday, December 3, 2012

Embassy Suites LAX/South

1440 East Imperial Avenue, El Segundo, CA 90245

DRAFT

EXAMINATION COMMITTEE PRESENT

Chair – Stephen Casagrande, DDS
Vice Chair – Steven Morrow, DDS
Rebecca Downing, Public Member
Judy Forsythe, RDA
Suzanne McCormick, DDS

ABSENT

STAFF PRESENT

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel

ROLL CALL AND ESTABLISHMENT OF QUORUM

Dr. Casagrande, Chair, called the Examination Committee to order at 10:54 a.m. Roll was called and a quorum established.

EX 1 - Update on Office of Professional Examination Services (OPES) Occupational Analysis of the Western Regional Examination Board (WREB) Examination

Dr. Casagrande reported that the periodic review of WREB, to determine if it continues to meet California's licensing examination standards is being conducted by OPES. Mr DeCuir stated that this analysis should be completed within 12 months. Mr. DeCuir stated that if the Board desires he will ask OPES to give an update at the February Board Meeting.

EX 2 - Update on Portfolio Licensure Examination for Dentistry

Dr. Casagrande reported that a lot had been accomplished in the past few months. Drafts of the candidate manual, examiner manual, grade sheet and audit manual are all complete. Dr. Casagrande and Dr. Morrow will conduct a workshop on December 13, 2012. Subject Matter Experts from a couple of different dental schools will be in attendance along with the chief

examiners and staff to do some final editing. The purpose of the workshop is to have a good representation ready for the Board members to review electronically prior to initiation of the regulatory process. Dr. Morrow commented that another important element needed for implementation is the development of standardization and calibration courses for each of the six competency examinations that are a part of the Portfolio Licensure process. Dr. Morrow is developing a prototype of the standardization and calibration courses for Endodontics. He expects to have the prototype ready by December 13th so that participants in the workshop can see what a standardization and calibration course for Endodontics might look like including clinical illustrations and radiographs demonstrating various components of the examination and identifying criteria for assessment; the ideal as compared to the not ideal. Dr. McCormick commented that WREB has an excellent calibration process that the Board may want to use as a resource.

There was no public comment.

The Examination Committee meeting adjourned at 11:11 a.m.

DRAFT



MEMORANDUM

DATE	February 19, 2013
TO	Dental Board of California
FROM	Karen Fischer, Interim Executive Officer Dental Board of California
SUBJECT	EX 2: Update on the Office of Professional Examination Services' (OPES) Occupational Analysis of the Western Regional Examining Board (WREB)

The Office of Professional Examination Services (OPES) is entering the final stage of completing the audit of the WREB examination in compliance with Business & Professions Code Section 139 and DCA Policy #OPES 12-01.

A one day workshop comprised of subject matter experts (SMEs) will be conducted in April 2013. Upon completion of this workshop, OPES will be able to present the final audit report, which is expected before the end of the fiscal year (June 30, 2013).



MEMORANDUM

DATE	January 17, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	EX 3: Update on the Western Regional Examining Board's (WREB) Activities

Dr. Suzanne McCormick, WREB liaison, will give an update on their activities.



MEMORANDUM

DATE	February 3, 2013
TO	Examination Committee Dental Board of California
FROM	Dawn Dill, Manager, Licensing and Examination Unit
SUBJECT	Agenda Item EX 4: Update on Portfolio Licensure Examination for Dentistry

On December 13, 2012 the Portfolio Licensure Exam Subcommittee met with staff, subject matter experts, and legal counsel at the Board office to review the draft Candidate Handbook, Examiner Training Manual and the Audit Process Manual.

Dr. Morrow provided the subject matter experts a copy of the Standardized Calibration for Endodontic Treatment that will be used as the template for the development of the Standardized Calibration for the other competencies of the Portfolio Licensure Examination.

The Candidate Handbook and Examiner Training Manual are currently being reviewed by legal counsel.



NOTICE OF PUBLIC MEETING – Notice is hereby given that a public meeting of Licensing, Certification and Permits Committee of the Dental Board of California will be held as follows:

NOTICE OF LICENSING, CERTIFICATION AND PERMITS COMMITTEE MEETING

Thursday, February 28, 2013

Upon Conclusion of the Examination Committee Meeting

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

(619)232-3861 or (916)263-2300

**LICENSING, CERTIFICATION, AND
PERMITS COMMITTEE**

Chair – Thomas Olinger, DDS

Vice Chair – Suzanne McCormick, DDS

Steve Afriat, Public Member

Judith Forsythe, RDA

Bruce Whitcher, DDS

CALL TO ORDER

ROLL CALL AND ESTABLISHMENT OF QUORUM

LCP 1 – Approval of the December 3, 2012 Licensing, Certification and Permits Committee Meeting Minutes

LCP 2 – Dental and Dental Assisting Program Licensure and Permit Statistics

LCP 3 – General Anesthesia/Conscious Sedation Permit Evaluation Statistics

LCP 4 – Update on General Anesthesia/Conscious Sedation Calibration Course Dates

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

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FUTURE AGENDA ITEMS

Stakeholders Are Encouraged to Propose Items for Possible Consideration by the Committee at a Future Meeting.

COMMITTEE MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

ADJOURNMENT

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LICENSING, CERTIFICATION AND PERMITS COMMITTEE

Meeting Minutes

Monday, December 3, 2012

Embassy Suites LAX/South

1440 East Imperial Avenue, El Segundo, CA 90245

DRAFT

Members Present

Chair – Thomas Olinger, DDS
Vice Chair – Suzanne McCormick, DDS
Steve Afriat, Public Member
Luis Dominicus, DDS
Judith Forsythe, RDA

Members Absent

Staff Present

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel

ROLL CALL AND ESTABLISHMENT OF QUORUM

Dr. Olinger called the meeting of the Licensing, Certification, and Permits Committee to order at 11:12 a.m. Roll was called and a quorum was established.

LCP 1 – Approval of the August 16, 2012 Licensing, Certification and Permits Committee Meeting Minutes

M/S/C (Afriat/McCormick) to approve the minutes from the August 16, 2012 meeting of the Licensing, Certification, and Permits Committee meeting. The motion passed unanimously.

LCP 2 – Dental and Dental Assisting Program Licensure and Permit Statistics

Richard DeCuir, Executive Officer reported that April Alameda will be Managing the Dental Assisting Unit as well as the Investigative Analysis Unit. Denise Johnson, Assistant Executive Officer gave an overview of the statistics provided including the 113 new RDAEF licenses issued since January 2010 and the 133 RDAEF licenses that have been enhanced since

January 2010. Dr. Olinger commented that it was good to know the different pathways to licensure taken.

LCP 3 – General Anesthesia/Conscious Sedation Permit Evaluation Statistics

Denise Johnson gave an overview of the statistics provided. Dr. Olinger commented that there were no evaluation failures. He asked how that was different from non-compliance. Mr. DeCuir answered that non-compliance means that the permit holder failed to set up an appointment for an evaluation.

LCP 4 – Update on Implementation of Sponsored Free Health Care Events (California Code of Regulations, Title 16, §§1023.15, 1023.16, 1023.17, 1023.18 and 1023.19)

Sarah Wallace, Legislative and Regulatory Analyst, reported that the Board has been working for the past year and a half on the Sponsored Free Health Care Events regulatory package which becomes effective December 7, 2012.

This regulation implements the provisions of Business and Professions Code Section 901 relating to the exemption from licensure for out-of-state licensed dentists to participate in sponsored free health care events in California. This regulation specifies the application and registration requirements, disciplinary actions, recordkeeping requirements and provisions for termination for the exemption of an out-of-state licensed dentist who wishes to participate in a sponsored free health care event. Additionally, the regulation specifies the necessary registration requirements for sponsoring entities to register their events.

To implement this new requirement, Board staff added information to the Board's web site notifying all visitors of the new requirement. Additionally staff sent an email blast to all who have signed up to receive email notifications from the Board. Registration forms are available on the Board's web site.

Dr. Guy Acheson, California Academy of General Dentistry, commented, referring back to Agenda Item LCP 2, would the Board consider an agenda item regarding what statistics AB 269 requires, including how many of the active dental licenses are actually practicing in California.

There was no further public comment.

The committee adjourned at 11:27 a.m.



MEMORANDUM

DATE	February 4, 2013
TO	Licensing, Certification and Permits Committee Dental Board of California
FROM	Dawn Dill, Manager, Licensing and Examination Unit
SUBJECT	Agenda Item LCP 2 – Dental and Dental Assisting Program Licensure & Permit Statistics

Following are statistics of current license/permits by type as of February 4, 2013

License Type	Active	Inactive	Delinquent	Renewal In Process	Total Current Population	Total Cancelled Since Implemented
Dental License	37,791	3,791	3,275	371	45,228	12,135
Registered Dental Assistant (RDA) License	33,870	10,057	9,280	1,215	53,071	34,352
Registered Dental Assistant in Extended Functions (RDAEF) License	1,290	120	184	41	1,635	149
Total Licenses	72,951	13,968	12,739	1,627	99,934	46,636

New RDAEF licenses issued since January 1, 2010 = 127.
 Existing RDAEF licenses enhanced since January 1, 2010 = 140.

Dental Licenses Issued via Pathway	Total Issued in 2013	Total Issued in 2012	Total Issued to Date	Date Pathway Implemented
California Exam	0	0	53,977	Prior to 1929
WREB Exam	37	697	4,793	January 1, 2006
Licensure by Residency	12	163	879	January 1, 2007
Licensure by Credential	15	148	2,410	July 1, 2002
LBC Clinic Contract	0	1	24	July 1, 2002
LBC Faculty Contract	0	0	3	July 1, 2002

License/Permit /Certification/Registration Type	Current Active Permits	Delinquent	Total Cancelled Since Implemented
Additional Office Permit	1,996	408	5,201
Conscious Sedation Permit	483	25	309
Continuing Education Registered Provider Permit	1,251	656	1,176
Elective Facial Cosmetic Surgery Permit	21	0	0
Extramural Facility Registration	*140	n/a	n/a
Fictitious Name Permit	5,203	1,003	3,677
General Anesthesia Permit	821	21	752
Mobile Dental Clinic Permit	22	12	23
Medical General Anesthesia Permit	67	26	131
Oral Conscious Sedation Certification (Adult Only 1,102; Adult & Minors 1,189)	2,294	446	125
Oral & Maxillofacial Surgery Permit	83	6	12
Referral Service Registration	*285	n/a	n/a
Special Permits	31	14	151
Dental Sedation Assistant Permit	17	0	0
Orthodontic Assistant Permit	58	1	0

*Current population numbers for Extramural Facilities and Referral Services are approximated because they are not automated programs.

Active Dental Licensees by County

Alameda	1,439	Placer	444
Alpine	0	Plumas	15
Amador	25	Riverside	1,079
Butte	167	Sacramento	1,093
Calaveras	25	San Benito	24
Colusa	4	San Bernardino	1,333
Contra Costa	1,047	San Diego	2,687
Del Norte	16	San Francisco	1,218
El Dorado	170	San Joaquin	374
Fresno	567	San Luis Obispo	233
Glenn	7	San Mateo	871
Humboldt	93	Santa Barbara	340
Imperial	43	Santa Clara	2,192
Inyo	13	Santa Cruz	201
Kern	351	Shasta	128
Kings	65	Sierra	3
Lake	27	Siskiyou	32
Lassen	30	Solano	300
Los Angeles	8,434	Sonoma	400
Madera	50	Stanislaus	279
Marin	342	Sutter	57
Mariposa	7	Tehama	28
Mendocino	64	Trinity	6
Merced	90	Tulare	202
Modoc	5	Tuolumne	53
Mono	3	Ventura	626
Monterey	297	Yolo	118
Napa	123	Yuba	10
Nevada	91		
Orange	3,679	Total	31,620

Total Active California Licensees 31,620



MEMORANDUM

DATE	February 6, 2013
TO	Licensing, Certification and Permits Committee Dental Board of California
FROM	Jessica Olney, Associate Governmental Program Analyst Dental Board of California
SUBJECT	Agenda Item: LCP 3: General Anesthesia/Conscious Sedation/Medical General Anesthesia Evaluation Statistics

2012-2013 Statistical Overview of the On-Site Inspections and Evaluations Administered by the Board

General Anesthesia Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
January	12	0	0	1	2	1
February	13	0	0	2	2	1
March	14	0	2	2	2	0
April	14	0	2	3	3	0
May	14	0	0	2	2	0
June	9	0	0	2	2	0
July	10	0	0	1	1	1
August	10	0	0	1	0	4
September	10	0	3	2	4	2
October	18	0	0	0	5	1
November	13	0	0	3	3	0
December	5	0	0	3	1	2
January*	12	0	0	1	5	0
February*	11	0	0	1	2	0
Total	165	0	7	24	34	12

*Approximate schedule for January/February

Conscious Sedation Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
January	1	0	0	1	2	0
February	3	1	3	4	1	2
March	4	0	1	1	0	2
April	7	0	1	1	1	2
May	5	0	0	0	2	1
June	4	0	2	2	1	1
July	0	0	0	3	2	1
August	2	0	0	3	1	2
September	4	0	1	2	4	1
October	1	0	1	2	1	4
November	5	1	2	1	0	0
December	1	0	0	0	2	5
January*	6	0	0	2	1	1
February*	6	0	0	2	0	1
Total	49	2	11	24	18	23

*Approximate schedule for January/February

There is a great need for conscious sedation evaluators throughout California. Several evaluations have been postponed recently due to a lack of available evaluators. The Board is actively recruiting for the evaluation program.

Medical General Anesthesia Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
January	1	0	0	1	0	0
February	0	0	0	1	0	0
March	0	0	0	1	1	0
April	1	0	0	1	0	0
May	1	0	0	1	0	0
June	0	0	0	1	0	0
July	1	0	0	0	0	0
August	1	0	0	0	0	0
September	0	0	1	1	0	0
October	0	0	0	1	1	0
November	0	0	0	1	1	0
December	0	0	0	1	0	0
January*	0	0	0	0	1	0
February*	2	0	0	0	0	0
Total	7	0	1	10	4	0

*Approximate schedule for January/February

Evaluators Approved after November 2012

Region	GA	CS	MGA
Northern California	0	0	0
Southern California	0	1	0

Pending Evaluator Applications*

Region	GA	CS	MGA
Northern California	0	2	0
Southern California	6	2	0

*Deficient, or do not meet 3 year requirement.

Current Evaluators per Region

Region	GA	CS	MGA
Northern California	155	69	15
Southern California	205	94	14



MEMORANDUM

DATE	February 6, 2013
TO	Licensing, Certification and Permits Committee Dental Board of California
FROM	Jessica Olney, Associate Governmental Program Analyst Dental Board of California
SUBJECT	Agenda Item: LCP 4: Evaluator Calibration Courses

Currently the Dental Board of California does not have an Evaluator Calibration Training Course scheduled for 2013. Due to current travel restrictions staff is researching the option of providing the calibration training through a web based provider.



NOTICE OF PUBLIC MEETING – Notice is hereby given that a public meeting of Dental Assisting Council of the Dental Board of California will be held as follows:

NOTICE OF DENTAL ASSISTING COUNCIL MEETING

Thursday, February 28, 2013

Upon Conclusion of the Licensing, Certification and Permits Committee Meeting

Holiday Inn on the Bay
1355 North Harbor Drive, San Diego, CA, 92101
(619)232-3861 or (916)263-2300

DENTAL ASSISTING COUNCIL

Judith Forsythe, RDA – Chair
Denise Romero, RDA – Vice Chair
Anne Contreras, RDA
Pamela Davis-Washington, RDA
Teresa Lua, RDAEF
Emma Ramos, RDA
Bruce Whitcher, DDS

CALL TO ORDER

ROLL CALL AND ESTABLISHMENT OF QUORUM

DAC 1 - Approval of the December 3, 2012 Dental Assisting Council Meeting Minutes.

DAC 2 - Update Regarding Status of Dental Assisting Programs and Courses

DAC 3 - Dental Assisting Program Licensure and Permit Statistics

DAC 4 - Review and Discussion of the Dental Assisting Program Examination Statistics

DAC 5 - Discussion and Possible Action Regarding Scheduling a Separate Dental Assisting Council Meeting Aside from the Board Meeting

DAC 6 - Subcommittee Report and Possible Action Regarding the California Association of Dental Assisting Teacher's (CADAT) Proposed Regulatory Amendments to Radiation Safety Course Requirements

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

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FUTURE AGENDA ITEMS

Stakeholders Are Encouraged to Propose Items for Possible Consideration by the Committee at a Future Meeting.

COMMITTEE MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA

Note: The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

ADJOURNMENT

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DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
P (916) 263-2300 F (916) 263-2140 www.dbc.ca.gov

DENTAL ASSISTING COUNCIL
Meeting Minutes
Monday, December 3, 2012
Embassy Suites LAX/South
1440 East Imperial Avenue, El Segundo, CA 90245
DRAFT

Members Present

Judith Forsythe, RDA – Chair
Denise Romero, RDA – Vice Chair
Anne Contreras, RDA
Pamela Davis-Washington, RDA
Teresa Lua, RDAEF
Emma Ramos, RDA
Bruce Witcher, DDS

Members Absent

Staff Present

Richard DeCuir, Executive Officer
Denise Johnson, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit Manager
Jocelyn Campos, Enforcement Coordinator
Sarah Wallace, Legislative and Regulatory Analyst
Karen Fischer, Special Assistant to the Executive Officer
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel

ROLL CALL AND ESTABLISHMENT OF QUORUM

Judith Forsythe, Chair, called the Dental Assisting Council meeting to order at 11:29 a.m. Roll was called and a quorum established.

DAC 1 - Approval of the August 16, 2012 Dental Assisting Council Meeting Minutes.

M/S/C (Contreras/Davis-Washington) to approve the August 16, 2012 Dental Assisting Council Meeting minutes. The motion passed unanimously.

DAC 2 - Staff Update Regarding the Dental Assisting Unit

April Alameda, Dental Assisting Unit Manager, reported that she has been working closely with staff to familiarize herself with the duties and responsibilities of each of her staff members. She has been assessing the operation and putting together improvement ideas for future

implementation. She is utilizing members of her Investigative Analysis Unit to update the website to make it more user friendly. Due to the high volume of calls, she is trying to address as many of the frequently asked questions as possible on the website.

Subject Matter Experts have been trained in course approvals and will be trained in program approvals as soon as they gain a little more experience.

DAC 3 - Report on the November 9, 2012 Special Training Session

Sarah Wallace, Legislative and Regulatory Analyst, reported that staff, legal counsel and Dr. Whitcher provided a special training course for the five new Dental Assisting Council members to provide them with additional background and clarification relating to the functions of the Council including:

- The Board's and the Council's Role in the Protection of the Public
- The Bagley-Keene Open Meeting Act
- Conflicts of Interest
- What is the Difference Between a Statute and a Regulation?
- California's Legislative Process and Council Involvement
- California's Regulatory Process and Council Involvement

All five of the newest members attended. The training was well received and helped to provide clarity to a series of procedural questions. Dr. Whitcher complimented staff and legal counsel on the high level at which the training was given. There were many commendations and kudos for the very interesting and informative training session put on by staff, legal counsel and Dr. Whitcher.

DAC 4 - Update Regarding Status of Dental Assisting Programs and Courses

Judith Forsythe, Committee Chair, gave an overview of the status of Dental Assisting Programs and Courses. Dr. Whitcher commented that he has had some feedback about the length of time it takes to gain approval after having a deficiency. Denise Johnson responded that the schools do have a provisional approval which allows them to teach. The provisional approval is good for one year. Anne Contreras asked if there was a notification of deficiencies that goes out to the program. Denise Johnson answered yes, but she is going to follow up on that due to Dr. Whitcher's comment. Dr. Lori Gagliardi representing the California Association of Dental Assisting Teachers (CADAT), commented that she was aware of a private college that submitted an application on October 1, 2012 with the same curriculum that has already been approved just for a different location. They received an initial letter stating that their application had been received but have had no communication since. She asked if the Dental Board reviews the applications differently if the same curriculum has already been approved. Ms. Johnson stated that she will follow up on that question. Dr. Earl Johnson, California Association of Orthodontists (CAO), asked how a school is notified that they are provisionally approved. Ms. Denise Johnson stated that when all of the application criteria has been met, "programs" are notified that they are provisionally approved while they wait for their site visit to be scheduled. "Courses" do not require a site visit.

Dr. Earl Johnson suggested that the Dental Assisting Council adopt the CAO's boiler plate training program for orthodontic assistants and just approve it once. Ms. Denise Johnson stated that the Dental Board has approved CAO's Orthodontic Assistant course and is in the process of

approving the many applications that have recently been received. Mr. DeCuir added that if there are issues specific to an office such as staffing, those issues are reviewed individually during the approval process.

DAC 5 - Dental Assisting Program Licensure and Permit Statistics

Judith Forsythe, Committee Chair, gave an overview of the statistics provided. She noted that there are currently sixteen active Dental Sedation Assistant Permits and forty-nine Orthodontic Assistant Permits. Dr. Whitcher mentioned that he is getting feedback that there have been some problems getting licensure due to issues with CPR cards. Dr. Lori Gagliardi commented that this issue has come up before because of the way the regulation is written. She stated that she provided the Board with a list of CPR providers that are approved for renewal of licenses but the same CPR provider criteria does not apply for initial licensure. Ms. Denise Johnson stated that she will check with staff to see if there is a problem with CPR providers.

DAC 6 - Review and Discussion of the Dental Assisting Program Examination Statistics

Judith Forsythe, Committee Chair, gave an overview of the Dental Assisting Program examination statistics noting that the updated RDA Written examination was implemented in March 2012.

The updated Law and Ethics examination was just implemented in November 2012 so the examination results are being withheld from the candidates until the examination has been validated by the Department of Consumer Affairs, Office of Professional Examination Services (OPES). The normal validation period is approximately 30 days or the first 100 candidates.

The Orthodontic Assistant written examination is in the final stages of being updated. There will be an item bank of approximately 130 questions and multiple versions of the examination will be tested. The anticipated implementation of the examination should be before the end of the year.

Staff has contacted the Department of Consumer Affairs, Office of Professional Examination Services (OPES) to begin the process to review and possibly update the Registered Dental Assistant in Extended Functions and the Dental Sedation Assistant (DSA) written examinations. Dr. Whitcher commented that he was getting feedback from the DSA course providers that the candidates were saying that the examination did not necessarily reflect the scope of their duties. He does not recommend changing anything right now. He stated that the candidates are just getting used to this new type of examination and we should give it time.

Dr. Lori Gagliardi, CADAT, asked again that the statistics for the RDA Written exam be broken out into the pathways by which the candidates are applying for the exam i.e. on the job training (OJT) versus an approved Dental Assisting program. She commented that most of the community colleges that she is aware of have close to a 100% pass rate but when all the numbers are combined the way that they are the pass rate percentages are much lower. She stated that they use the statistics to determine if there are weaknesses in the programs they are teaching. When all the numbers are combined it is hard to tell if the schools are doing a good job of preparing the candidates or not. Mr. DeCuir stated that there is a contract pending to determine the rate of passing via each pathway to licensure. He stated that in order to obtain the number of OJT candidates versus approved programs you can look at the numbers by school site and draw conclusions by adding up those numbers. Denise Romero, as an educator, gave an explanation as to why the statistics are important to the schools as far as their funding goes.

Dr. Earl Johnson, CAO, asked if the old exam material is analyzed before the new exams are created. Mr. DeCuir stated that prior to creating a new exam, all of the questions are reviewed to see whether or not they are relevant.

Recess for lunch 12:11 p.m.

Return from lunch 1:34 p.m.

DAC 7 - Discussion and Possible Action Regarding the Merits of Retaining a Registered Dental Assistant (RDA) License While Holding a Registered Dental Assistant in Extended Functions (RDAEF) License

Spencer Walker, Senior Legal Counsel, reported that during the review of the dental assisting licensure and examination statistics at the August 2012 meeting, a question arose as to why there appeared to be trend of declining Registered Dental Assistant (RDA) licensees and an increase in RDA license renewal delinquencies. Staff explained that once a RDA becomes licensed as a Registered Dental Assistant in Extended Functions (RDAEF), it is no longer necessary for the licensee to maintain the RDA license since those duties are included within the scope of practice of a RDAEF. Therefore, RDAEF's tend to allow their RDA licenses to go delinquent rather than renewing. If a license is delinquent for five (5) years, then the license goes into a cancelled status. The Council Chair asked if a process could be developed by which a RDA may cancel their license rather than have it fall to a delinquent status. Staff informed the Council that it may be possible to include a form with the results of a RDAEF exam so that a RDA license could be cancelled. Mr. Walker clarified that a regulation would be required to make that change as well as to clarify that maintaining both licenses is not necessary.

Following that discussion, a member of the public inquired about the legality of a RDAEF performing only RDA duties in an office where there are more than three (3) RDAEF's. Business and Professions Code (Code) Section 1753.7 specifies that, as of January 1, 2010, a licensed dentist may simultaneously utilize in their practice no more than three (3) RDAEF's or Registered Dental Hygienists in Extended Functions (RDHEF). Staff consulted with Board Legal Counsel and determined the following:

(1) Since Code Section 1753 authorizes the Board to license as a RDAEF a person who is currently licensed as a RDA or has completed the requirements for licensure as a RDA, and does not require a RDAEF to maintain the RDA license if the RDAEF license was issued based on possession of a RDA license at the time the application for a RDAEF license was made, a RDAEF may cancel his or her RDA license and still perform the duties of a RDA, as provided in Code Section 1752.4. This finding is predicated on the fact that licensure as a RDA is not required to obtain a license as a RDAEF. It is at the discretion of the licensee if they wish to maintain the RDA license after being licensed as a RDAEF.

(2) Furthermore, if a dentist simultaneously utilizes four RDAEF's in their office, the dentist would be in violation of Business and Professions Code section 1753.7, even if one of them also holds an RDA license and only performs the duties of an RDA.

For example, if a dentist simultaneously utilizes four (4) RDAEF's in their office and one of them also holds a RDA license and performs only RDA duties, the RDAEF who also holds a RDA license cannot say that he or she is performing the duties under his or her RDA license

only. Since both licenses authorize the performance of RDA duties, the duties would actually be performed under both licenses. This is why the dentist would be in violation of the statute.

From an enforcement point of view, if a RDAEF, who also holds a RDA license and only performs RDA duties, causes an injury to a patient, both licenses would be subject to discipline. If the RDA license is only disciplined, the RDAEF would still be able to perform the duties of a RDA, thus creating a public protection issue.

Mr. Walker commented that a “voluntary surrender” of the RDA license might be the answer. Ms. Trefry stated that a “voluntary surrender” is a disciplinary action used only within the disciplinary process. Mr. Walker mentioned that some boards allow licensees to surrender their licenses when they don’t want them anymore.

Mr. Walker further suggested that the DAC may want to promulgate regulations allowing the “voluntary surrender” of a RDA license once a RDAEF license has been issued. Ms. Fischer stated that this issue has come before the Board regarding other licensees who want to surrender their licenses and/or permits. Mr. Walker suggested the Board promulgate a regulation whereby all licensees and permit holders can “voluntarily surrender” a license and/or permit.

Mr. Walker stated that another option might be a notation next to the delinquent status on the Board’s website under License Verification, clarifying that the RDA license is no longer necessary because the license holder is now licensed as a RDAEF. Ms. Fischer stated that we were unable to do that in the current system but may be able to do that when the new BreZE system is implemented. Judith Forsythe directed staff to discuss the recommended changes with Dawn Dill, BreZE liaison, to determine if it is possible to make these changes with the implementation of BreZE and report back at the next meeting.

DAC 8 – Subcommittee Report and Possible Action Regarding the California Association of Dental Assisting Teacher’s (CADAT) Proposed Regulatory Amendments to Radiation Safety Course Requirements

Sarah Wallace reported that at the August 2012 meeting, the Board President appointed a two-person subcommittee of Anne Contreras and Emma Ramos to review proposed regulatory amendments to dental assisting courses provided by the California Association of Dental Assisting Teachers (CADAT). Since the last meeting, CADAT submitted proposed regulatory amendments to the California Code of Regulations, Title 16, Sections 1014 and 1014.1 relative to radiation safety course requirements.

Staff and the subcommittee conducted a preliminary review of the proposal and noted some initial comments. The proposal and subcommittee/staff comments were included for review and may be found on the Board’s website

http://www.dbc.ca.gov/about_us/materials/20121203mm.pdf .

The subcommittee and staff will continue reviewing the proposal and will be setting up a meeting with CADAT representatives to review comments and concerns. Additionally, Board Legal Counsel will be conducting a review for compliance with existing law and the Administrative Procedure Act. Staff anticipates a final proposal will be available for the Council’s review at the February Board meeting.

Ms. Wallace requested that comments, questions or concerns be addressed to Ms. Karen Fischer or Ms. Sarah Wallace by December 28, 2012.

Spencer Walker, Senior Legal Counsel commented that going back to DAC 7, he reviewed the Dental Practice Act (DPA) regulations and nowhere does it state that “surrender” is only a disciplinary action. Mr. Walker stated that he will get back to the Committee and staff regarding whether or not the “voluntary surrender” of a license and/or permit can be implemented with the new BreEZe program.

Returning to DAC 8, Ms. Wallace noted that it is her understanding that there are public protection issues surrounding radiation safety and film versus digital radiography and they will be addressing those issues. In addition, this regulation falls under §1014 which is applicable to General Provisions and applies to all licensees of the Board and Dental Hygiene. Staff is working with all parties involved to determine if §1014 is the appropriate place for this regulatory document. A recommendation will be brought forward at the February meeting as to where the Radiation Safety regulation should reside.

Dr. Witcher commented about his concerns with the proposed changes and will submit them to the appropriate parties.

Pamela Davis-Washington commented that analog film is still the most viable option on small children where the digital sensors are too large.

Dr. Lori Gagliardi, CADAT, commented that it was the intent to have either/or for radiographs not limit it to one or make one obsolete.

There was discussion regarding radiography for children and pregnant women.

Bill Lewis asked what the dates were for the comment period. Sarah Wallace answered December 5th through December 28th.

Dr. Lori Gagliardi, CADAT, requested an agenda item to discuss the word “film” versus “image receptor” as it applies to the General Provisions of the Regulation §§1040 and 1041. She stated that her rationale is that the General Provisions include all providers; Dental schools, Dental Hygiene schools, Dental Assisting schools and stand alone providers who would all be subject to compliance under this regulation. Therefore further clarification may be needed if it only needs to apply to Dental Assisting. Ms. Forsythe asked what the basis for this request was. Dr. Gagliardi answered that using the term “image receptor” would allow either film or digital to capture the image.

There was no further public comment.

The Dental Assisting Council meeting adjourned at 2:11 p.m.



MEMORANDUM

DATE	February 20, 2013
TO	Dental Assisting Council Dental Board of California
FROM	April Alameda, Acting Manager, Dental Assisting Program
SUBJECT	Agenda Item DAC 2: Update Regarding Status of Dental Assisting Programs and Courses

This report is provided to update the Board on the status of dental assisting program and course applications, as they move through the process, as well as those which have received Board approval. Since the December Board meeting, 11 course applications have been approved, and five (5) new course applications have been received. There have been no program applications approved or received. We currently have 30 course applications and eight (8) program applications at various stages of the approval process. The table below identifies the total number of applications that were approved during calendar year 2012.

DA Program and Course Applications Approved for 2012									
PROGRAM or COURSE TITLE	RDA Program	Radiation Safety	Coronal Polish	Pit and Fissure Sealants	Ultrasonic Scaler	Infection Control	Orthodontic Assistant	Dental Sedation Assistant	TOTAL APPROVED APPLICATIONS
Course Totals	4	3	3	4	0	9	23	6	52



MEMORANDUM

DATE	February 4, 2013
TO	Dental Assisting Council Dental Board of California
FROM	April Alameda, Acting Manager, Dental Assisting Program
SUBJECT	Agenda Item DAC 3: Dental Assisting Program Licensure & Permit Statistics

Following are statistics of current license/permits by type as of February 4, 2013

License Type	Active	Inactive	Delinquent	Renewal In Process	Total Current Population	Total Cancelled Since Implemented
Registered Dental Assistant (RDA) Licenses	33,870	10,057	9,280	1,215	53,071	34,352
Registered Dental Assistant in Extended Functions (RDAEF) Licenses	1,290	120	184	41	1,635	149
Total Licenses	35,160	10,177	9,464	1,256	54,706	34,501

New RDAEF licenses issued since January 1, 2010 = 127
 Existing AEF licenses enhanced since January 1, 2010 = 140

Permit Type	Current Active Permits	Delinquent	Total Cancelled Since Implemented
Dental Sedation Assistant (DSA) Permit	17	0	0
Orthodontic Assistant (OA) Permit	58	1	0



MEMORANDUM

DATE	February 4, 2013
TO	Dental Assisting Council Dental Board of California
FROM	April Alameda, Acting Manager, Dental Assisting Program
SUBJECT	Agenda Item DAC 4: Review and Discussion of the Dental Assisting Program Examination Statistics

Written Examination Statistics for 2012 ALL CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	2898	62%	38%
RDA Law & Ethics	3313	56%	44%
RDAEF	109	63%	37%
Orthodontic Assistant	83	53%	47%
Dental Sedation Assistant	6	67%	33%

Written Examination Statistics for 2012 FIRST TIME CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	2155	68%	32%
RDA Law & Ethics	2354	60%	40%
RDAEF	69	70%	30%
Orthodontic Assistant	54	54%	46%
Dental Sedation Assistant	4	100%	0%

Written Examination Statistics for 2012 REPEAT CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	743	45%	55%
RDA Law & Ethics	959	47%	53%
RDAEF	40	53%	47%
Orthodontic Assistant	29	52%	48%
Dental Sedation Assistant	2	0%	100%

Written Examination Statistics for **2013 ALL CANDIDATES**

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	210	62%	38%
RDA Law & Ethics	186	54%	46%
RDAEF	4	50%	50%
Orthodontic Assistant	8	50%	50%
Dental Sedation Assistant	0	0%	0%

Written Examination Statistics for **2013 FIRST TIME CANDIDATES**

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	145	74%	26%
RDA Law & Ethics	120	59%	41%
RDAEF	3	33%	67%
Orthodontic Assistant	6	50%	50%
Dental Sedation Assistant	0	0%	0%

Written Examination Statistics for **2013 REPEAT CANDIDATES**

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	65	35%	65%
RDA Law & Ethics	66	45%	55%
RDAEF	1	100%	0%
Orthodontic Assistant	2	50%	50%
Dental Sedation Assistant	0	0%	0%

RDA Practical Examination Statistics for **2012 ALL CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	236	86%	14%
RDA – February South	269	78%	22%
RDA – April North	208	84%	16%
RDA – April South	288	76%	24%
RDA – August North	511	93%	7%
RDA – August Central	115	90%	10%
RDA – August South	560	88%	12%
RDA – Nov – North	355	89%	11%
RDA – Nov – South	387	84%	16%
Total for Year	2929	85%	15%

*Scheduled. Exam results pending – Not included in Total for Year

RDA Practical Examination Statistics for **2012 FIRST TIME CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	201	86%	14%
RDA – February South	174	91%	9%
RDA – April North	182	85%	15%
RDA – April South	223	74%	26%
RDA – August North	482	94%	6%
RDA – August Central	111	94%	6%
RDA – August South	513	89%	11%
RDA – Nov - North	324	89%	11%
RDA – Nov - South	333	86%	14%
Total for Year	2543	88%	12%

RDA Practical Examination Statistics for **2012 REPEAT CANDIDATE**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	35	89%	11%
RDA – February South	95	55%	45%
RDA – April North	26	73%	27%
RDA – April South	65	82%	18%
RDA – August North	29	90%	10%
RDA – August Central	4	50%	50%
RDA – August South	47	77%	23%
RDA – Nov - North	31	90%	10%
RDA – Nov - South	54	76%	24%
Total for Year	386	76%	24%

RDA Practical Examination Statistics for 2013 ALL CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North*	315		
RDA – February South*	334		
RDA – April North			
RDA – April South			
RDA – August North			
RDA – August Central			
RDA – August South			
RDA – Nov – North			
RDA – Nov – South			
Total for Year			

*Scheduled. Exam results pending – Not included in Total for Year

RDA Practical Examination Statistics for 2013 FIRST TIME CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North			
RDA – February South			
RDA – April North			
RDA – April South			
RDA – August North			
RDA – August Central			
RDA – August South			
RDA – Nov - North			
RDA – Nov - South			
Total for Year			

RDA Practical Examination Statistics for 2013 REPEAT CANDIDATE

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North			
RDA – February South			
RDA – April North			
RDA – April South			
RDA – August North			
RDA – August Central			
RDA – August South			
RDA – Nov - North			
RDA – Nov - South			
Total for Year			

RDAEF Clinical/Practical Examination Statistics for **2013** ALL CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – January North	21	86%	14%
RDAEF – June North			
RDAEF – June South			
RDAEF – September North			
RDAEF – October South			
RDAEF – December North			
Total for Year	21	86%	14%

RDAEF Clinical/Practical Examination Statistics for **2013** FIRST TIME CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – January North	18	94%	6%
RDAEF – June North			
RDAEF – June South			
RDAEF – September North			
RDAEF – October South			
RDAEF – December North			
Total for Year	18	94%	6%

RDAEF Clinical/Practical Examination Statistics for **2013** REPEAT CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – January North	3	33%	67%
RDAEF – June North			
RDAEF – June South			
RDAEF – September North			
RDAEF – October South			
RDAEF – December North			
Total for Year	3	33%	67%

Update on the Dental Assisting Program Written examinations:

The updated RDA Law and Ethics examination was implemented in November 2012. The examination results have been validated by the Department of Consumer Affairs, Office of Professional Examination Services and the test results were released to the candidates, effective December 27, 2012.

A contract has been put in place with a vendor to review and possibly update the Dental Sedation Assistant written examination. We expect a final report from the vendor in spring 2014. Staff is still working with the Department of Consumer Affairs, Office of Professional Examination Services (OPES) to begin the necessary process to review and possibly update the Registered Dental Assistant in Extended Functions written examination.



MEMORANDUM

DATE	February 19, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	DAC 5: Discussion and Possible Action Regarding Scheduling a Separate Dental Assisting Council Meeting Aside From the Board Meeting

The California Association of Dental Assisting Teachers (CADAT) has requested that the Dental Assisting Council consider scheduling a one-day public meeting in Sacramento prior to the next Dental Board meeting to discuss issues of concern within the dental assisting community. Stakeholders would have the opportunity to outline specific concerns and, at the same time, inform and educate the Council on the relevant issues without the time constraints of other Dental Board business. The Council would then be able to discuss and prioritize how to move forward to address the needs of their constituency.

If the Council determines that an additional meeting would be helpful in understanding the issues and concerns within the dental assisting community, staff will work with Council members to determine a date agreeable to all.



MEMORANDUM

DATE	February 14, 2013
TO	Dental Assisting Council Members, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item DAC 6: Subcommittee Report and Possible Action Regarding the California Association of Dental Assisting Teacher's (CADAT) Proposed Regulatory Amendments to Radiation Safety Course Requirements

Background

In October 2012, the California Association of Dental Assisting Teachers (CADAT) submitted a regulatory proposal to the Dental Assisting Council (Council) to amend California Code of Regulations, Title 16, Sections 1014 and 1014.1 relative to radiation safety course requirements. The Board President appointed a two-person subcommittee to review the proposal and to provide recommendations to the Council for consideration.

The subcommittee and staff conducted a preliminary review of the proposal and noted some initial comments for the Council's consideration at its December 2012 meeting. The subcommittee and staff stated that they would continue reviewing the proposal and would be setting up a meeting with CADAT representatives to review comments and concerns. Additionally, staff requested Council members, Board members, stakeholders, or general members of the public review the proposed amendments and provide informal comments by the end of December 2012 for the subcommittee and staff to consider when developing recommendations for the Council's consideration.

Staff compiled the comments received from interested parties and met with the subcommittee to discuss final recommendations regarding CADAT's proposed amendments to the radiation safety course requirements to bring forth to the Council for consideration.

Subcommittee and Staff Recommendations:

When determining recommendations to be forwarded to the Council for consideration, the subcommittee and staff considered comments received from interested parties, and the six legal review standards established in the Administrative Procedure Act. Those six legal review standards are:

- (1) Authority: Has the Legislature delegated the power to adopt this regulation?
- (2) Clarity: Can the regulation be easily understood by those affected?
- (3) Consistency: Does the regulation conflict with other regulations or statutes?
- (4) Necessity: Is there demonstrated evidence that there is a need for the regulation?
- (5) Non-Duplication: Does the regulation duplicate other regulations or statutes?
- (6) Reference: Which statute does the regulation implement, interpret, or make specific?

The subcommittee and staff have developed the following recommendations in response to CADAT's proposed amendments to Cal. Code of Regs., Title 16, Sections 1014 and 1014.1 relative to radiation safety course requirements:

Recommendation No. 1

The subcommittee and staff recommend maintaining the regulatory requirements for radiation safety courses within Sections 1014 and 1014.1 of Article 3.1 of Chapter 1 of Division 10, of Title 16 of the Cal. Code of Regs. During the initial review, the subcommittee and staff questioned if the requirements would be better suited for inclusion with the dental assisting educational programs and course requirements (Cal. Code of Regs., Title 16, Chapter 3, Article 2, Section 1070 *et seq.*). After further evaluation, the subcommittee and staff determined that it is necessary to maintain the course requirements within Sections 1014 and 1014.1 as the radiation safety course is a requirement of all Board licensees, pursuant to Business and Professions Code Sections 1645.1 and 1656.

Recommendation No. 2

The subcommittee and staff agree with CADAT's proposal that the radiation safety courses should comply with the requirements set forth in Cal. Code of Regs., Title 16, Sections 1070 and 1070.1 relative to general provisions governing all dental assistant educational programs and courses. However, after further evaluation, the subcommittee and staff concluded that simply referencing compliance requirements with Sections 1070 and 1070.1 within the radiation safety course requirements would not be clear. Provisions of Sections 1070 and 1070.1 require compliance with the provisions within Chapter 3, Article 2 relative to dental assisting educational programs and course requirements. The radiation safety course requirements are located in Chapter 1, Article 3.1 relative to radiation safety course requirements and are applicable to all licensees. Since there would be inconsistency within the regulatory language, the staff and subcommittee recommend using the provisions currently found in Section 1070 and 1070.1 and include those provisions as part of the proposed regulatory amendments to Sections 1014 and 1014.1 to maintain consistency and clarity.

Recommendation No. 3

The subcommittee and staff recommend rejection of all provisions within the proposal relating to “stand-alone” courses versus those included as part of registered dental assisting programs. Additionally, the subcommittee and staff recommend rejection of all provisions within the proposal relating the renewal of course provider approval on a biennial basis.

The subcommittee and staff have determined that it would be unnecessary to refer to a course as “stand-alone”. Courses are independent of programs and it is implied that they are “stand-alone”. No other regulatory requirement within Division 10 of Title 16 of the Cal. Code of Regs., refer to a course as “stand-alone”. This has been an internal term used by staff but is not necessary nor does it provide further clarity to the proposed language. Additionally, Section 1070.2(d)((9)(A) requires all registered dental assisting programs to provide instruction in radiation safety that meets all of the requirements of Cal. Code of Regs., Title 16, Sections 1014 and 1014.1. Therefore, it could cause greater confusion for the general public by specifying differing requirements for courses and programs.

The subcommittee and staff have determined that requiring a course to renew approval with the Board on a biennial basis would be unnecessary and could create undue burden for the course providers. Additionally, the Board does not have the staff resources to review course renewals on a biennial basis. The subcommittee and staff understand that CADAT proposed the renewal in order to comply with the biennial renewal requirement for continuing education course providers; however, the purpose for continuing education course providers and the purpose for individual courses required for initial licensure are different. Continuing education courses are intended to provide existing licensees with updated information to continue their education after licensure. The Board only approves the continuing education provider and not the continuing education course content. Therefore, it is necessary for the Board to audit continuing education course providers on a biennial basis to ensure patient protection. In contrast, Board-approved courses (e.g. radiation safety, infection control, etc.) are intended to provide students with the theory and clinical application necessary to gain initial licensure within California. The Board-approved courses are required to comply with specific course requirements provided in regulation. The subcommittee and staff recommend that radiation safety courses be required to comply with the same requirements for program and course approval as provided in Section 1070, including re-evaluation every seven years. A re-evaluation would require a site visit and inspection of course records. The subcommittee and staff feel that this would provide better public protection than requiring the course to submit documentation to the Board for auditing on a biennial basis.

Recommendation No. 4

The subcommittee and staff recommend acceptance of CADAT’s proposal to adopt an application form and fee as part of the regulatory language. Business and Professions Code Section 1725(o) specifies that the fee for review of each approval application for a course that is not accredited by a Board-approved agency, or the Chancellor’s office of

the California Community Colleges shall not exceed three hundred dollars (\$300). The current fee for course applications is \$300 and was established via Board resolution. In January 2012, as a result of the Board's sunset legislation (SB 540, Chapter 385, Statutes of 2011) the Board is required to establish any future dental assisting fees via regulation.

Recommendation No. 5

After reviewing CADAT's proposed amendments to Section 1014(c), the subcommittee and staff have determined the following:

- The subcommittee and staff have determined it is necessary to provide a specific timeframe for the course provider to respond to the Board's notice of withdrawal of approval. CADAT proposed a timeframe of 30 days. The subcommittee recommends the timeframe be extended to 45 calendar days. This would provide the course provider with approximately 30 working days to respond.
- The subcommittee and staff have determined that specifying that "course records shall be subject to inspection by the Board at any time" would be more beneficial than listing the specific course records that would be subject to inspection. The subcommittee and staff would not want the regulatory language to inadvertently limit the Board's authority when conducting course record inspection.
- The subcommittee and staff recommend that all course records should be retained for a period of no less than five (5) years to maintain consistency with the provisions of Section 1070.
- The subcommittee and staff do not recommend including a provision to provide notice on the Board's web site of a course's approval being withdrawn. This is an internal staff operation and does not necessarily need to be included as part of the regulation.

Recommendation No. 6

The subcommittee and staff recommend acceptance of CADAT's proposal to require existing radiation safety courses to provide a notice of compliance with the new regulatory requirements. This would maintain consistency with the regulatory requirements established for registered dental assisting programs, registered dental assisting in extended functions programs, infection control courses, dental sedation assistant courses, and orthodontic assistant courses.

Recommendation No. 7

After reviewing CADAT's proposed addition of Section 1014(e)(1), the subcommittee and staff do not believe it is necessary to specify that all faculty and instructional staff shall have been licensed to include a "radiation safety certificate". All licensees should be in compliance with the radiation safety course requirements as a condition of licensure. Additionally, the subcommittee and staff do not believe it is necessary to specify that the two-hour methodology course to be completed by all faculty and instructional staff should be specific to radiation safety. This would require the creation of a new methodology course and could cause undue burden for course providers, faculty, and instructional staff. The subcommittee and staff believe the current methodology course requirements are sufficient to ensure patient safety.

Recommendation No. 8

The subcommittee and staff recommend rejection of CADAT's proposed addition of Section 1014(e)(2), because:

- It is not necessary to reiterate provisions of other regulations as part of these regulatory requirements. Licensees and students are responsible for compliance with all applicable statutes and regulations governed by all state agencies unless expressly exempted by law.
- Dentists are required to supervise as instructors pursuant to Health and Safety Code Section 106975(b).
- The Board does not have the authority to implement an age requirement for radiography students. Additionally, such age requirements may adversely impact ROP programs.
- Dental radiographs prescribed to pregnant patients are the responsibility of the prescribing dentist.
- Obtaining consent is the responsibility of the prescribing dentist.

However, the subcommittee and staff recommend acceptance of the provision relating to the patient's history being kept in the student's record.

Recommendation No. 9

After reviewing CADAT's proposed addition of Section 1014(f), the subcommittee and staff recommend maintaining the existing course hour requirements of no less than 32 hours, including 8 hours of didactic instruction, 12 hours of laboratory instruction, and 12 hours of clinical instruction. The Board does not have the authority to include the instruction in the 8-hour infection control or the review of the Dental Practice Act into the radiation safety course requirements. These courses are required as separate requirements for initial licensure. Additionally, these requirements are not found in any other course requirement regulation governed by the Board and would create inconsistency.

However, the subcommittee and staff understand that there could be a potential patient protection issue when students take a radiation safety course before they have taken any other course requirements, especially the 8-hour infection control course. Staff recommends the Council discuss this issue and possibly defer to Legal Counsel if there is sufficient statutory authority to implement such a prerequisite in the interest of patient protection.

Recommendation No. 10

After reviewing CADAT's proposed addition of Section 1014(f)(2), the subcommittee and staff believe that the proposed provision exceeds the authority of Cal. Code of Regs., Title 17, Section 30305. Therefore, the subcommittee and staff recommend that courses only be required to provide students with the requirements of Cal. Code of Regs., Title 17, Division 1, Chapter 5, Subchapter 4, Group 3, Article 4 (Section 30305 *et seq.*) relative to the special requirements for the use of x-ray in the healing arts.

Recommendation No. 11

After reviewing CADAT's proposed addition of Section 1014(f)(3) and 1014(m), the subcommittee and staff recommend acceptance of CADAT's proposal relative to written examinations. However, the subcommittee and staff recommend rejection of the provision that would allow a student to use a current passing score from the DANB radiation certification examination in lieu of a comprehensive final exam. The Board does not currently recognize any DANB certifications and this proposal is inconsistent with other Board dental assisting regulations.

Recommendation No. 12

After reviewing CADAT's proposed addition of Section 1014(g), the subcommittee and staff recommend only requiring certificates of completion be issued rather than a wall certificate and certificates of completion. A certificate of completion is sufficient evidence to employers and the Board that a student has completed the necessary course requirements. The subcommittee and staff recommend amending the certificate of completion provision to be more aligned with CADAT's proposal.

Recommendation No. 13

After reviewing CADAT's proposed addition of Section 1014(h), the subcommittee and staff recommend incorporating CADAT's proposed language into the facility requirements for radiation safety courses.

Recommendation No. 14

After reviewing CADAT's proposed addition of Sections 1014(i), (j), (k), and (l), the subcommittee and staff recommend accepting CADAT's proposed requirements of instruction with the following exceptions:

- The subcommittee and staff do not recommend specifying that radiograph exposure and processing techniques should include exposure guidelines for ALARA and recommendations for exposure by the American Dental Association as part of didactic instruction. The subcommittee and staff consider this curriculum level detail and unnecessary to include as part of the regulation.
- The subcommittee and staff do not recommend including review of general provisions of the California Dental Practice Act as part of didactic instruction for reasons previously specified.

Recommended Proposed Language:

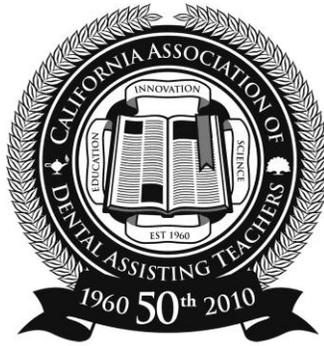
Based on the recommended responses to CADAT's proposal, the subcommittee and staff have developed the attached proposed regulatory language to amend Cal. Code of Regs., Title 16, Sections 1014 and 1014.1 relative to radiation safety courses.

Council Action Requested:

Staff requests the Council take the following actions:

- Consider and possibly accept the subcommittee's and staff's recommendations in response to CADAT's proposed amendments to Cal. Code of Regs., Title 16, Sections 1014 and 1014.1 relative to radiation safety course requirements;
- Consider and possibly accept the subcommittee's and staff's recommended proposed language and recommend the proposed language be considered by the Board at the May 2013 meeting for the purpose of initiating a formal rulemaking to amend Sections 1014 and 1014.1, of Title 16, of the Cal. Code of Regs. relative to radiation safety course requirements. Additionally, direct staff to continue working with the subcommittee and representatives of CADAT to: (1) develop the forms to incorporate by reference as part of the proposed regulation, and (2) address any issues that may arise between the February and May Board meeting.

CADAT Proposal



October 22, 2012

Ms. Sarah Wallace
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815-3831

Dear Ms. Wallace:

Please find attached the proposed regulations with justification statements for Cal. Code of Regs. Section 1014 and 1014.1 submitted by the California Association of Dental Assisting Teachers. We appreciate the opportunity to work with you on this very important project affecting numerous schools and programs in the State.

Please note the following:

- The format used for current regulations pertaining to certifications in subjects such as coronal polishing and infection control was never applied to Radiation Safety language. CADAT is proposing that CCR Section 1014.1 be repealed and the relevant language from the Section be incorporated into existing Section 1014. Therefore, you will note the striking of all existing language from Section 1014.1 and, where incorporated, language is reiterated in Section 1014 by underlining as new language.
- The renewal application process proposed in CCR Section 1014(b)(1) is consistent with the regulatory language in CCR Sections 1016 and 1017. The draft "Application for Provider Renewal" referenced in proposed language is attached and is consistent with the application form utilized by the Board for CE provider renewal. Once reviewed and a regulatory package developed, a form number will need to be inserted into the proposed language.
- The "Notice of Compliance" referenced in proposed CCR Section 1014(d) is consistent with the notice adopted by regulation in November 2011. The draft notice is attached and once reviewed, a form number will need to be inserted into the proposed language.
- The "Course Completion Card" referenced in proposed language CCR Section 1014(g)(1)(A) was developed with Board staff one year ago but not adopted into regulatory language. The document has been revised to address proposed changes in the regulations and is attached for

inclusion in the draft document. Once reviewed, a form number will need to be issued and inserted into the proposed language.

To assist with the review and comment process, CADAT has incorporated page line numbers; please reference the page number and line number when communicating any questions or comments you may have as to the proposed language.

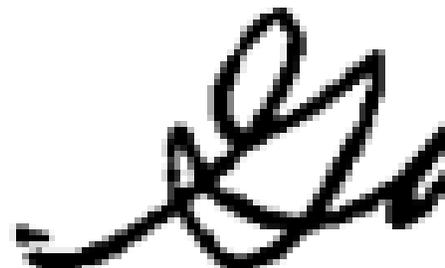
CADAT recognizes that the needs of dental assisting educational programs and courses may not be consistent with the needs of dental schools and dental hygiene schools, nor are those disciplines held to the same educational regulations as our profession. As such, CADAT is prepared to discuss the option of separating out the educational requirements in Radiation Safety for stand-alone course providers and dental assisting educational programs from the current general provisions of Sections 1014 and 1014.1. Should that be the case, we would suggest bringing our proposed language forward as part of the other dental assisting-related educational regulatory Sections beginning with Section 1070 et.al.

Please let us know if there are any issues requiring clarification prior to the advancement of the proposed language which we anticipate will be placed on the Dental Assisting Council agenda for December 2012.

Respectfully,

Lorraine Gagliardi, CDA, RDA, RDH, Ed.D
Director – Council on Regulatory and Statutory Affairs

Cc: Ms. Michele Jawad, CDA, RDA, BS, MA – Council Member
Ms. Lindsay Shubin, RDA, AS – Council Member
CADAT Executive Board



1 Article 3.1 – Radiation Safety Courses

2 CCR § 1014:

3 **Approval of Radiation Safety Courses – Approval; Continued Approved Status for Stand-Alone Courses**
4 **in Radiation Safety; Curriculum Requirements; Issuance of Certification**

5
6 (a) A California Radiation Safety course is one which has as its primary purpose providing theory and
7 clinical application in radiographic techniques. A single standard of care shall be maintained and the
8 board shall approve and continue to approve only programmatically curricula and these stand-alone courses
9 which continuously maintain a high quality standard of instruction where protection of the public is the
10 principal focus.

11
12 *Justification: (a) The word California is added to specify that the course should be a CA course and not a*
13 *course recognized in another state that may also offer a Radiation Safety course; (b) Radiation Safety*
14 *course providers should reapply for approval biannually consistent with continuing education providers*
15 *to ensure the program continues to comply with the Radiation Safety curriculum requirements and*
16 *issuance of certification.*

17 *Rationale: Provides the board the opportunity to review courses biannually and withdraw approval if*
18 *applicable.*

19 *Benefit: The consumer and students enrolled in the course can be assured the program is in compliance*
20 *and following the guidelines for a Radiation Safety course as outline herein.*

21
22 (b) A Radiation Safety course provider applying for initial approval shall submit to the board an
23 application and other required documents and information on forms prescribed by the board.
24 Consistent with Section 1070, the board may approve or deny approval of any such course. Approval
25 may be granted after evaluation of all components of the course has been performed and the report of
26 such evaluation indicates that the course meets the board's requirements. ~~The board may, in lieu of~~
27 ~~conducting its own investigation, accept the findings of any commission or accreditation agency~~
28 ~~approved by the board and adopt those findings as its own.~~

29
30 *Justification: (a) The addition of Section 1070 which pertains to the course qualification requirements*
31 *should be referenced; (b) Radiation Safety course providers are not approved by the Commission unless*
32 *part of an entire program of study for dentistry or dental hygiene required to be Commission accredited.*

33 *Rationale: Provides clarity and consistency with newly established regulations for education.*

34 *Benefit: The clarity of the proposed language offers clear guidelines for reviewers, applicants and*
35 *providers.*

36
37 (1) All stand-alone course providers of Radiation Safety courses shall seek renewal as a registered
38 course provider every two years by submitting a provider renewal application prescribed by the
39 board [insert form number] that is hereby incorporated by reference and accompanied by a fee
40 consistent with B&P Code 1725(o). The applicant or, if the applicant is not an individual but
41 acting on behalf of a business entity, the individual authorized by the business to act on its

1 behalf shall certify that the provider will only offer the course and issue certificates of
2 completion to participants that meet the requirements of the course as defined herein.

3 (2) To renew its provider status, and in addition to a renewal application, a stand-alone course
4 provider shall submit a biennial report prescribed by the board which shall include, at minimum,
5 copies of current course outlines, competencies used for evaluation, a report of current faculty
6 and instructional staff with copies of teacher credentials and verification of teacher
7 qualifications, a report of all locations used for instruction, and all other supporting
8 documentation necessary to demonstrate compliance with current course regulations.

9 (3) Current RDA programs approved by the board are exempt from submitting Radiation Safety
10 biennial reporting but will retain all required records set in this Section as part of the RDA
11 program records, unless the program or institution is offering a stand-alone course in the
12 subject area.

13
14 *Justification: (a) The addition of proposed subsections 1 – 3 above help ensure provider compliance*
15 *through reporting consistent with CCR 1016 – 1017 for continuing education course providers; (b)*
16 *Radiation Safety course providers have not been assessed for compliance with educational regulations*
17 *since initial approval; the absence of monitoring of providers has led to a wide range of inconsistencies*
18 *amongst providers of courses; (c) fees associated with initial application and biennial review application*
19 *are currently enacted with CE providers as defined in B&P Code 1725(o).*

20 *Rationale: Provides clarity and consistency with newly established regulations for courses; lack of*
21 *adherence to current educational regulations and the absence of provider monitoring has led to concerns*
22 *of the validity of the certification process, patient protection during radiation exposures by students in*
23 *courses and the overall competence of course completers by unmonitored providers.*

24 *Benefit: The clarity of the proposed language offers clear guidelines for both board SMEs/course*
25 *evaluators and providers.*

26
27 (c) Upon review, audit or investigation, the Board may withdraw its approval of a course at any time,
28 after giving the course provider written notice setting forth its reason for withdrawal and after affording
29 a reasonable provider the opportunity to respond within 30 days. Approval may be withdrawn for failure
30 to comply with the board's regulations, standards or for fraud, misrepresentation or violation of any
31 applicable federal or state laws relating to the operation of radiographic equipment, or for violation or
32 non-compliance of this Section and all applicable requirements. The board shall be notified, by report, of
33 all providers whose approved status has been withdrawn and such action noticed accordingly via the
34 board's website.

35
36 (1) An audit of a provider of a Radiation Safety course may include an on-site visit. If an audit is
37 conducted, the provider shall submit to the board the following information and
38 documentation:

39 (A) All faculty and staff documentation;

40 (B) Course content outlines and examination records;

41 (C) Educational objectives or outcomes;

42 (D) Competency forms for each participant;

- 1 (E) Evidence of registration documents and protocols used for participant registration;
- 2 (F) Attendance records and rosters;
- 3 (G) Copies of all course completion certification cards issued to participants; and
- 4 (H) Copies of safety and final exams.

5

6 All course provider records described in this Article shall be retained for a period of no less than four

7 years.

8

9 *Justification: (a) The addition of proposed amendments above help ensure provider compliance through*

10 *reporting consistent with CCR 1016 – 1017 for continuing education course providers.*

11 *Rationale: Provides clarity and consistency with newly established regulations for courses; lack of*

12 *adherence to current educational regulations and the absence of provider monitoring has led to concerns*

13 *of the validity of the certification process, patient protection during radiation exposures by students in*

14 *courses and the overall competence of course completers by unmonitored providers.*

15 *Benefit: The clarity of the proposed language offers clear guidelines for both board SMEs/course*

16 *evaluators and providers.*

17

18 ~~(d) The processing times for radiation safety course approval are set forth in Section 1061.~~

19

20 *Justification: Lack of necessity.*

21

22 **~~Section 1014.1 Requirements for Radiation Safety Courses.~~**

23 ~~A radiation safety course shall comply with the requirements set forth below in order to secure and~~

24 ~~maintain approval by the board. The course of instruction in radiation safety and radiography~~

25 ~~techniques offered by a school or program approved by the board for instruction in dentistry, dental~~

26 ~~hygiene or dental assisting shall be deemed to be an approved radiation safety course if the school or~~

27 ~~program has submitted evidence satisfactory to the board that it meets all the requirements set forth~~

28 ~~below.~~

29 ~~(a) Educational Level. The course shall be established at the postsecondary educational level or a level~~

30 ~~deemed equivalent thereto by the board.~~

31 ~~(b) Program Director. The program director, who may also be an instructor, shall actively participate in~~

32 ~~and be responsible for at least all of the following:~~

33 ~~(1) Providing daily guidance of didactic, laboratory and clinical assignments;~~

34 ~~(2) Maintaining all necessary records, including but not limited to the following:~~

35 ~~(A) Copies of current curriculum, course outline and objectives;~~

36 ~~(B) Faculty credentials;~~

37 ~~(C) Individual student records, which shall include pre-clinical and clinical evaluations,~~

38 ~~examinations and copies of all successfully completed radiographic series used toward~~

39 ~~course completion. Records shall be maintained for at least five years from the date of~~

40 ~~course completion.~~

41 ~~(3) Issuing certificates to each student who has successfully completed the course and~~

42 ~~maintaining a record of each certificate for at least five years from the date of its issuance;~~

1 ~~(4) Transmitting to the board on a form prescribed by the board the name, last four digits of the~~
2 ~~social security number and, where applicable, license number of each student who has~~
3 ~~successfully completed the course;~~

4 ~~(5) Informing the board of any significant revisions to the curriculum or course outlines.~~

5 ~~(c) Faculty. The faculty shall be adequate in number, qualifications and composition and shall be suitably~~
6 ~~qualified through academic preparation, professional expertise, and/or appropriate training, as provided~~
7 ~~herein. Each faculty member shall possess the following qualifications:~~

8 ~~(1) Hold a valid special permit or valid license as a dentist, registered dental hygienist, registered~~
9 ~~dental assistant, registered dental assistant in extended functions, registered dental hygienist in~~
10 ~~extended functions, or registered dental hygienists in alternative practice issued by the board;~~

11 ~~(2) All faculty shall have been licensed for a minimum of two years. All faculty shall have the~~
12 ~~education, background, and occupational experience and/or teaching expertise necessary to~~
13 ~~perform, teach, and evaluate dental radiographs. All faculty responsible for clinical evaluation~~
14 ~~shall have completed a two-hour methodology course which shall include clinical evaluation~~
15 ~~criteria, course outline development, process evaluation, and product evaluation;~~

16 ~~(3) Shall have either passed the radiation safety examination administered by the board or~~
17 ~~equivalent licensing examination as a dentist, registered dental hygienist, registered dental~~
18 ~~assistant, registered dental assistant in extended functions, registered dental hygienist in~~
19 ~~extended functions, or registered dental hygienists in alternative practice or, on or after January~~
20 ~~1, 1985, shall have successfully completed a board approved radiation safety course.~~

21 ~~(d) Facilities. There shall be a sufficient number of safe, adequate, and educationally conducive lecture~~
22 ~~classrooms, radiography operatories, developing or processing facilities, and viewing spaces for~~
23 ~~mounting, viewing and evaluating radiographs. Adequate sterilizing facilities shall be provided and all~~
24 ~~disinfection and sterilization procedures specified by board regulations shall be followed.~~

25 ~~(1) A radiographic operatory shall be deemed adequate if it fully complies with the California~~
26 ~~Radiation Control Regulations (Title 17, Cal. Code Regs., commencing with section 30100), is~~
27 ~~properly equipped with supplies and equipment for practical work and includes for every seven~~
28 ~~students at least one functioning radiography machine which is adequately filtered and~~
29 ~~collimated in compliance with Department of Health Services regulations and which is equipped~~
30 ~~with the appropriate position indicating devices for each technique being taught.~~

31 ~~(2) The developing or processing facility shall be deemed adequate if it is of sufficient size, based~~
32 ~~upon the number of students, to accommodate students' needs in learning processing~~
33 ~~procedures and is properly equipped with supplies and equipment for practical work using~~
34 ~~either manual or automatic equipment.~~

35 ~~(3) X-ray areas shall provide protection to patients, students, faculty and observers in full~~
36 ~~compliance with applicable statutes and regulations.~~

37 ~~(e) Program Content. Sufficient time shall be available for all students to obtain laboratory and clinical~~
38 ~~experience to achieve minimum competence in the various protocols used in the application of dental~~
39 ~~radiographic techniques.~~

40 ~~(1) A detailed course outline shall be provided to the board which clearly states curriculum~~
41 ~~subject matter and specific instructional hours in the individual areas of didactic, laboratory, and~~
42 ~~clinical instruction.~~

1 ~~(2) General program objectives and specific instructional unit objectives shall be stated in~~
2 ~~writing, and shall include theoretical aspects of each subject as well as practical application. The~~
3 ~~theoretical aspects of the program shall provide the content necessary for students to make~~
4 ~~judgments regarding dental radiation exposure. The course shall assure that students who~~
5 ~~successfully complete the course can expose, process and evaluate dental radiographs with~~
6 ~~minimum competence.~~

7 ~~(3) Objective evaluation criteria shall be used for measuring student progress toward attainment~~
8 ~~of specific course objectives. Students shall be provided with specific unit objectives and the~~
9 ~~evaluation criteria that will be used for all aspects of the curriculum including written, practical~~
10 ~~and clinical examinations.~~

11 ~~(4) Areas of instruction shall include at least the following as they relate to exposure, processing~~
12 ~~and evaluations of dental radiographs:~~

13 ~~(A) Radiation physics and biology~~

14 ~~(B) Radiation protection and safety~~

15 ~~(C) Recognition of normal anatomical landmarks and abnormal conditions of the oral~~
16 ~~cavity as they relate to dental radiographs~~

17 ~~(D) Radiograph exposure and processing techniques using either manual or automatic~~
18 ~~methods~~

19 ~~(E) Radiograph mounting or sequencing, and viewing, including anatomical landmarks of~~
20 ~~the oral cavity~~

21 ~~(F) Intraoral techniques and dental radiograph armamentaria, including holding devices~~

22 ~~(G) Interproximal examination including principles of exposure, methods of retention~~
23 ~~and evaluation~~

24 ~~(H) Intraoral examination including, principles of exposure, methods of retention and~~
25 ~~evaluation~~

26 ~~(I) Identification and correction of faulty radiographs~~

27 ~~(J) Supplemental techniques including the optional use of computerized digital~~
28 ~~radiography~~

29 ~~(K) Infection control in dental radiographic procedures~~

30 ~~(L) Radiographic record management.~~

31
32 ~~Students may be given the opportunity to obtain credit by the use of challenge examinations and other~~
33 ~~methods of evaluation.~~

34 ~~(f) Laboratory Instruction. Sufficient hours of laboratory instruction shall be provided to ensure that a~~
35 ~~student successfully completes on an x-ray manikin at least the procedures set forth below. A procedure~~
36 ~~has been successfully completed only if each radiograph is of diagnostic quality. There shall be no more~~
37 ~~than 6 students per instructor during laboratory instruction.~~

38 ~~(1) Two full mouth periapical series, consisting of at least 18 radiographs each, 4 of which must~~
39 ~~be bitewings; no more than one series may be completed using computer digital radiographic~~
40 ~~equipment;~~

41 ~~(2) Two bitewing series, consisting of at least 4 radiographs each;~~

42 ~~(3) Developing or processing, and mounting or sequencing of exposed radiographs;~~

1 ~~(4) Student and instructor written evaluation of radiographs.~~

2 ~~(g) Clinical Experience. The course of instruction shall include sufficient clinical experience, as part of an~~
3 ~~organized program of instruction, to obtain clinical competency in radiographic techniques. There shall~~
4 ~~be no more than 6 students per instructor during clinical instruction. Clinical instruction shall include~~
5 ~~clinical experience on four patients with one of the four patients used for the clinical examination.~~
6 ~~Clinical experience shall include:~~

7 ~~(1) Successful completion of a minimum of four full mouth periapical series, consisting of at least~~
8 ~~18 radiographs each, 4 of which must be bitewings. Traditional film packets must be double film.~~
9 ~~No more than three series may be completed using computer digital radiographic equipment.~~
10 ~~Such radiographs shall be of diagnostic quality. All exposures made on human subjects shall only~~
11 ~~be made for diagnostic purposes, and shall in no event exceed three (3) exposures per subject.~~
12 ~~All clinical procedures on human subjects shall be performed under the supervision of a licensed~~
13 ~~dentist in accordance with section 106975 of the Health and Safety Code.~~

14 ~~(2) Developing or processing, and mounting or sequencing of exposed human subject~~
15 ~~radiographs;~~

16 ~~(3) Student and instructor written evaluation of radiographs.~~

17 ~~(h) Clinical Facilities. There shall be a written contract of affiliation with each clinical facility utilized by a~~
18 ~~course. Such contract shall describe the settings in which the clinical training will be received and shall~~
19 ~~provide that the clinical facility has the necessary equipment and accessories appropriate for the~~
20 ~~procedures to be performed and that such equipment and accessories are in safe operating condition.~~
21 ~~Such clinical facilities shall be subject to the same requirements as those specified in subdivision (g).~~

22 ~~(i) Length of Course. The program shall be of sufficient duration for the student to develop minimum~~
23 ~~competence in the radiation safety techniques, but shall in no event be less than 32 clock hours,~~
24 ~~including at least 8 hours of didactic instruction, at least 12 hours of laboratory instruction, and at least~~
25 ~~12 hours of clinical instruction.~~

26 ~~(j) Certificates. A certificate shall be issued to each student who successfully completes the course. The~~
27 ~~certificate shall specify the number of course hours completed. A student shall be deemed to have~~
28 ~~successfully completed the course if the student has met all the course requirements and has obtained~~
29 ~~passing scores on both written and clinical examinations.~~

30
31 ~~Note: Authority cited: Sections 1614 and 1656, Business and Professions Code. Reference: Section 1656,~~
32 ~~Business and Professions Code; and Section 106975, Health and Safety Code.~~

33
34 *Justification: Repealing Section 1014.1 to allow all educational requirements to be contained in Section*
35 *1014. This format is consistent with the format used in recent regulatory language for other courses,*
36 *most recently Infection Control education course.*

37 *Rationale: Provides clarity and consistency with newly established regulations for courses.*

38 *Benefit: The clarity of the proposed language offers clear guidelines for the board, course evaluators and*
39 *providers.*

40
41 (d) In addition to the requirements of Sections 1070 and 1070.1, the following criteria shall be met by a
42 course in Radiation Safety to secure and maintain approval by the board. The curriculum content

1 pertaining to radiation safety and radiography techniques offered by a school or program approved by
2 the board or Commission on Dental Accreditation for instruction in dentistry, dental hygiene or dental
3 assisting shall be deemed to be approved if the school or program has submitted evidence satisfactory
4 to the board that it meets all the requirements set forth below and shall not be subject to biennial
5 renewal unless offering a stand-alone course aside from the program in dentistry, dental hygiene and
6 dental assisting. Programs in dentistry, dental hygiene or dental assisting approved by the board or the
7 Commission prior to the effective date of these regulations shall submit to the board a completed
8 “Notice of Compliance with New Requirements for Instruction in California Radiation Safety”,
9 [Insert form number] hereby incorporated by reference, within ninety (90) days of the effective date of
10 these regulations.

11
12 *Justification: (a) Existing regulatory language from 1014.1 is retained with amendments; (b) proposed*
13 *language is consistent with the format used in recent regulatory language for educational programs in*
14 *dental assisting where curriculum for required certification is incorporated into a full program of*
15 *instruction; Notice of Compliance by existing programs and courses provides a record for the board upon*
16 *review or audit.*

17 *Rationale: Provides clarity and consistency with current educational regulations.*

18 *Benefit: The clarity of the proposed language offers clear guidelines for the board, course evaluators and*
19 *providers.*

20
21 (e) Adequate provisions for the instructor supervision and operation of the course or program of
22 instruction in Radiation Safety shall be made in compliance with Sections 1070 and 1070.1.

23
24 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
25 *educational programs in dental assisting; (b) provides enforcement support for staff and course reviewers*
26 *upon review or audit to ensure compliance with related sections previously not referenced in this Section.*

27 *Rationale: Provides direction to current and new providers and is consistent with current educational*
28 *regulations in related subjects.*

- 29
30 1. In addition, all faculty and instructional staff shall have been licensed to include a Radiation
31 Safety Certificate for a minimum of two years, and shall have the education, background,
32 and occupational experience and/or teaching expertise necessary to perform, teach, and
33 evaluate dental radiographs. Prior to instruction, all faculty and instructional staff shall
34 complete a two-hour methodology course specific to radiation safety which shall include
35 curriculum addressing clinical evaluation, and clinical criteria, course outline development,
36 test construction, and developing student learning outcomes.

37
38 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
39 *educational programs in dental assisting; (b) proposed language pertaining to teaching qualifications is*
40 *consistent with national standards for educational programs in dental disciplines.*

1 *Rationale: Provides direction and enforcement support for staff and course reviewers upon review or*
2 *audit to ensure compliance to current and new providers and is consist with current educational*
3 *regulations in related subjects.*

4 *Benefit: The clarity of the proposed language provides clear guidelines for the board, course evaluators*
5 *and providers to use upon initial application and continued application for provider status.*
6

- 7 2. Consistent with Title 17, Division 1, Chapter 5, Subchapter 4, Group 3, Article 4, Section
8 30305(b)(4), deliberate exposure of an individual to the useful beam for training or
9 demonstration purposes shall not be permitted unless there is also a medical or dental
10 indication for the exposure and the exposure is prescribed by a physician or dentist.
11 Dental assisting programs and stand-alone courses in Radiation Safety shall not be
12 required to employ a dentist or physician for the purposes of oversight during
13 laboratory or clinical instruction but must seek permission or prescription by a licensed
14 dentist for each patient utilized during clinical experiences. Additionally, all radiology
15 students in a dental assisting or registered dental assisting program or Radiation Safety
16 course must be at least 18 years of age. Dental radiographs may be prescribed for
17 pregnant patients with careful adherence to the US Department of Health and Human
18 Services, Food and Drug Administration (FDA) selection criteria guidelines. All patient's
19 used for clinical radiographic experiences must complete a health history form with
20 consent acknowledging the procedure is being performed by a student with permission
21 by a licensed dentist or the patient's dentist of record. Such documentation shall be
22 maintained in the student records. If the patient presented for exposure is a minor,
23 proper consent from the parent or legal guardian must be obtained prior to the dentist
24 authorization.
25

26 *Justification: (a) Proposed language provides information for educational providers absent from existing*
27 *regulations and is consistent with the stated requirements of the radiology health and safety codes; (b)*
28 *programs and courses have for many years requested staff clarification of the health and safety codes as*
29 *it pertains to the educational environment with mixed results – the proposed language provides clear*
30 *requirements; (c) lack of regulation pertaining to patient selection standards has led to sub-standard*
31 *criteria and lack of patient and operator protection.*

32 *Rationale: Pertaining to clinical supervision: As indicated above, the proposed language provides*
33 *direction to current and new providers and allows faculty and staff of educational programs to oversee*
34 *the instruction of students in a manner consistent with all other subjects taught within a program of*
35 *instruction. The health and safety regulations sited in Section 30305 require the exposure as prescribed by*
36 *a dentist and does not require the physical presence of one. Prior assessment of the faculty supervision*
37 *issue was addressed by COMDA yet no language exists in regulation to provide clarity consistent with*
38 *opinion currently provided to educators. Currently, programs obtain a prescription or permission letter*
39 *from a licensed dentist, or the patient's dentist of record, allowing the student to perform exposures.*
40 *Educators need for the regulations to reflect this practice as acceptable.*

1 *Pertaining to patient selection and operator criteria: The current lack of regulatory language pertaining*
2 *to student operators has led to user confusion and safety concerns. Consistent with safety standards, the*
3 *age limit for the student participating in the course of study ensures standard application of safety*
4 *measures. In addition, national standards used in dental disciplines relating to radiation safety*
5 *encourage the use of a variety of radiographic experiences whenever possible. CADAT proposes that*
6 *under the supervision of qualified faculty and staff of courses or programs students should be able to*
7 *experience procedures involving mixed dentition or edentulous patients as well as permanent dentitions*
8 *wherever possible. Clear language addressing these issues will be very helpful for school and programs*
9 *to use to establish their patient selection criteria.*

10 *Benefit: The clarity of the proposed language provides incredibly beneficial teaching opportunities for*
11 *the schools, programs and providers of the subject area and does not limit the instructional staff to only*
12 *dentists.*

13
14 (f) In addition to the requirements of Section 1070, a course in Radiation Safety shall be of sufficient
15 duration for the student to develop minimum competency in all aspects of the subject area, but in no
16 event less than 36 hours, including at least 16 hours of didactic instruction, at least 12 hours
17 of laboratory instruction performed specifically on X-ray training mannequins, and at least eight hours of
18 clinical instruction. Of the 16 hours of didactic instruction, no less than two hours shall be dedicated to a
19 review of the board's Minimum Standards for Infection Control (Cal. Code of Regs., Title 16, Section
20 1005) and no less than two hours shall be dedicated to a review of the Dental Practice Act specific to the
21 allowable duties and functions of all applicable dental disciplines, the obtaining of a license or permit to
22 practice, and all applicable patient safety requirements.

- 23 1. Prior to patient exposure, the student must provide proof of completion of board-approved
24 coursework totaling eight hours in infection control and two hours in Dental Practice Act
25 whose curriculum shall be consistent with the educational requirements set forth in Cal.
26 Code of Regs., Title 16, Article 4, Section 1016. Stand-alone course providers shall ensure
27 compliance by obtaining and retaining records of course completion from the student at the
28 time of course enrollment. Students of dental assisting and registered dental
29 assisting programs shall have completed instruction in each of the two required areas prior
30 to beginning laboratory or clinical instruction in the subject area as part of an organized
31 program of instruction.

32
33 *Justification: (a) Proposed language provides information for educational providers absent from existing*
34 *regulations and is consistent with the stated requirements of the dental assisting program regulations*
35 *already approved; (b) programs and courses have not been required to increase instructional hours to*
36 *include new technologies or advances in radiology – the proposed language provides clearer*
37 *requirements while continuing to address patient safety during clinical exposures.*

38 *Rationale: Additional time in didactic instruction is necessary to address technologies, techniques, safety*
39 *measures, personal protective equipment and a review of infection control and OSHA, particularly for*
40 *those who are newly entered into the profession. ADA Guidelines in the Use of Radiographs (JADA Vol.*
41 *137, Sept. 2006) recommend the addition of training in infection control procedures because*
42 *radiographic operators are subjected to occupational exposure to bloodborne pathogens. Based on the*

1 curriculum criteria currently required of providers, CADAT believes that the lack of quality didactic
2 instruction is contributing to an ill-prepared and unsafe operators at the end of the course.

3 *Benefits: More didactic and classroom time will lead to improved student learning outcomes. Providers
4 enrolling students without required pre-requisites is inconsistent with the requirements of other
5 certification courses – the proposed language will benefit the board staff and reviewers in assessing
6 compliance by courses and programs upon audit or review.*

- 7 2. Consistent with Title 17, Division 1, Chapter 5, Subchapter 4, Group 3, Article 4, Section
8 30305(b)(2), faculty and instructional staff shall provide California radiation health and
9 safety rules to each student operating X-ray equipment including any restrictions of the
10 operating technique required for the safe operation of the particular X-ray apparatus,
11 and require that each student demonstrate competence with these safety rules by
12 written examination prior to operating X-ray equipment in either laboratory or clinical
13 assignments.
- 14 3. A written safety exam as described in subsection(m) and a comprehensive final exam shall
15 be successfully completed by each student prior to the completion of the course or program
16 of instruction. All written examinations shall be issued and administered in a manner
17 consistent with all licensing examinations administered by the state or national testing
18 boards. Each student must successfully pass the radiation safety and final exams prior to
19 completion of the course and may use a current passing score from the DANB radiation
20 certification examination in lieu of a comprehensive final exam.
- 21 4. A detailed course outline shall be established and maintained consistent with Section
22 1070(i) and shall be provided to students prior to the start of instruction.

23
24 *Justification: (a) Proposed language provides information for educational providers absent from existing*
25 *regulations and is consistent with national requirements for dental disciplines in radiation safety; (b)*
26 *programs and courses have not been required to administer examinations in a manner consistent with*
27 *standardized testing – specifically, those providers offering open-book or oral testing reviews as opposed*
28 *to traditional testing mechanisms using appropriate psychometrics has led to lack of proven competency*
29 *testing prior to exposures on mannequins or patients; (c) COMDA established criteria years ago requiring*
30 *examination of radiation safety theory prior to progressing to mannequin and clinical patient exposures*
31 *– absent from the regulations for many years, the proposed language provides a standardized criteria for*
32 *patient safety and operator protection PRIOR to continued competency performances. Health and Safety*
33 *Code 30305(a)(5)(b1-2) addresses the educator must provide safety rules to each operator under their*
34 *instruction.*

35 *Rationale: CADAT believes that the lack of quality didactic instruction in Radiation Safety for both*
36 *patients and operators has led to ill-prepared clinicians upon entering into the dental workplace. Safety*
37 *measures and compliance with safety standards are not enforced without specific educational*
38 *requirements.*

39
40 (g) Providers of Radiation Safety courses and programs of instruction in dental assisting shall issue wall
41 certificates of completion and/or board-approved Course Completion Certification cards to each student
42 as follows:

1 (1) For stand-alone courses in Radiation Safety, wall certificates of course completion shall be
2 issued to demonstrate compliance with educational requirements in the subject area and
3 shall include the providers name, board-approved course provider number, total hours of
4 instruction completed, and certification signature indicating successful completion of a
5 board-approved course of instruction.

6 (A) In addition, Course Completion Certification Cards[insert form number] hereby
7 incorporated by reference shall be issued to each participant upon successful
8 completion of the course. Each card shall transmit to the board the name, address, and
9 date of birth of each course completer, all provider information, date(s) of the course,
10 course approval code issued by the board, and certification by signature verifying
11 completion requirements. Programs in dentistry and dental hygiene approved by the
12 Commission shall be exempt from this requirement unless offering a stand-alone
13 certification course.

14 (2) Programs in dental assisting and registered dental assisting approved by the board or
15 Commission shall issue wall certificates of completion in Radiation Safety to students
16 successfully completing and graduating from the program for use by the graduate to
17 demonstrate to an employer their ability to legally perform X-ray exposures in the event the
18 graduate does not obtain licensure.

19 (A) Certificates of program completion or diplomas from a dental assisting or registered
20 dental assisting program approved by the board shall be deemed “all inclusive” for the
21 purposes of applying for the RDA licensure examination; however, Course Completion
22 Cards may also be issued to program graduates in the event the graduate does not file
23 for examination by the formal education pathway. Programs shall be identified on the
24 card using their DA or RDA program provider number issued by the board.

25 (B) Completion of some or all of the curriculum in California Radiation Safety as part of a
26 total program of instruction for dental assisting or registered dental assisting approved
27 by the board where the student does not successfully complete and graduate from the
28 program does not allow for certification in Radiation Safety unless the institution is
29 approved as a stand-alone provider in the subject area. In such case, all documentation
30 requirements of a stand-alone provider shall be adhered to.

31
32 *Justification: (a) Proposed language provides clarifying information for educational providers absent*
33 *from existing regulations and is consistent with the stated requirements of the dental assisting program*
34 *regulations already approved; (b) courses have not been required to issue proof of educational*
35 *compliance for those newly entering the workforce where programs have been required to issue specific*
36 *documentation – the proposed requirement provides consistency for both programs and course*
37 *providers; (c) language addresses DA and RDA program certificate issuance that is considered*
38 *“programmatic” and where lack of regulatory language has led to staff interpretation of the intent of a*
39 *program.*

40 *Rationale: In the past, the use of Course Completion Cards issued by COMDA provided proof to not only*
41 *employers but also the necessary certifications for the Board to evaluate an examination candidate’s*
42 *application for licensure. By establishing the past practice again, the board and workforce will have the*

1 *documentation needed to show educational requirements have been met by a board-approved provider*
2 *or school.*

3 *Benefits: The clarity and necessity of the proposed language provides clear guidelines for the board,*
4 *course evaluators, providers and workforce to use upon completion of certification requirements. The*
5 *issuance of board-approved cards for certification will assist in making all providers more accountable to*
6 *ensure course completers are adequately prepared and credentialed to enter into the workplace.*

7
8 (h) In addition to the requirements of Section 1070, there shall be a sufficient number of safe, adequate,
9 and educationally conducive lecture classrooms, radiography operatories, developing or processing
10 facilities as defined in subdivision (2) below, and viewing spaces for mounting, recording and evaluating
11 radiographs. Adequate cleaning, disinfecting and sterilizing facilities shall be provided in accordance
12 with Section 1070 and all disinfection and sterilization procedures specified in the Board's Minimum
13 Standards for Infection Control (Cal. Code of Regs., Title 16, Section 1005) shall be incorporated in
14 instruction and followed during all laboratory and clinical experiences.

15
16 (1) A radiographic operatory shall be deemed adequate if it is properly equipped with supplies
17 and equipment for practical work and includes, for every six students, at least the following:

18 (A) One functioning radiography (X-ray) machine which is adequately filtered and
19 collimated that is equipped with the appropriate position-indicating devices for
20 each technique being taught, and is properly registered and permitted in
21 compliance with the Department of Health Services and the California Radiation
22 Safety Regulations (Title 17, Cal. Code of Regulations, commencing with Section
23 30100);

24 (B) One X-ray training mannequin head designed for instruction in radiographic
25 techniques per X-ray unit;

26 (C) One film view box per operatory;

27 (D) One lead impregnated adult-size X-ray apron with cervical (thyroid) collar, either
28 attached or detached from the apron, per X-ray unit;

29 (2) The area shall be deemed adequate if it is of sufficient size to accommodate students' needs
30 in learning and is properly equipped with supplies and equipment for practical work which
31 may include processing and viewing equipment or any combination thereof. Such facility
32 requirements may be deemed met if computer-based equipment for digital radiographic
33 procedures is solely or in part utilized within the program or course facility and where such
34 equipment may be located in the operatory area where exposures will occur.

35 (3) X-ray exposure areas shall provide protection to patients, students, faculty and observers in
36 full compliance with applicable statutes and regulations.

37
38 *Justification: (a) Proposed language provides information for educational providers absent from existing*
39 *regulations and is more consistent with national standards for instruction in the subject area, allowing*
40 *for more modernized equipment options; (b) programs and courses have not been required to use*
41 *training mannequins specifically designed for instruction in radiography causing schools and course*
42 *providers to differ in meeting their obligation— the proposed requirement provides consistency for both*

1 *programs and courses; (c) the proposed language provides clarity and necessity for board staff and*
2 *program evaluators to utilize during site visits and course approvals.*

3 *Rationale: Clarification was needed to ensure equipment usage by providers and schools was consistent.*
4 *Proposed language allows for a wide variety of modern and emerging technologies for both traditional*
5 *and non-traditional imaging.*

6 *Benefits: Broadened language for equipment will ensure that all providers and schools have the*
7 *opportunity to meet requirements with or without the incorporation of modern technologies, allowing*
8 *for programs without funding to continue to operate using more traditional equipment and those with*
9 *the ability to purchase advanced technologies to do without consequence.*

10
11 (i) As part of an organized program of instruction, sufficient time shall be available for all students to
12 obtain applicable theory in didactic instruction, laboratory, and preclinical/clinical instruction and
13 experience to achieve minimum competence in the various protocols and procedures used in the
14 application of dental radiographic techniques and radiation safety.

15
16 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
17 *educational programs in dental assisting; (b) provides enforcement support for staff and course*
18 *reviewers upon review or audit to ensure compliance with related sections previously not referenced in*
19 *this Section.*

20 *Rationale: Provides direction to current and new providers and is consistent with current educational*
21 *regulations in related subjects.*

22
23 (j) Didactic Instruction: Areas of didactic instruction shall include at least the following as they relate to
24 exposure, processing and evaluation of dental radiographs:

- 25 (1) Radiation physics and biology
- 26 (2) Radiation protection and safety
- 27 (3) Recognition of normal anatomical landmarks, structures, hard and soft tissues, normal and
28 abnormal conditions of the oral cavity as they relate to dental radiographs (D) Radiograph
29 exposure and processing techniques including exposure guidelines for ALARA and
30 recommendations for exposure by the American Dental Association
- 31 (4) Radiograph mounting or sequencing, and viewing, including anatomical landmarks of the
32 oral cavity
- 33 (5) Intraoral techniques and dental radiograph armamentaria, including holding devices and
34 image receptors
- 35 (6) Intraoral and extraoral examination including principles of exposure, methods of retention
36 and evaluation
- 37 (7) Proper use of patient protection devices and personal protective equipment for operator
38 use
- 39 (8) Identification and correction of faulty radiographs
- 40 (9) Introduction to contemporary exposure techniques including the use of computerized
41 digital radiography and extraoral imaging which may include panoramographs or cone-beam
42 imaging

1 (10) Infection control procedures contained in the Board’s Minimum Standards for Infection
2 Control(Cal. Code of Regs., Title 16, Section 1005) and Cal-DOSH Bloodborne Pathogens
3 Standards

4 (11) Radiographic records management

5 (12) Identification and recognition of common errors in techniques and processing for intra and
6 extra oral exposures

7 (13) Identification of various extra oral techniques, machine types, and uses

8 (14) Introduction to techniques and exposure guidelines for special exposures to include, but
9 not limited to pediatric, edentulous, partially edentulous, endodontic and patients with
10 special needs

11 (15) Review of general provisions of the California Dental Practice Act

12
13 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
14 *educational programs in dental assisting; (b) provides minimal amendments to existing curriculum in*
15 *programs and courses with some modernization of topic areas.*

16 *Rationale: Provides direction to current and new providers and is more consist with current national*
17 *standards for education in the subject area.*

18 *Benefits: Minimal changes to curriculum that provide some clarification while including emerging*
19 *technologies newly adopted into the workplace.*

20
21 (k) Laboratory Instruction: Sufficient hours of laboratory instruction and experiences shall ensure that a
22 student successfully completes, on an x-ray training mannequin head only, at least the procedures set
23 forth below:

24
25 (1) Two full mouth periapical series, consisting of at least 18 radiographs each, four of which
26 must be bitewings;

27 (2) Two horizontal or vertical bitewing series, consisting of at least four radiographs each;

28 (3) Developing, digitizing or processing, and mounting or sequencing of exposed radiographs;

29 (4) Completion of student and instructor written evaluation of radiographs identifying errors,
30 causes of errors, corrections and, if applicable, the number of re-exposures necessary for
31 successful completion of a series to minimum competency.

32 (A) A laboratory procedure has been successfully completed only if each series of
33 radiographs is evaluated and deemed to be of diagnostic quality.

34 (B) In accordance with the requirements of Section 1070, students shall be provided
35 with written competencies identifying specific objective evaluation criteria and
36 performance objectives for all laboratory experiences.

37 (C) Notwithstanding Section 1070.1, there shall be no more than six students per
38 instructor during laboratory instruction and experiences.

39 (D) Successful completion of all laboratory competencies must occur prior to clinical
40 instruction and experiences.

1 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
2 *educational programs in dental assisting; (b) provides minimal amendments to existing laboratory*
3 *curriculum in programs and courses with some modernization of topic areas; (c) makes student/teacher*
4 *ratios for laboratory consistent with Health and Safety standards for radiology and reduces the number*
5 *of students per instructor from seven to six for more consistency with all other certifications involving*
6 *patient-based procedures.*

7 *Rationale: Provides direction to current and new providers and is more consist with current national*
8 *standards for education in the subject area.*

9 *Benefits: Minimal changes to lab instruction that provide some clarification while including emerging*
10 *technologies newly adopted into the workplace.*

11
12 (l) Clinical Instruction and Evaluation: As part of an organized program of instruction clinical instruction
13 shall include clinicalperformances on human subjects as set forth below and only after each patient has
14 met the requirements as set forth in Section (e)(2) herein:

15
16 (1) Successful completion of a minimum of four full mouth periapical series, consisting of at
17 least 18 radiographs each, four of which must be bitewings utilizing either traditional
18 films or computerized digital radiographic equipment, if utilized by the program or
19 course, or a combination of both. All exposures made on human subjects shall only be
20 made using diagnostic criteria established during the clinical instructional period, and
21 shall in no event exceed three re-exposures per subject per series.

22 (2) Successful developing or processing, and mounting or sequencing of exposed human
23 subject radiographs;

24 (3) Completion of student and instructor written evaluations of each radiographic series
25 identifying errors, causes of error, and correction and, if applicable, the number of re-
26 exposures necessary for successful completion of a series to clinical competency.

27 (4) One full-mouth clinical series shall serve a final clinical examination.

28 (A) In accordance with the requirements of Section 1070, students shall be provided
29 with written competencies identifying specific objective evaluation criteria and
30 performance objectives for all clinical experiences.

31 (B) Notwithstanding Section 1070.1, there shall be no more than six studentsper
32 instructor during clinical instruction and experiences.

33
34 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
35 *educational programs in dental assisting; (b) provides minimal amendments to existing curriculum in*
36 *programs and courses with some modernization of topic areas;(c) makes student/teacher ratios for*
37 *clinical consistent with Health and Safety standards for radiology and reduces the number of students*
38 *per instructor from seven to six for more consistency with all other certifications involving patient-based*
39 *procedures.*

40 *Rationale: Provides clearer direction to current and new providers and is more consist with current*
41 *national standards for education in the subject area; provides enforcement support for staff and course*

1 *reviewers for use during course review or audit to ensure compliance in areas previously not addressed in*
2 *this Section.*

3 *Benefits: Minimal changes to curriculum that provide more specific direction for the user.*
4

5 (m) Successful completion of a written examination in radiation health and safety must occur prior to
6 laboratory and clinical instruction and experiences. At minimum, the written examinations for Radiation
7 Safety shall include questions specific to items addressed in the State Radiation Health and Safety
8 Rules (Title 17, Division 1, Chapter 5, Subchapter 4, Group 3, Article 4, Section 30305, 30306 and 30311),
9 and shall be constructed and administered in a manner consistent with all licensing examinations
10 administered by the state or national testing boards.

11
12 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
13 *educational programs in dental assisting; (b) provides enforcement support for staff and course*
14 *reviewers upon review or audit to ensure compliance with related sections previously not referenced in*
15 *this Section.*

16 *Rationale: Provides more clarity and direction to current and new providers and is consist with current*
17 *educational regulations in related subjects. Examination content provides specific direction to educators*
18 *preparing and administering the examinations with clarification as to the content needed to be covered*
19 *in the course of instruction and testing.*
20

21 (n) Extramural dental facilities may be utilized by a program or course for the purposes of radiographic
22 laboratory and clinical competencies provided the faculty or instructional staff is present at all times.
23 There shall be a written contract of affiliation with each clinical facility utilized by a course or program.
24 Such contract shall describe the settings in which extramural dental facility will be used, cancellation
25 terms and conditions, and shall provide that the clinical facility has the necessary equipment and
26 armamentaria appropriate for the procedures to be performed. Such clinical facilities shall be subject to
27 the same requirements as those specified herein.

28
29 (1) If an extramural dental facility is utilized, students shall be provided with planned,
30 supervised clinical instruction by faculty or instructional staff at all times. Didactic and
31 laboratory instruction shall be performed by program or course faculty or instructional staff
32 and shall not be provided in an extramural dental facility.

33 (2) The program or course director, or a designated faculty member, shall be responsible for
34 selecting extramural clinical sites.

35 (3) Programs and courses using extramural faculty for a Radiation Safety course shall provide to
36 the board, upon request or renewal of provider status, if applicable, copies of all contracts
37 of affiliation and documentation demonstrating compliance with this Section.
38

39 *Justification: (a) Proposed language is consistent with the format used in recent regulatory language for*
40 *educational programs in dental assisting; (b) provides minimal amendments to existing programs or*
41 *courses utilizing extramural facilities (EMFs) for instruction.*

- 1 *Rationale: Provides more clarity and direction to current and new providers and is applicable to current*
- 2 *educational environments using EMFs. The proposed language establishes more defined parameters for*
- 3 *schools and institutions.*
- 4 *Benefits: Elimination of the guesswork in defining what an EMF is and how supervision can and should*
- 5 *be addressed. Supervision is an open-issue at present and CADAT believes this language will help to*
- 6 *alleviate some of the confusion with these regulations.*

Dental Board of California

2005 Evergreen Street, Suite 1550, Sacramento, California 95815

P (916) 263-2300 | F (916)263-2140 | www.dbc.ca.gov



Application for Renewal – Stand-Alone Course Provider

An application for provider renewal of a stand-alone certification course in Infection Control, Radiation Safety, Coronal Polishing, Pit and Fissure Sealants or Ultrasonic Scaling for Orthodontic Cement Renewal is required biennially with supporting documentation. A non-refundable application fee of \$300 must be enclosed with each renewal application and report. Required documentation is detailed on page 2 of the application.

Non-Refundable Fee Application: \$300 for each provider renewal application.	For Office Use Only Rec # _____ Fee Paid: _____ Date Cashiered: _____		Date Received: _____ Date Reviewed: _____ Date Renewal Notification Issued: _____						
	For Office Use Only Reviewed By: _____ Provider Code: _____ Course Type Being Renewed:								
	IC		CP		P/F		US		RS

Provider Data:

1. Current Course Provider Number:		2. Date of Initial Approval of Course:	
3. Name of Provider Business or Entity:			
4. Street Address:			
5. City, State, Zip Code:			
6. Name of Course Director:			
7. Telephone Number (Include area code):		8. Fax Number (Include area code):	
9. Type of Provider: (check one)			
<input type="checkbox"/> Institutional School	<input type="checkbox"/> Private Business	<input type="checkbox"/> Dental Society	<input type="checkbox"/> Professional Organization
<input type="checkbox"/> Government Agency	<input type="checkbox"/> Educational Institute	<input type="checkbox"/> Dental Specialty Group	<input type="checkbox"/> Other
FEIN or SSN #		Corporation #	

Documentation Requirements:

1. Submit a list detailing each course offered during the renewal period that includes the following data and supporting documentation:
 - Date(s) of each course offered
 - Name(s) of instructor(s) for each course offered
 - Number of students enrolled in each course offered
 - Number of hours taught in didactic, laboratory/preclinical and clinical instruction with a list of student/teacher ratios for each area of instruction
 - Copy of course roster from each course date with student's name, when the student started and completed the course, and the date of certificate issuance including wall certificates and Course Completion Cards as required by applicable regulation
2. Submit a listing of all faculty/instructional staff used to teach the course including the course director with the following data and supporting documentation:
 - Name and credentials including license numbers for each instructor including the course director
 - Date of hire of each instructor of the course
 - Copies of all licenses and certificates as required by regulation to teach the course including methodology certification, licenses, permits, and CPR (if applicable)
 - Description of each instructor's qualifications, experience and background in the subject area being taught
3. If applicable, submit a listing of each facility used during the renewal period for clinical instruction and experiences if other than the principal location of the business or entity.
4. Provide a sample of the wall certificate of completion issued to the student upon course completion.
5. Provide a sample of a completed board-approved Course Completion Card issued to the student upon course completion.
6. Provide a copy of each of the following required documents (CCR §1070) currently being used by the course:
 - A copy of the detailed course outline stating all the required elements as defined in CCR §1070(i)
 - A copy of each of competency (evaluation) forms used in the course for laboratory and clinical experiences in each required area as defined by the regulations for the specific course of study
 - A copy of the written standards of performance objectives and evaluation criteria issued to each student prior to performance evaluation
 - A copy of the courses written laboratory and clinical protocols for infection control
 - A copy of the courses current protocols for ensuring all required pre-requisites have been met prior to the start of instruction; protocols shall include the specific documents required at the time of course enrollment and the manner in which the provider retains the records in the event of an audit
7. Provide a copy of all instructional materials issued to students and used for instruction in the subject area
8. Provide a description of the written evaluation method used for measuring theoretical competency including the number of questions, the type of questions, the method of administration, the required pass rate, and the point of issuance within the total course of instruction

Certification:

I certify under the penalty of perjury under the laws of the State of California that the statements made in the application are true and correct, and that all courses offered for certification meet the current requirements set forth by the Board.

Signature of Course Director

Date

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 2005 Evergreen Street, Suite 1500, Sacramento, CA 95815, Executive Officer, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq. Except for Social Security numbers, the information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Disclosure of your Social Security number is mandatory and collection is authorized by §30 of the Business & Professions Code and Pub. L. 94-455 (42 U.S.C.A. §405(c)(2)(C)). Your Social Security number will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination Board, and where licensing is reciprocal with the requesting state. If you fail to disclose your Social Security number, you may be reported to the Franchise Tax Board and be assessed a penalty of \$100. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the name(s) and address(es) submitted may, under limited circumstances, be made public.

RADIATION SAFETY (X-RAY) – CERTIFICATE OF COURSE COMPLETION

Type or Print Data

Participant Name:		Date of Birth: (MM/DD/YYYY)	
Street Address:		<i>I hereby certify under penalty of perjury under the laws of the State of California that the bearer of this card successfully completed a stand-alone course in Radiation Safety as required by CCR §1014 that included at least 36 hours of instruction involving no less than sixteen (16) hours of didactic, twelve (12) hours of laboratory, and eight (8) hours of clinical instruction and experiences involving at least four (4) patients and has demonstrated minimum proficiency and clinical competency in this function.</i>	
City/Zip:			
Signature of Course Participant:			
Name of Course Provider:			
Street Address:			
City/Zip:			
Date(s) of Course:			
_____ Signature of Course Instructor		_____ Signature of Course Director	
_____ DBC Approved Course #:		Provider Stamp or School Seal	

This card is to be completed by course provider and issued to student upon course completion.

NOTICE: Course Completion Certification cards are to be used as proof of completion of a Board-approved course when issued to the Dental Board of California as part of an application for licensure and may be used as notification of certification to an employer.

For Office Use Only:

Date Received:	Date Recorded:	File #:	Recorded By:

Dental Board of California * 2005 Evergreen Street, Suite 1550 * Sacramento, CA 95815

RADIATION SAFETY (X-RAY) – CERTIFICATE OF COURSE COMPLETION

Type or Print Data

Participant Name:		Date of Birth: (MM/DD/YYYY)	
Street Address:		<i>I hereby certify under penalty of perjury under the laws of the State of California that the bearer of this card successfully completed a stand-alone course in Radiation Safety as required by CCR §1014 that included at least 36 hours of instruction involving no less than eight (8) hours of didactic, twelve (12) hours of laboratory, and eight (8) hours of clinical experiences involving at least four (4) patients and has demonstrated minimum proficiency and clinical competency in this function.</i>	
City/Zip:			
Signature of Course Participant:			
Name of Course Provider:			
Street Address:			
City/Zip:			
Date(s) of Course:			
_____ Signature of Course Instructor		_____ Signature of Course Director	
_____ DBC Approved Course #:		Provider Stamp or School Seal	

This card is to be completed by course provider and issued to student upon course completion.

NOTICE: Course Completion Certification cards are to be used as proof of completion of a Board-approved course when issued to the Dental Board of California as part of an application for licensure and are not intended to be used as notification of certification to an employer.

For Office Use Only:

Date Received:	Date Recorded:	File #:	Recorded By:

Dental Board of California * 2005 Evergreen Street, Suite 1550 * Sacramento, CA 95815

Performing X-Ray Functions: Completion of a Board-approved certification course allows you to perform the function as an unlicensed dental healthcare worker and will meet application requirements for those seeking to obtain a license as a Registered Dental Assistant. Dental radiographs (x-rays) are an allowable duty of an unlicensed dental assistant under general supervision of a licensed dentist.

Unlicensed Assistants: As the bearer of this card, it is your responsibility to submit the original card (no copies) to the Dental Board of California at the time of application for examination to become a Registered Dental Assistant. Instructions for application completion, filing, and mailing of certification documents can be found on the application for examination available through the Dental Board or on-line at www.dbc.ca.gov. It is not the course provider's responsibility to submit certification course cards to the Board.

Provider Responsibilities: This card is to be used by stand-alone course providers. Approved providers are required by law to ensure all participants have met mandatory pre-requisites prior to enrollment in a certification course. Upon conclusion of each course, a Report of Participant Course Completion must be filed with the Board within 30 days. Wall-sized certificates of course completion should be issued to all participants to meet employment requirements.

Dental Board of California * 2005 Evergreen Street, Suite 1550 * Sacramento, CA 95815

RHS Cert – Rev. 10/2012

Performing X-Ray Functions: Completion of a Board-approved certification course allows you to perform the function as an unlicensed dental healthcare worker and will meet application requirements for those seeking to obtain a license as a Registered Dental Assistant. Dental radiographs (x-rays) are an allowable duty of an unlicensed dental assistant under general supervision of a licensed dentist.

Unlicensed Assistants: As the bearer of this card, it is your responsibility to submit the original card (no copies) to the Dental Board of California at the time of application for examination to become a Registered Dental Assistant. Instructions for application completion, filing, and mailing of certification documents can be found on the application for examination available through the Dental Board or on-line at www.dbc.ca.gov. It is not the course provider's responsibility to submit certification course cards to the Board.

Provider Responsibilities: This card is to be used by stand-alone course providers. Approved providers are required by law to ensure all participants have met mandatory pre-requisites prior to enrollment in a certification course. Upon conclusion of each course, a Report of Participant Course Completion must be filed with the Board within 30 days. Wall-sized certificates of course completion should be issued to all participants to meet employment requirements.

Dental Board of California * 2005 Evergreen Street, Suite 1550 * Sacramento, CA 95815

RHS Cert – Rev. 10/2011



90-DAY NOTICE OF COMPLIANCE WITH NEW REQUIREMENTS FOR REGISTERED PROVIDERS - RADIATION SAFETY CERTIFICATION COURSES

To maintain approval by the Board, the Course Director of each California Radiation Safety certification course that was approved prior to the date that Cal. Code Regs., Title 16, Sections 1041 became effective must complete and submit this form to the Board at its offices no later than 90 days from the effective date of these new requirements. Any certification or Course Completion Card issued to a student graduating from such a course will not be recognized by the Board until such time as the course certifies compliance with all new educational requirements.

I, (enter full name),

the Course Director for _____
(enter full name of institution or program)

DO HEREBY CERTIFY:

- 1) That I have read the attached regulations pertaining to the approval and renewal of the certification course in Radiation Safety for which I/the institution/business entity/organization is currently approved, including Sections 1014, 1070 and 1070.1 of Title 16 of the California Code of Regulations,
- 2) That I have the authority to sign this notice on behalf of the educational institution, program or business entity, and,
- 3) That the institution, business entity, group or organization adopted all the necessary changes to the current course to comply with these new regulations as of the date indicated below with my signature.

I certify under penalty of perjury under the laws of the State of California that this Notice of Compliance is true and correct.

Signature of Course Director

Date

Printed Name of Course Director: _____ Name of Educational Institution, Business Entity, Organization or

Group: Address of Educational Institution or Program:

Telephone Number: _____ Email Address: _____

NOTICE OF COLLECTION OF PERSONAL INFORMATION

Disclosure of your personal information is mandatory. The information on this application is required pursuant to Cal. Code Regs., Title 16, Sections 1070, 1070.1 and 1070.2. Failure to provide any of the required information will result in the form being rejected as incomplete and your approval may be withdrawn for noncompliance. The information provided will be used to determine compliance with Article 2 of Division 10 of Title 16 of the California Code of Regulations (beginning at Section 1070). The information collected may be transferred to other governmental and enforcement agencies. Individuals have a right of access to records containing personal information pertaining to that individual that are maintained by the Board, unless the records are exempted from disclosure by Section 1798.40 of the Civil Code. Individuals may obtain information regarding the location of his or her records by contacting the Executive Officer at the Board at the address and telephone number listed above.

REGULATIONS PERTAINING TO THE APPROVAL AND CONTINUED APPROVAL OF COURSE IN RADIATION

Title 16 of the California Code of Regulations

CCR §1070:

General Provisions Governing All Dental Assistant Educational Programs and Courses

- (a) (1) The criteria in subdivisions (b) to (j), inclusive, shall be met by a dental assisting program or course and all orthodontic assisting and dental sedation assisting permit programs or courses to secure and maintain approval by the Board as provided in this article.
- (2) The Board may approve, provisionally approve, or deny approval of any program or course for which an application to the Board for approval is required. All Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) programs and dental assisting educational courses shall be re-evaluated approximately every seven years, but may be subject to re-evaluation and inspection by the Board at any time to review and investigate compliance with this article and the Act. Re-evaluation may include a site visit or written documentation that ensures compliance with all regulations. Results of re-evaluations shall be reported to the Board or its designee for final consideration and continuance of program or course approval, provisional approval and denial of approval.
- (3) Program and course records shall be subject to inspection by the Board at any time.
- (4) The Board may withdraw approval at any time that it determines that a program or course does not meet the requirements of this article or any other requirement in the Act.
- (5) All programs and courses shall be established at the postsecondary educational level or deemed equivalent thereto by the Board.
- (6) The Board or its designee may approve, provisionally approve, or deny approval to any such program. Provisional approval shall not be granted for a period which exceeds beyond the length of the program. When the Board provisionally approves a program, it shall state the reason therefore. Provisional approval shall be limited to those programs which substantially comply with all existing standards for full approval. A program given provisional approval shall immediately notify each student of such status. If the Board denies approval of a program, the specific reason therefore shall be provided to the program by the Board in writing within 90 days after such action.
- (b) The program or course director shall possess a valid, active, and current license issued by the Board or the dental hygiene committee. The program or course director shall actively participate in and be responsible for the administration of the program or course. Specifically, the program or course director shall be responsible for the following requirements:
- (1) Maintaining for a period of not less than five years copies of curricula, program outlines, objectives, and grading criteria, and copies of faculty credentials, licenses, and certifications, and individual student records, including those necessary to establish satisfactory completion of the program or course.
- (2) Informing the Board of any major change to the program or course content, physical facilities, or faculty, within 10 days of the change.
- (3) Ensuring that all staff and faculty involved in clinical instruction meet the requirements set forth in this article.
- (c) Course faculty and instructional staff shall be authorized to provide instruction by the program or course director and the educational facility in which instruction is provided.
- (d) No faculty or instructional staff members shall instruct in any procedure that he or she does not hold a license or permit in California to perform. Each faculty or instructional staff member shall possess a valid, active, and current license issued by the Board or the Dental Hygiene Committee of California, shall have been licensed or permitted for a minimum of two years and possess experience in the subject matter he or she is teaching. An instructor who has held a license as a registered dental assistant or registered dental assistant in extended functions for at least two years, who then becomes a permit holder as an Orthodontic Assistant on or after January 1, 2010 shall not be required to have held such permit for two years in order to instruct in the subject area.

(e) A certificate, diploma, or other evidence of completion shall be issued to each student who successfully completes the program or course and shall include the following: the student's name, the name of the program or course, the date of completion, and the signature of the program or course director or his or her designee.

(f) Facilities and class scheduling shall provide each student with sufficient opportunity, with instructor supervision, to develop minimum competency in all duties for which the program or course is approved to instruct.

(1) The location and number of general use equipment and armamentarium shall ensure that each student has the access necessary to develop minimum competency in all of the duties for which the program or course is approved to instruct. The program or course provider may either provide the specified equipment and supplies or require that the student provide them. Nothing in this section shall preclude a dental office that contains the equipment required by this section from serving as a location for laboratory instruction.

(2) Clinical instructions shall be of sufficient duration to allow the procedure to be performed to clinical proficiency. Operatories shall be sufficient in number to allow a ratio of at least one operatory for every five students who are simultaneously engaged in clinical instruction.

(A) Each operatory shall contain functional equipment, including a power-operated chair for patient or simulation-based instruction in a supine position, operator and assistant stools, air-water syringe, adjustable light, oral evacuation equipment, work surface, handpiece connection, and adjacent hand-washing sink.

(B) Each operatory shall be of sufficient size to simultaneously accommodate one student, one instructor, and one patient or student partner.

(C) Prior to clinical assignments, students must demonstrate minimum competence in laboratory or preclinical performance of the procedure they will be expected to perform in their clinical experiences.

(g) The program or course shall establish written clinical and laboratory protocols that comply with the Board's Minimum Standards for Infection Control (Cal. Code of Regs., Title 16, Section 1005) and other federal, state, and local requirements governing infection control. The program or course shall provide these protocols to all students, faculty, and instructional staff to ensure compliance. Adequate spaces shall be provided for handling, processing and sterilizing all armamentarium.

(h) A written policy on managing emergency situations shall be made available to all students, faculty, and instructional staff. All faculty and staff involved in the direct oversight of patient care activities shall be certified in basic life support procedures, including cardiopulmonary resuscitation. Recertification intervals may not exceed two years. The program or course director shall ensure and document compliance by faculty and instructional staff. A program or course shall sequence curriculum in such a manner so as to ensure that student's complete instruction in basic life support prior to performing procedures on patients used for clinical instruction and evaluation.

(i) A detailed program or course outline shall clearly state, in writing, the curriculum subject matter, hours of didactic, laboratory, and clinical instruction, general program or course objectives, instructional objectives, theoretical content of each subject, and, where applicable, the use of practical application. Objective evaluation criteria shall be used for measuring student progress toward attainment of specific program or course objectives. Students shall be provided with all of the following:

(1) Specific performance objectives and the evaluation criteria used for measuring levels of competence for each component of a given procedure including those used for examinations.

(2) Standards of performance that state the minimum number of satisfactory performances that are required for each performance-evaluated procedure.

(3) Standards of performance for laboratory, preclinical, and clinical functions, those steps that would cause the student to fail the task being evaluated, a description of each of the grades that may be utilized during evaluation procedures, and a defined standard of performance.

(j) (1) If an extramural dental facility is utilized, students shall, as part of an extramural organized program of instruction, be provided with planned, supervised clinical instruction. Laboratory and preclinical instructions shall be performed under the direct supervision of program or course faculty or instructional staff and shall not be provided in an extramural dental facility.

(2) The program or course director, or a designated faculty member, shall be responsible for selecting extramural clinical sites and evaluating student competence before and after the clinical assignment.

(3) Prior to student assignment in an extramural dental facility, the program or course director, or a designated faculty or instructional staff member, shall orient dentists and all licensed dental healthcare workers whom they provide instruction, evaluation and oversight of the student in the clinical setting. Orientations shall include, at a minimum, the objectives of the program or course, the student's preparation for the clinical assignment, and a review of procedures and criteria to be used by the dentist or the licensed personnel in the extramural dental facility in evaluating the student during the assignment, which shall be the same as the evaluation criteria used within the program or course.

(4) There shall be a written contract of affiliation between the program and each extramural dental facility that includes a written affirmation of compliance with the regulations of this Article.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1750, 1750.2, 1750.4, 1752.1, 1752.4, 1752.6, and 1753, Business and Professions Code.

CCR §1070.1:

Educational Program and Course Definitions and Instructor Ratios

As used in this article, the following definitions shall apply:

- (a) "Clinical instruction" means instruction in which students receive supervised experience in performing procedures in a clinical setting on patients. Clinical procedures shall only be allowed upon successful demonstration and evaluation of laboratory and preclinical skills. There shall be at least one instructor for every six students who are simultaneously engaged in clinical instruction.
- (b) "Didactic instruction" means lectures, demonstrations, and other instruction involving theory that may or may not involve active participation by students. The faculty or instructional staff of an educational institution or approved provider may provide didactic instruction via electronic media, home study materials, or live lecture modality.
- (c) "Extramural dental facility" means any clinical facility utilized by a Board-approved dental assisting educational program for instruction in dental assisting that exists outside or beyond the walls, boundaries or precincts of the primary location of the Board-approved program and in which dental treatment is rendered.
- (d) "Laboratory instruction" means instruction in which students receive supervised experience performing procedures using study models, mannequins, or other simulation methods. There shall be at least one instructor for every 14 students who are simultaneously engaged in instruction.
- (e) "Preclinical instruction" means instruction in which students receive supervised experience within the educational facilities performing procedures on simulation devices or patients which are limited to students, faculty, or instructional staff members. There shall be at least one instructor for every six students who are simultaneously engaged in instruction.
- (f) "Simulated clinical instruction" means instruction in which students receive supervised experience performing procedures using simulated patient heads mounted in appropriate position and accommodating an articulated typodont in an enclosed intraoral environment, or mounted on a dental chair in a dental operatory. Clinical simulation spaces shall be sufficient to permit one simulation space for each 2 students at any one time.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1750, 1750.2, 1750.4, 1752.1, 1752.4, 1752.6, and 1753, Business and Professions Code.

CCR §1014:

Radiation Safety Courses – Approval; Continued Approved Status for Stand-Alone Courses in Radiation Safety; Curriculum Requirements; Issuance of Certification

**Subcommittee and Staff
Recommended
Proposed Language**

1 TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS
2 DIVISION 10. DENTAL BOARD OF CALIFORNIA

3
4 SUBCOMMITTEE AND STAFF RECOMMENDED
5 PROPOSED LANGUAGE
6

7 Amend Sections 1014 and 1014.1 of Article 3.1 of Chapter 1 of Division 10 of Title 16
8 of the California Code of Regulations to read as follows:
9

10 Chapter 1. General Provisions Applicable to All Licensees
11 Article 3.1. Radiation Safety Courses
12

13 § 1014. Approval of Radiation Safety Courses.

14 (a) A radiation safety course is one which has as its primary purpose providing theory
15 and clinical application in radiographic techniques. A single standard of care shall be
16 maintained and the ~~b~~Board shall approve only those courses which continuously
17 maintain a high quality standard of instruction. The criteria in subdivisions (b) to (j),
18 inclusive, shall be met by a radiation safety course to secure and maintain approval by
19 the Board as provided by this Article.
20

21 (b) A radiation safety course applying for approval shall submit to the ~~b~~Board a
22 completed "Application for Approval of Course in Radiation Safety (New INSERT
23 DATE)", which is hereby incorporated by reference, accompanied by a non-refundable
24 processing fee of \$300an application and other required documents and information on
25 forms prescribed by the board. The ~~b~~Board may approve, provisionally approve, or
26 deny approval of any such course. The Board may, in lieu of conducting its own
27 investigation, accept the findings of any commission or accreditation agency approved
28 by the Board and adopt those findings as its own.
29

30 (1) Approval may be granted after evaluation of all components of the course
31 has been performed and the report of such evaluation indicates that the course
32 meets the ~~b~~Board's requirements. The board may, in lieu of conducting its own
33 investigation, accept the findings of any commission or accreditation agency
34 approved by the board and adopt those findings as its own.
35

36 (2) Courses shall be re-evaluated approximately every seven years, but may be
37 subject to re-evaluation and inspection by the Board at any time to review and
38 investigate compliance with this Article and the Dental Practice Act (Act). Re-
39 evaluation may include a site visit or written documentation that ensures
40 compliance with all regulations. Results of re-evaluation shall be reported to the

1 Board, or its designee, for final consideration and continuance of program or
2 course approval, provisional approval or denial of approval.

3
4 (3) Course records shall be subject to inspection by the Board at any time.

5
6 (4) Provisional approval shall not be granted for a period which exceeds the
7 length of the course. When the Board provisionally approves a course, it shall
8 state the reasons therefore. Provisional approval shall be limited to those
9 courses which substantially comply with all existing standards for full approval. A
10 course given provisional approval shall immediately notify each student of such
11 status. If the Board denies approval of a course, the specific reasons therefore
12 shall be provided to the program by the Board in writing within 90 days after such
13 action.

14
15 (5) The course shall be established at the postsecondary educational level or
16 deemed equivalent thereto by the Board.

17
18 ~~(e)~~(6) The Board may withdraw its approval of a course at any time, after giving
19 the course provider written notice setting forth its reason for withdrawal and after
20 affording an reasonable opportunity for the course provider to respond within 45
21 calendar days. Approval may be withdrawn for failure to comply with the board's
22 standards-requirements of this Article or any other requirements of the Act, or for
23 fraud, misrepresentation or violation of any applicable federal or state laws
24 relating to the operation of radiographic equipment.

25
26 (c) Course Director. The course director, who may also be an instructor, shall possess
27 a valid, active, and current license issued by the Board or the Dental Hygiene
28 Committee of California, shall have been licensed or permitted for a minimum of two
29 years, and possess the experience in the subject matter he or she is teaching. The
30 program director shall actively participate in and be responsible for the administration
31 of the course. Specifically, the course director shall be responsible for the following
32 requirements:

33
34 (1) Providing daily guidance of didactic, laboratory and clinical assignments;

35
36 (2) Maintaining for a period of not less than five (5) years, copies of:

- 37 (A) Curricula,
38 (B) Course content outlines and examination records,
39 (C) Educational objectives or outcomes,
40 (D) Grading criteria,

1 (E) Copies of faculty credentials, licenses, and certifications, and
2 (F) Individual student records, including those necessary to establish
3 satisfactory completion of the course.

4
5 (3) Issuing certificates of completion to each student who has successfully
6 completed the course and maintaining a record of each certificate of completion
7 for at least five years from the date of its issuance;

8
9 (4) Transmitting to the Board on a form prescribed by the Board the name, last
10 four digits of the social security number and, where applicable, license number
11 of each student who has successfully completed the course;

12
13 (5) Informing the Board of any major change to the course content or outlines,
14 physical facilities, or faculty, within ten (10) days of the change.

15
16 (6) Ensuring that all staff and faculty involved in clinical instruction meet the
17 requirements set forth in this Article.

18
19 (d) Course Faculty and Instructional Staff. Course faculty and instructional staff shall be
20 authorized to provide instruction by the program or course director at the educational
21 facility in which instruction is provided. The faculty shall be adequate in number,
22 qualifications and composition and shall be suitably qualified through academic
23 preparation, professional expertise, and/or appropriate training, as provided herein.
24 Each faculty member shall possess the following qualifications:

25
26 (1) Hold a valid special permit or valid license as a dentist, registered dental
27 hygienist, registered dental assistant, registered dental assistant in extended
28 functions, registered dental hygienist in extended functions, or registered dental
29 hygienists in alternative practice issued by the Board or the Dental Hygiene
30 Committee;

31
32 (2) All faculty and instructional staff shall have been licensed for a minimum of
33 two years. All faculty shall have the education, background, and occupational
34 experience and/or teaching expertise necessary to perform, teach, and evaluate
35 dental radiographs. All faculty and instructional staff responsible for clinical
36 evaluation shall have completed a two hour methodology course which shall
37 include clinical evaluation criteria, course outline development, process
38 evaluation, and product evaluation;

1 (3) Shall have either passed the radiation safety examination administered by
2 the Board or equivalent licensing examination as a dentist, registered dental
3 hygienist, registered dental assistant, registered dental assistant in extended
4 functions, registered dental hygienist in extended functions, or registered dental
5 hygienists in alternative practice or, on or after January 1, 1985, shall have
6 successfully completed a Board-approved radiation safety course.
7

8 (e) Facilities. Facilities and class scheduling shall provide each student with sufficient
9 opportunity, with instructor supervision, to develop minimum competency in all duties for
10 which the program or course is approved to instruct.
11

12 (1) The location and number of general use equipment and armamentaria shall
13 ensure that each student has the access necessary to develop minimum
14 competency in all of the duties for which the program or course is approved to
15 instruct. The program or course provider may either provide the specified
16 equipment and supplies or require that the student provide them. Nothing in this
17 Section shall preclude a dental office that contains the equipment required by this
18 Section from serving as a location for laboratory instruction.
19

20 (2) Clinical instruction shall be of sufficient duration to allow the procedures to be
21 performed to clinical proficiency. Operatories shall be sufficient in number to
22 allow a ratio of at least one operatory for every five students who are
23 simultaneously engaged in clinical instruction.
24

25 (A) Each operatory shall contain functional equipment, including a power-
26 operated chair for patient or simulation-based instruction in a supine
27 position, operator and assistant stools, air-water syringe, adjustable light,
28 oral evacuation equipment, work surface, hand-piece connection, and
29 adjacent hand-washing sink.
30

31 (B) Each operatory shall be of sufficient size to simultaneously
32 accommodate one student, one instructor, and one patient or student
33 partner.
34

35 (C) Prior to clinical assignments, students must demonstrate minimum
36 competence in laboratory performance of the procedures they will be
37 expected to perform in their clinical experiences.
38

39 (3) There shall be a sufficient number of safe, adequate, and educationally
40 conducive lecture classrooms, radiography operatories, developing or processing

1 facilities, and viewing spaces for mounting, recording, and evaluating
2 radiographs. Adequate, cleaning, disinfecting, and sterilizing facilities shall be
3 provided and all disinfection and sterilization procedures specified in the Board's
4 Minimum Standards for Infection Control (Cal. Code of Regs., Title 16, Section
5 1005) shall be incorporated in instruction and followed during all laboratory and
6 clinical experiences.

7
8 (A) A radiographic operatory shall be deemed adequate if it is properly
9 equipped with supplies and equipment for practical work and includes, for
10 every six students, at least the following:

11
12 (i) One functioning radiography (X-ray) machine which is
13 adequately filtered and collimated that is equipped with the
14 appropriate position-indicating devices for each technique being
15 taught, and is properly registered and permitted in compliance with
16 the Department of Health Services and the California Radiation
17 Safety Regulations (Title 17, Cal. Code of Regulations,
18 commencing with Section 30100);

19
20 (ii) One (1) X-ray training mannequin head designed for instruction
21 in radiographic techniques per X-ray unit;

22
23 (iii) One (1) film view box per operatory;

24
25 (iv) One (1) lead impregnated adult-size X-ray apron with cervical
26 (thyroid) collar, either attached or detached from the apron, per X-
27 ray unit;

28 (B) The area shall be deemed adequate if it is of sufficient size to
29 accommodate students' needs in learning and is properly equipped with
30 supplies and equipment for practical work which may include processing
31 and viewing equipment or any combination thereof. Such facility
32 requirements may be deemed met if computer-based equipment for digital
33 radiographic procedures is solely or in part utilized within the program or
34 course facility and where such equipment may be located in the operatory
35 area where exposures will occur.

36
37 (C) X-ray exposure areas shall provide protection to patients, students,
38 faculty and observers in full compliance with applicable statutes and
39 regulations.

1 (f) Course Content. A detailed course outline shall clearly state, in writing, the
2 curriculum subject matter, hours of didactic, laboratory, and clinical instruction, general
3 course objectives, instructional objectives, theoretical content of each subject, and,
4 where applicable, the use of practical application. Objective evaluation criteria shall be
5 used for measuring student progress toward attainment of specific program or course
6 objectives. Students shall be provided with all of the following:

7
8 (1) Specific performance objectives and the evaluation criteria used for
9 measuring levels of competence for each component of a given procedure
10 including those used for examinations.

11
12 (2) Standards of performance that state the minimum number of satisfactory
13 performances that are required for each performance-evaluated procedure.

14
15 (3) Standards of performance for laboratory and clinical functions, those steps
16 that would cause the student to fail the task being evaluated, and a description of
17 each of the grades that may be assigned during evaluation procedures.

18
19 (4) The curriculum content pertaining to radiation safety and radiography
20 techniques offered by a school or program approved by the Board or
21 Commission on Dental Accreditation for instruction in dentistry, dental hygiene
22 or dental assisting shall be deemed to be approved if the school or program has
23 submitted evidence satisfactory to the Board that it meets all the requirements of
24 this Article.

25
26 (5) Requirements of California Code of Regulations, Title 17, Division 1, Chapter
27 5, Subchapter 4, Group 3, Article 4 (Section 30305 et seq.) relative to the
28 special requirements for the use of x-ray in the healing arts.

29
30 (g) Infection Control Protocols. The course shall establish written clinical and laboratory
31 protocols that comply with the Board's Minimum Standards for Infection Control (Cal.
32 Code Regs., Title 16, Section 1005) and other federal, state, and local requirements
33 governing infection control. The program or course shall provide these protocols to all
34 students, faculty, and instructional staff to ensure compliance. Adequate space shall be
35 provided for handling, processing, and sterilizing all armamentarium.

36
37 (h) Emergency Situation Policy. A written policy on managing emergency situations
38 shall be made available to all students, faculty, and instructional staff. All faculty and
39 staff involved in the direct oversight of patient care activities shall be certified in basic
40 life support procedures, including cardiopulmonary resuscitation. Recertification

1 intervals may not exceed two years. The course director shall ensure and document
2 compliance by faculty and instructional staff. Students shall complete instruction in
3 basic life support prior to performing procedures on patients used for clinical instruction
4 and evaluation.

5
6 (i) Certificate of Completion. A certificate of completion shall be issued to each student
7 who successfully completes the course. The certificate of completion shall specify the
8 student's name, address, and date of birth, the course provider's name, the course
9 provider's identification number, total number of course hours completed, the date(s) of
10 the course, and certification signature verifying successful completion of the Board-
11 approved radiation safety course. A student shall be deemed to have successfully
12 completed the course if the student has met all the course requirements and has
13 obtained passing scores on both written and clinical examinations. Programs in
14 dentistry and dental hygiene approved by the Commission shall be exempt from this
15 requirement unless offering a stand-alone certification course.

16
17 (j) Notice of Compliance. To maintain approval, courses approved prior to the effective
18 date of these regulations shall submit to the Board a completed "Notice of Compliance
19 with New Requirements for Radiation Safety Courses (New INSERT DATE)", which is
20 hereby incorporated by reference, within ninety (90) days of the effective date of these
21 regulations.

22
23 ~~(d)~~(k) The processing times for radiation safety course approval are set forth in Section
24 1061.

25
26 Note: Authority cited: Sections 1614 and 1656, Business and Professions Code.
27 Reference: Section 1656 Business and Professions Code; and Section 106975, Health
28 and Safety Code.

29
30 **§ 1014.1. Requirements for Radiation Safety Courses.**

31 In addition to the requirements of Section 1014, a A-radiation safety course shall
32 comply with the requirements set forth below in order to secure and maintain approval
33 by the bBoard. The course of instruction in radiation safety and radiography techniques
34 offered by a school or program approved by the bBoard for instruction in dentistry,
35 dental hygiene or dental assisting shall be deemed to be an approved radiation safety
36 course if the school or program has submitted evidence satisfactory to the bBoard that
37 it meets all the requirements set forth below:

38
39 (a) Definitions: As used in this Article, the following definitions shall apply:
40

1 (1) “Clinical instruction” means instruction in which students receive supervised
2 experience in performing procedures in a clinical setting on patients. Clinical
3 procedures shall only be allowed upon successful demonstration and evaluation
4 of laboratory skills. There shall be at least one instructor for every six students
5 who are simultaneously engaged in clinical instruction.

6
7 (2) “Didactic instruction” means lectures, demonstrations, and other instruction
8 involving theory that may or may not involve active participation by students. The
9 faculty or instructional staff of an educational institution or approved provider may
10 provide didactic instruction via electronic media, home study materials, or live
11 lecture modality.

12
13 (3) “Extramural dental facility” means any clinical facility utilized by a Board-
14 approved radiation safety course used for instruction that exists outside or
15 beyond the walls, boundaries or precincts of the primary location of the Board-
16 approved radiation safety course and in which dental treatment is rendered.

17
18 (4) “Laboratory instruction” means instruction in which students receive
19 supervised experience performing procedures using study models, mannequins,
20 or other simulation methods. There shall be at least one instructor for every 14
21 students who are simultaneously engaged in instruction.

22
23 (b) Adequate provisions for the supervision and operation of the course in radiation
24 safety shall be made in compliance with Section 1014.

25
26 (c) A course in radiation safety shall be of sufficient duration, but in no event less than
27 32 hours; including at least 8 hours of didactic instruction, at least 12 hours of laboratory
28 instruction, and at least 12 hours of clinical instruction, for the student to obtain
29 applicable theory in didactic instruction, laboratory instruction, and clinical instruction
30 and experience to achieve minimum competence in the various protocols and
31 procedures used in the application of dental radiographic techniques and radiation
32 safety. A course shall,

33
34 (d) Areas of instruction shall include, at a minimum, the instruction specified in
35 subdivisions (e) through (g).

36
37 (e) Didactic Instruction. Areas of didactic instruction shall include, at a minimum, the
38 following as they relate to exposure, processing and evaluation of dental radiographs:

39
40 (1) Radiation physics and biology;

- 1
- 2 (2) Radiation protection and safety;
- 3
- 4 (3) Recognition of normal anatomical landmarks, structures, hard and soft
- 5 tissues, normal and abnormal conditions of the oral cavity as they relate to dental
- 6 radiographs;
- 7
- 8 (4) Radiograph exposure and processing techniques;
- 9
- 10 (5) Radiograph mounting or sequencing, and viewing, including anatomical
- 11 landmarks of the oral cavity;
- 12
- 13 (6) Intraoral techniques and dental radiograph armamentaria, including holding
- 14 devices and image receptors;
- 15
- 16 (7) Intraoral and extraoral examination including principles of exposure, methods
- 17 of retention and evaluation;
- 18
- 19 (8) Proper use of patient protection devices and personal protective equipment
- 20 for operator use;
- 21
- 22 (9) Identification and correction of faulty radiographs;
- 23
- 24 (10) Introduction to contemporary exposure techniques including the use of
- 25 computerized digital radiography and extraoral imaging which may include
- 26 panographs or cone-beam imaging;
- 27
- 28 (11) Infection control procedures in compliance with the Board's Minimum
- 29 Standards for Infection Control (Cal. Code of Regs., Title 16, Section 1005);
- 30
- 31 (12) Radiographic records management;
- 32
- 33 (13) Identification and recognition of common errors in techniques and
- 34 processing for intra and extra oral exposures;
- 35
- 36 (14) Identification of various extra oral techniques, machine types, and uses; and
- 37
- 38 (15) Introduction to techniques and exposure guidelines for special exposures to
- 39 include, but not limited to pediatric, edentulous, partially edentulous, endodontic
- 40 and patients with special needs;

1
2 (f) Laboratory Instruction. Sufficient hours of laboratory instruction and experiences
3 shall ensure that a student successfully completes, on an x-ray training mannequin
4 head only, at least the procedures set forth below:

5
6 (1) Two full mouth periapical series, consisting of at least 18 radiographs each,
7 four of which must be bitewings;

8
9 (2) Two horizontal or vertical bitewing series, consisting of at least four
10 radiographs each;

11
12 (3) Developing, digitizing or processing, and mounting or sequencing of exposed
13 radiographs;

14
15 (4) Completion of student and instructor written evaluation of radiographs
16 identifying errors, causes of errors, corrections and, if applicable, the number of
17 re-exposures necessary for successful completion of a series to minimum
18 competency.

19
20 (A) A laboratory procedure has been successfully completed only if each
21 series of radiographs is evaluated and deemed to be of diagnostic quality.

22
23 (B) Notwithstanding Section 1070.1, there shall be no more than six
24 students per instructor during laboratory instruction and experiences.

25
26 (C) Successful completion of all laboratory competencies must occur prior
27 to clinical instruction and experiences.

28
29 (g) Clinical Instruction and Evaluation. As part of an organized program of instruction
30 clinical instruction shall include clinical performances on human subjects as set forth
31 below. All patients used for clinical radiographic experiences shall complete a health
32 history form with consent acknowledging the procedure is being performed by a
33 student with permission by a licensed dentist or the patient's dentist of record. Such
34 documentation shall be maintained in the student records.

35
36 (1) Successful completion of a minimum of four full mouth periapical series,
37 consisting of at least 18 radiographs each, four of which must be bitewings
38 utilizing either traditional films or computerized digital radiographic equipment, if
39 utilized by the program or course, or a combination of both. All exposures made
40 on human subjects shall only be made using diagnostic criteria established

1 during the clinical instructional period, and shall in no event exceed three re-
2 exposures per subject per series.

3
4 (2) Successful developing or processing, and mounting or sequencing of
5 exposed human subject radiographs;

6
7 (3) Completion of student and instructor written evaluations of each radiographic
8 series identifying errors, causes of error, and correction and, if applicable, the
9 number of re-exposures necessary for successful completion of a series to
10 clinical competency.

11
12 (4) One full-mouth clinical series shall serve a final clinical examination.

13
14 (h) Written Examinations:

15
16 (1) Successful completion of a written examination in radiation health and safety
17 must occur prior to laboratory and clinical instruction and experiences. The
18 written examination shall include questions specific to items addressed in
19 California Code of Regulations, Title 17, Division 1, Chapter 5, Subchapter 4,
20 Group 3, Article 4 (Section 30305 et seq.) relative to the special requirements for
21 the use of x-ray in the healing arts, and shall be constructed and administered in
22 a manner consistent with all licensing examinations administered by the state or
23 national testing boards.

24
25 (2) A comprehensive final exam shall be successfully completed by each
26 student prior to the completion of the radiation safety course. Such examination
27 shall be constructed and administered in a manner consistent with all licensing
28 examinations administered by the state or national testing boards.

29
30 (i) Extramural Dental Facilities. Extramural dental facilities may be utilized by a course
31 for the purposes of radiographic laboratory and clinical competencies. Laboratory and
32 clinical instruction shall be performed under the direct supervision of course faculty or
33 instructional staff. Didactic and laboratory instruction shall be performed by course
34 faculty or instructional staff and shall not be provided in an extramural dental facility.

35
36 (1) The course director, or a designated faculty member, shall be responsible for
37 selecting a extramural dental facility and evaluating student competence before
38 and after the clinical assignment.

1 (2) Prior to student assignment in an extramural dental facility, the course
2 director, or a designated faculty or instructional staff member, shall orient all
3 licensed dental healthcare workers who may provide instruction, evaluation, and
4 oversight of the student in the clinical setting. Orientation shall include, at a
5 minimum, the objectives of the course, the student's preparation for the clinical
6 assignment, and a review of procedures and criteria to be used by the licensed
7 dental healthcare workers in the extramural dental facility in evaluating the
8 student during the assignment, which shall be the same as the evaluation criteria
9 used within the course.

10
11 (3) Programs and courses using extramural faculty for a Radiation Safety course
12 shall provide to the Board, upon request or renewal of provider status, if
13 applicable, copies of all contracts of affiliation and documentation demonstrating
14 compliance with this Section.

15
16 (4) There shall be a written contract of affiliation with each clinical facility utilized
17 by a course. Such contract shall describe the settings in which the clinical facility
18 will be used, cancellation terms and conditions, and shall provide that the clinical
19 facility has the necessary equipment and armamentaria appropriate for the
20 procedures to be performed and that such equipment and armamentaria are in
21 safe operating condition. Such clinical facilities shall be subject to the same
22 requirements as those specified in subdivisions (f) and (g) of this Section and
23 Section 1014(e).

24
25 ~~(a) Educational Level. The course shall be established at the postsecondary~~
26 ~~educational level or a level deemed equivalent thereto by the board.~~

27
28 ~~(b) Program Director. The program director, who may also be an instructor, shall~~
29 ~~actively participate in and be responsible for at least all of the following:~~

30
31 ~~(1) Providing daily guidance of didactic, laboratory and clinical assignments;~~

32
33 ~~(2) Maintaining all necessary records, including but not limited to the following:~~

34
35 ~~(A) Copies of current curriculum, course outline and objectives;~~

36
37 ~~(B) Faculty credentials;~~

38
39 ~~(C) Individual student records, which shall include pre-clinical and clinical~~
40 ~~evaluations, examinations and copies of all successfully completed~~

1 radiographic series used toward course completion. Records shall be
2 maintained for at least five years from the date of course completion.

3
4 ~~(3) Issuing certificates to each student who has successfully completed the~~
5 ~~course and maintaining a record of each certificate for at least five years from~~
6 ~~the date of its issuance;~~

7
8 ~~(4) Transmitting to the board on a form prescribed by the board the name, last~~
9 ~~four digits of the social security number and, where applicable, license number~~
10 ~~of each student who has successfully completed the course;~~

11
12 ~~(5) Informing the board of any significant revisions to the curriculum or course~~
13 ~~outlines.~~

14
15 ~~(c) Faculty. The faculty shall be adequate in number, qualifications and composition~~
16 ~~and shall be suitably qualified through academic preparation, professional expertise,~~
17 ~~and/or appropriate training, as provided herein. Each faculty member shall possess the~~
18 ~~following qualifications:~~

19
20 ~~(1) Hold a valid special permit or valid license as a dentist, registered dental~~
21 ~~hygienist, registered dental assistant, registered dental assistant in extended~~
22 ~~functions, registered dental hygienist in extended functions, or registered dental~~
23 ~~hygienists in alternative practice issued by the board;~~

24
25 ~~(2) All faculty shall have been licensed for a minimum of two years. All faculty~~
26 ~~shall have the education, background, and occupational experience and/or~~
27 ~~teaching expertise necessary to perform, teach, and evaluate dental~~
28 ~~radiographs. All faculty responsible for clinical evaluation shall have completed a~~
29 ~~two-hour methodology course which shall include clinical evaluation criteria,~~
30 ~~course outline development, process evaluation, and product evaluation;~~

31
32 ~~(3) Shall have either passed the radiation safety examination administered by~~
33 ~~the board or equivalent licensing examination as a dentist, registered dental~~
34 ~~hygienist, registered dental assistant, registered dental assistant in extended~~
35 ~~functions, registered dental hygienist in extended functions, or registered dental~~
36 ~~hygienists in alternative practice or, on or after January 1, 1985, shall have~~
37 ~~successfully completed a board approved radiation safety course.~~

38
39 ~~(d) Facilities. There shall be a sufficient number of safe, adequate, and educationally~~
40 ~~conducive lecture classrooms, radiography operatories, developing or processing~~

1 facilities, and viewing spaces for mounting, viewing and evaluating radiographs.
2 Adequate sterilizing facilities shall be provided and all disinfection and sterilization
3 procedures specified by board regulations shall be followed.

4
5 (1) A radiographic operatory shall be deemed adequate if it fully complies with
6 the California Radiation Control Regulations (Title 17, Cal. Code Regs.,
7 commencing with section 30100), is properly equipped with supplies and
8 equipment for practical work and includes for every seven students at least one
9 functioning radiography machine which is adequately filtered and collimated in
10 compliance with Department of Health Services regulations and which is
11 equipped with the appropriate position-indicating devices for each technique
12 being taught.

13
14 (2) The developing or processing facility shall be deemed adequate if it is of
15 sufficient size, based upon the number of students, to accommodate students'
16 needs in learning processing procedures and is properly equipped with supplies
17 and equipment for practical work using either manual or automatic equipment.

18
19 (3) X-ray areas shall provide protection to patients, students, faculty and
20 observers in full compliance with applicable statutes and regulations.

21
22 (e) Program Content. Sufficient time shall be available for all students to obtain
23 laboratory and clinical experience to achieve minimum competence in the various
24 protocols used in the application of dental radiographic techniques.

25
26 (1) A detailed course outline shall be provided to the board which clearly states
27 curriculum subject matter and specific instructional hours in the individual areas
28 of didactic, laboratory, and clinical instruction.

29
30 (2) General program objectives and specific instructional unit objectives shall be
31 stated in writing, and shall include theoretical aspects of each subject as well as
32 practical application. The theoretical aspects of the program shall provide the
33 content necessary for students to make judgments regarding dental radiation
34 exposure. The course shall assure that students who successfully complete the
35 course can expose, process and evaluate dental radiographs with minimum
36 competence.

37
38 (3) Objective evaluation criteria shall be used for measuring student progress
39 toward attainment of specific course objectives. Students shall be provided with

1 specific unit objectives and the evaluation criteria that will be used for all aspects
2 of the curriculum including written, practical and clinical examinations.

3
4 (4) Areas of instruction shall include at least the following as they relate to
5 exposure, processing and evaluations of dental radiographs:

6
7 (A) Radiation physics and biology

8
9 (B) Radiation protection and safety

10
11 (C) Recognition of normal anatomical landmarks and abnormal conditions
12 of the oral cavity as they relate to dental radiographs

13
14 (D) Radiograph exposure and processing techniques using either manual
15 or automatic methods

16
17 (E) Radiograph mounting or sequencing, and viewing, including
18 anatomical landmarks of the oral cavity

19
20 (F) Intraoral techniques and dental radiograph armamentaria, including
21 holding devices

22
23 (G) Interproximal examination including principles of exposure, methods
24 of retention and evaluation

25
26 (H) Intraoral examination including, principles of exposure, methods of
27 retention and evaluation

28
29 (I) Identification and correction of faulty radiographs

30
31 (J) Supplemental techniques including the optional use of computerized
32 digital radiography

33
34 (K) Infection control in dental radiographic procedures

35
36 (L) Radiographic record management.

37
38 Students may be given the opportunity to obtain credit by the use of challenge
39 examinations and other methods of evaluation.

1 ~~(f) Laboratory Instruction. Sufficient hours of laboratory instruction shall be provided to~~
2 ~~ensure that a student successfully completes on an x-ray manikin at least the~~
3 ~~procedures set forth below. A procedure has been successfully completed only if each~~
4 ~~radiograph is of diagnostic quality. There shall be no more than 6 students per~~
5 ~~instructor during laboratory instruction.~~

6
7 ~~(1) Two full mouth periapical series, consisting of at least 18 radiographs each, 4~~
8 ~~of which must be bitewings; no more than one series may be completed using~~
9 ~~computer digital radiographic equipment;~~

10
11 ~~(2) Two bitewing series, consisting of at least 4 radiographs each;~~

12
13 ~~(3) Developing or processing, and mounting or sequencing of exposed~~
14 ~~radiographs;~~

15
16 ~~(4) Student and instructor written evaluation of radiographs.~~

17
18 ~~(g) Clinical Experience. The course of instruction shall include sufficient clinical~~
19 ~~experience, as part of an organized program of instruction, to obtain clinical~~
20 ~~competency in radiographic techniques. There shall be no more than 6 students per~~
21 ~~instructor during clinical instruction. Clinical instruction shall include clinical experience~~
22 ~~on four patients with one of the four patients used for the clinical examination. Clinical~~
23 ~~experience shall include:~~

24
25 ~~(1) Successful completion of a minimum of four full mouth periapical series,~~
26 ~~consisting of at least 18 radiographs each, 4 of which must be bitewings.~~
27 ~~Traditional film packets must be double film. No more than three series may be~~
28 ~~completed using computer digital radiographic equipment. Such radiographs~~
29 ~~shall be of diagnostic quality. All exposures made on human subjects shall only~~
30 ~~be made for diagnostic purposes, and shall in no event exceed three (3)~~
31 ~~exposures per subject. All clinical procedures on human subjects shall be~~
32 ~~performed under the supervision of a licensed dentist in accordance with section~~
33 ~~406975 of the Health and Safety Code.~~

34
35 ~~(2) Developing or processing, and mounting or sequencing of exposed human~~
36 ~~subject radiographs;~~

37
38 ~~(3) Student and instructor written evaluation of radiographs.~~

1 ~~(h) Clinical Facilities. There shall be a written contract of affiliation with each clinical~~
2 ~~facility utilized by a course. Such contract shall describe the settings in which the~~
3 ~~clinical training will be received and shall provide that the clinical facility has the~~
4 ~~necessary equipment and accessories appropriate for the procedures to be performed~~
5 ~~and that such equipment and accessories are in safe operating condition. Such clinical~~
6 ~~facilities shall be subject to the same requirements as those specified in subdivision~~
7 ~~(g).~~

8
9 ~~(i) Length of Course. The program shall be of sufficient duration for the student to~~
10 ~~develop minimum competence in the radiation safety techniques, but shall in no event~~
11 ~~be less than 32 clock hours, including at least 8 hours of didactic instruction, at least 12~~
12 ~~hours of laboratory instruction, and at least 12 hours of clinical instruction.~~

13
14 ~~(j) Certificates. A certificate shall be issued to each student who successfully completes~~
15 ~~the course. The certificate shall specify the number of course hours completed. A~~
16 ~~student shall be deemed to have successfully completed the course if the student has~~
17 ~~met all the course requirements and has obtained passing scores on both written and~~
18 ~~clinical examinations.~~

19
20 Note: Authority cited: Sections 1614 and 1656, Business and Professions Code.
21 Reference: Section 1656, Business and Professions Code; and Section 106975, Health
22 and Safety Code.



MEMORANDUM

DATE	February 5, 2013
TO	Dental Board Members
FROM	Nellie Forgét, Program Coordinator Elective Facial Cosmetic Surgery (EFCS) Permit Program
SUBJECT	Agenda Item 8: Report on the January 16, 2013 Meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; and Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permits.

The Elective Facial Cosmetic Surgery (EFCS) Permit Credentialing Committee met on January 16, 2013 by teleconference.

The Committee reviewed *The Report on the Elective Facial Cosmetic Surgery Permit Program as Provided by Business and Professions Code Section 1638.1, January 1, 2013.* (A copy of this report is included in your packet.)

Business and Professions Code Section 1638.1(k) required the Dental Board to provide a report to the Joint Committee on Boards, Commissions, and Consumer Protection on January 1, 2009 and every four years thereafter. The report is required to contain information on all of the following:

1. The number of persons licensed pursuant to Section 1634 who apply to receive a permit to perform elective facial cosmetic surgery from the board pursuant to subdivision (a).
2. The recommendations of the credentialing committee to the board.
3. The board's action on recommendations received by the credentialing committee.
4. The number of persons receiving a permit from the board to perform elective facial cosmetic surgery.
5. The number of complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery.
6. Action taken by the board resulting from complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery.

In closed session, the Credentialing Committee reviewed three (3) applications, one of which was deferred to a future meeting because the Committee requested the applicant submit additional information. The Board is being asked to consider issuing two permits.

According to statute, the Committee shall make a recommendation to the Dental Board on whether to issue a permit to the applicant. The permit may be unqualified, entitling the permit holder to perform any facial cosmetic surgical procedure authorized by the statute, or it may contain limitations if the Credentialing Committee is not satisfied that the applicant has the training or competence to perform certain classes of procedures, or if the applicant has not requested to be permitted for all procedures authorized in statute.

The Committee's Recommendations to the Board are as follows:

1. Applicant: Dr. Jeffrey D. Politz. - Requested unlimited privileges for Category II (cosmetic soft tissue contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

The Committee recommends the Board issue Dr. Jeffrey D. Politz a permit limited to the following Category II procedures: facial fillers and facial neurotoxins.

2. Applicant: Dr. Sanford L. Ratner. - Requested unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but not limited to, rhinoplasty and otoplasty).

The Committee recommends the Board issue Dr. Sanford L. Ratner a permit limited to the following Category I procedures: Genioplasty and chin implants.

Action Requested:

1. Staff requests a motion from the Board to accept the EFCS Permit Credentialing Committee Report.
2. Staff requests the Board issue Dr. Jeffrey D. Politz an EFCS Permit in Category II procedures limited to facial fillers and facial neurotoxins. Staff also requests the Board issue Dr. Sanford L. Ratner an EFCS Permit in Category I procedures limited to genioplasty and chin implants.

DENTAL BOARD OF CALIFORNIA

**REPORT ON THE ELECTIVE FACIAL COSMETIC
SURGERY PERMIT PROGRAM AS PROVIDED BY
BUSINESS AND PROFESSIONS CODE SECTION 1638.1**

**REPORT PREPARED BY:
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JANUARY 1, 2013

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Karen M. Fischer

ELECTIVE FACIAL COSMETIC SURGERY PERMIT PROGRAM COORDINATOR

Nellie Forgét, Analyst

Introduction

The Dental Board of California (Board) is submitting this report on the Elective Facial Cosmetic Surgery (EFCS) Permit Program pursuant to Business and Professions Code (Code) Section 1638.1. The last report was submitted in January 2009, and statute requires additional reports to be submitted every four years thereafter.

On September 30, 2006, Governor Arnold Schwarzenegger signed Senate Bill 438 (Chapter 909, Statutes of 2006), which took effect on January 1, 2007. This statute allows Oral and Maxillofacial Surgeons licensed by the Board, who are not also licensed as physicians and surgeons by the Medical Board of California, to seek authorization to perform elective facial cosmetic surgery. Additionally, this statute establishes a Credentialing Committee (Committee) to review the qualifications of each applicant and specifies the application requirements for an EFCS permit.

Code Section 1638.1(e) provides for the establishment of a Committee to be appointed by the Board and specifies that the Committee be comprised of five members consisting of one (1) physician and surgeon with a specialty in plastic and reconstructive surgery, one (1) physician and surgeon with a specialty in otolaryngology, and three (3) oral and maxillofacial surgeons licensed by the Board who are board certified by the American Board of Oral and Maxillofacial Surgeons, all of whom are required to maintain active status on the staff of a licensed general acute care hospital in California. At its February 9, 2007 meeting, the Board appointed five members to the Committee. The Committee is responsible for reviewing applications for EFCS permits in closed session during Committee meetings and providing recommendations to the Board as to whether an applicant is qualified to be issued a permit.

Code Section 1638.1(c) specifies the application requirements to obtain an EFCS permit from the Board to perform procedures from the following categories:

- **Category I:** Cosmetic contouring of the osteocartilaginous facial structure which may include, but is not limited to, rhinoplasty and otoplasty.
- **Category II:** Cosmetic soft tissue contouring or rejuvenation, which may include, but is not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

The Board may grant unlimited or limited permits upon the recommendation of the Committee. An unlimited permit allows the licensee to perform Category I and Category II procedures as previously specified. A limited permit would limit the procedures that may be performed by the permit holder. The Committee may recommend permit limitations if it is not satisfied that the applicant has the training or competence necessary to perform all procedures, or if the applicant has not requested to be permitted for all procedures authorized in the statute. Permits may also be issued for Category I only, unlimited or limited; Category II only, unlimited or limited; or a combination of any of the above.

Report

Code Section 1638.1(k) requires the Board to provide a report to the Legislature on January 1, 2009 and every four years thereafter. The report is required to contain the following information:

1. The number of persons licensed pursuant to Section 1634 who apply to receive a permit to perform elective facial cosmetic surgery from the board pursuant to subdivision 1638.1(a).
2. The recommendations of the credentialing committee to the board.
3. The board's action on recommendations received by the credentialing committee.
4. The number of persons receiving a permit from the board to perform elective facial cosmetic surgery.
5. The number of complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery.
6. Action taken by the board resulting from complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by persons who have received a permit from the board to perform elective facial cosmetic surgery.

The following information is being submitted on behalf of the Board in compliance with the requirements contained in Code Section 1638.1(k):

In 2009, the Board received a total of nine (9) applications; five (5) applications had been carried over from the previous year and the Board received four (4) new applications. Of the nine (9) applications, the staff referred six (6) applications to the Committee for evaluation. Three (3) applications were deemed deficient; all three applicants were notified by staff of the deficiencies and the applications were held for Committee evaluation until the deficiencies were corrected. Of the six (6) applications evaluated, the Committee recommended the Board approve five (5) Category I and II, Unlimited Permits and one (1) Category II, Limited Permit. The Board approved the Committee's recommendations. A total of six (6) permits were issued in 2009.

In 2010, the Board received a total of six (6) applications; three (3) applications had been carried over from the previous year and the Board received three (3) new applications. Of the six (6) applications, staff referred one (1) application to the Committee for evaluation. Four (4) applications were deemed deficient; all four applicants were notified by staff of the deficiencies and applications were held for Committee evaluation until the deficiencies were corrected. Staff deemed one (1) application ineligible for the permit because the applicant was licensed as a physician and surgeon by the Medical Board of California. For this reason the applicant was refunded the \$500 application fee. The Committee recommended the Board approve one (1) Category I and II, Unlimited Permit.

Report on the Elective Facial Cosmetic Surgery Permit Program As Provided by
Business and Professions Code Section 1638.1 (Submitted January 1, 2013)

The Board approved the Committee's recommendation. A total of one (1) permit was issued in 2010.

In 2011, the Board received a total of seven (7) applications; four (4) applications had been carried over from the previous year and the Board received three (3) new applications. Of the seven (7) applications, staff referred two (2) applications to the Committee for evaluation. Six (6) applications were deemed deficient; all six applicants were notified by staff of the deficiencies and applications were held for Committee evaluation until the deficiencies were corrected. The Committee recommended the Board approve one (1) Category I and II, Unlimited Permit. The Board approved the Committee's recommendation. A total of one (1) permit was issued in 2011.

In 2012, the Board received a total of eleven (11) applications; six (6) applications had been carried over from the previous year and the Board received five (5) new applications. Of the eleven (11) applications, staff referred three (3) applications to the Committee for evaluation. Seven (7) applications were deemed deficient; all seven applicants were notified by staff of the deficiencies and applications were held for Committee evaluation until the deficiencies could be corrected. The Committee recommended the Board approve two (2) Category I and II, Unlimited Permits and one (1) Category II, Limited Permit. The Board approved the Committee's recommendations. A total of three (3) permits were issued in 2012.

The Board has provided a table summarizing the applications received, Committee recommendations, Board actions, and total permits issued on page 6 of this report (Table 1: Summary of Applications Received, Committee Recommendations, Board Actions, and Total Permits Issued).

In conclusion, the Board has issued a total of eleven (11) EFCS permits between January 2009 and December 2012 ; nine (9) permits for Category I and Category II, Unlimited and two (2) for Category II, limited. The Board currently oversees a total of twenty-two EFCS permits that have been issued since the program's inception.

To date, the Board has not received any complaints filed by or on behalf of patients who have received elective facial cosmetic surgery by those who have received a permit from the Board to perform elective facial cosmetic surgery; therefore, the Board has not had to pursue disciplinary action due to such complaints. The Committee will continue to receive and evaluate applications for the EFCS permit and provide recommendations to the Board that are in the best interest of public protection.

**Table 1: Summary of Applications Received,
Committee Recommendations, Board Actions, and Total Permits Issued**

	Jan. 2009 to Dec. 2009	Jan. 2010 to Dec. 2010	Jan. 2011 to Dec. 2011	Jan. 2012 to Dec. 2012
APPLICATIONS RECEIVED				
Applications Carried Over from Previous Year	5	3	4	6
New Applications Received	4	3	3	5
Total Applications Received and Reviewed by Staff	9	6	7	11
Applications Referred to the Committee for Evaluation	6	1	2	3
Applications Deemed Deficient	3	4	6	7
Applications Deemed Ineligible	0	1	0	0
Applications Carried Over to Next Year	3	4	6	7
COMMITTEE RECOMMENDATIONS TO THE BOARD				
Committee Recommended Approval for Category I and Category II, Unlimited	5	1	1	2
Committee Recommended Approval of Category II, Limited	1	0	0	1
BOARD ACTIONS ON RECOMMENDATIONS RECEIVED BY THE COMMITTEE				
Board Approved Committee Recommendation for Issuance of Category I and Category II, Unlimited	5	1	1	2
Board Approved Committee Recommendation for Issuance of Category II, Limited	1	0	0	1
TOTAL NUMBER OF PERMITS ISSUED BY THE BOARD TO PERFORM EFCS	6	1	1	3



MEMORANDUM

DATE	February 20, 2013
TO	Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst Dental Board of California
SUBJECT	Agenda Item 9: Update on the Patient Protection and Affordable Care Act

Report by the California Health Benefit Exchange to the Governor and the Legislature, January 2013:

The California Health Benefits Exchange (Covered California) issued its first annual report regarding implementation of the provisions of the federal Patient Protection and Affordable Care Act (PPACA) to Governor Brown in January 2013. The annual report is enclosed for the Board's review.

Special Legislative Session:

Governor Brown has convened a special legislative session that is being held concurrently with the current regular session. This special session has been convened to continue the implementation of the federal PPACA. Staff is currently tracking legislation related to health benefits and changes to Medi-Cal eligibility and will keep the Board apprised of any changes impacting dentistry in the State of California.

Covered California Announces Standard Benefit Plans for Consumers:

On February 13, 2013, Covered California issued a press release announcing standard benefit plans for consumers. The following documents are included in the Board packet for the Board's review: (1) press release announcing the standard benefits plan for consumers, (2) standard benefits plan designs and summary of benefits and coverage, and (3) frequently asked questions regarding the standard benefits announcement.

Impact of the PPACA on the Dental Board of California:

The impact of the PPACA upon the Dental Board licensees is unknown at this time. However, the ability of Californians to access dental care should not be directly impacted by this law. Staff will continue to monitor the PPACA and provide reports to the Board of its potential impact on dentistry once further information is obtained.

Action Requested:

No action necessary.



COVERED CALIFORNIA

REPORT BY THE
CALIFORNIA HEALTH
BENEFIT EXCHANGE
TO THE GOVERNOR
AND LEGISLATURE

JANUARY 2013



**COVERED
CALIFORNIA**



560 J STREET, SUITE 290
SACRAMENTO, CA 95814

WWW.COVERED.CA.GOV

January 8, 2013

To the Governor of the State of California and the Members of the Legislature,

On behalf of the governing Board of the California Health Benefit Exchange, recently named Covered California, I am pleased to present our first annual report.

Covered California is proud to be at the forefront nationally in implementing the federal Patient Protection and Affordable Care Act of 2010, the most significant health care reform since the enactment of Medicare and Medicaid in 1965. The provisions of this new law that expand health coverage to millions of Californians will take effect on January 1, 2014. We understand the importance of this task, and the challenges ahead. We are also confident that we will get the job done.

Covered California's progress and ultimate success are only possible with the hard work and dedication of our staff working in partnership with the Health and Human Services Agency, the Department of Health Care Services, the Managed Risk Medical Insurance Board, the Department of Insurance and the Department of Managed Health Care.

Our partners extend beyond state agencies. They include consumers, health plans and health providers, large and small businesses, labor unions, community leaders and organizations, philanthropic organizations, and many others who have come together to help shape the vision and future of Covered California and the health care system in California.

We are grateful to the Governor and the Legislature for their strong support as Covered California prepares to create a new marketplace for health coverage that will help millions of Californians and small businesses secure the affordable, high-quality health insurance they need.

A handwritten signature in blue ink, appearing to read "Peter V. Lee".

Peter V. Lee
Executive Director

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EXECUTIVE SUMMARY

California was the first state in the nation to enact legislation creating a Health Benefit Exchange following the passage of the Patient Protection and Affordable Care Act.

In 2010, state law [Chapter 655, Statutes of 2010 (Perez) and Chapter 659, Statutes of 2010 (Alquist)] was enacted to implement the provisions of the Affordable Care Act and to “reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act.” These authorizing statutes also call for strengthening the health care delivery system, guaranteeing the availability of coverage to qualified individuals and small employers, and requiring that health care service plans and insurers compete based on price, quality and service rather than risk selection.

Since its creation, Covered California has begun building the foundations that will be essential to the success of this new innovative health coverage marketplace. In 2011, the Board of Covered California adopted its vision, mission and values statement, setting the framework for doing business with a primary focus being on making it easy and affordable for Californians who are eligible to obtain health coverage.

Recognizing that California is unique among all states in terms of its diversity, size and complexity, Covered California has worked closely with the federal government to help facilitate smooth and effective implementation of the Affordable Care Act. Enrollment for new subsidized coverage will begin on October 1, 2013 — 90 days in advance of when coverage begins on January 1, 2014. At that time, Californians will have access to the online Covered California portal to shop for health insurance coverage. Some will learn they qualify for existing public insurance programs; others will qualify for federal subsidies to offset the cost of their premiums for plans purchased through Covered California. Small business owners will have the same purchasing power as large employers to shop for low-cost coverage for their employees, and many small employers will qualify for federal tax credits to help offset coverage costs. To be ready, Covered California’s tasks include:

- Selecting and certifying health plans by designating them as “Qualified Health Plans” for participation in the individual market and the Small Business Health Options Program (SHOP);



- Building the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS), a consumer-friendly, Web-based portal designed to be the single streamlined resource for Californians to find out what health program they are eligible for, and to make buying health insurance as easy as possible. This state-of-the-art system will allow California consumers to compare health plans to make the purchase that best meets their individual or small business needs and receive federal subsidies if eligible;
- Launching marketing, outreach and education strategies to increase awareness and knowledge of Covered California's coverage options for individuals and small businesses, with special attention to California's diverse populations including, developing a grant-based program to facilitate community participation in outreach and education; and
- Building and supporting a wide spectrum of support to help consumers with questions, including service center staff, county workers, community-based assisters and agents, and many more to help explain insurance and coverage options under the Affordable Care Act so that consumers can get the help they need to make choices that best meet their health coverage needs.

When fully implemented in 2019 more than two million Californians are projected to be receiving subsidized health coverage for themselves and their families through Covered California. Another 2.1 million Californians are expected to purchase coverage without subsidies through Covered California or in the individual market. Ultimately, millions of Californians will obtain health coverage as a result of the Affordable Care Act — a historic increase in health care coverage.

In the months ahead, Covered California will be choosing health plan offerings and begin testing the online enrollment portal. Grants will be awarded to community organizations for public awareness efforts, and assisters will be trained to understand Covered California enrollment offerings. In the spring of 2013, Covered California will begin expanding the media campaign to spread the word to millions of Californians about a new way to get affordable health care — all leading up to pre-enrollment on October 1, 2013.

SECTION 1

BACKGROUND: HEALTH CARE CHALLENGES IN CALIFORNIA

The federal Patient Protection and Affordable Care Act provides the framework to address the health care challenges of unsustainable costs, inconsistent quality, lack of focus on wellness, health disparities and millions without coverage. The Affordable Care Act provides a comprehensive approach to address these problems.

Health care costs continue to grow at unsustainable rates. Even though the rate of spending increases has slowed during the recession, nationally, the United States spends far more on health care — both per capita and as a share of gross domestic product — than any other country in the world. The high costs of health care is making coverage unattainable for families, hindering competition of small and large businesses and aggravating deficits for both state and federal budgets.

As the cost of care has risen — due to waste, inappropriate care, an aging population, higher incidence of chronic conditions and new expensive medical technologies, among other factors — families and small businesses have been increasingly priced out of the insurance market.

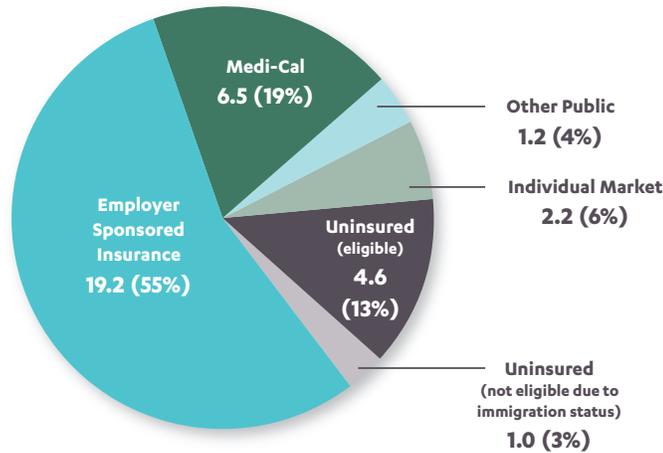
MANY CALIFORNIANS LACK HEALTH CARE COVERAGE

According to a model of California insurance markets known as the California Simulation of Insurance Markets (CalSIM)¹, 5.6 million Californians were without health insurance in 2012, or 16 percent of the population under age 65. Of the 5.6 million, 4.6 million people are eligible for coverage under the Affordable Care Act and one million are ineligible due to immigration status.

¹ The California Simulation of Insurance Markets (CalSIM) is a model developed by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center to estimate impacts of the ACA in California.

FIGURE 1: TYPES OF INSURANCE COVERAGE FOR CALIFORNIANS UNDER AGE 65

(Projected for 2014, without impacts of the Affordable Care Act)



Figures in millions. Source: California Simulation of Insurance Markets (CalSIM) Version 1.8, 2012

According to the California HealthCare Foundation’s 2011 Health Care Almanac:

- Employees in businesses of all sizes are more likely to be uninsured in California than in the United States as a whole;
- Nearly one-third of the uninsured in California and the nation have family incomes of \$50,000 or more; and
- Fifty-three percent of California’s uninsured children are in families where the head of household worked full-time during calendar year 2010.

Over the past decade, small employers have seen the number of available health plans shrink at the same time premiums have risen significantly, making coverage less accessible and affordable, and increasing the number of employed Californians who are uninsured. In 2014, an estimated 2.6 working Californians will lack employer-sponsored health coverage. A December 2011 California HealthCare Foundation (CHCF) survey found that only 53 percent of small businesses with three to nine employees provided health coverage for their workers, and 74 percent of businesses with 10 to 49 employees provided coverage. For those small businesses that do not offer coverage, the vast

majority cite cost as the main reason they do not offer coverage to their workers, in fact, according to a 2011 survey conducted by Pacific Community Ventures², as many as 71 percent of small businesses don't offer coverage due to cost.

Similarly, the main reason that individuals go without coverage is they simply cannot afford the high cost of coverage. In a recent Kaiser Family Foundation survey conducted in May 2012 among U.S. adults, 26 percent reported they or a family member had problems paying for medical bills in the past year.³ In addition 58 percent reported foregoing or delaying medical care in the past year. The result is that for uninsured individuals and families, a major illness can have catastrophic consequences on personal finances. Savings accounts can be depleted easily and bankruptcy often becomes the only option. Providers — hospitals, clinics and physicians — face higher and higher rates of uncompensated care. These uncompensated costs are then shifted to other payers, ultimately resulting in higher health premiums.

The provisions of the Affordable Care Act are designed to close the gaps that leave too many Americans, including millions of Californians, without the access to regular health care they need.

RISING HEALTH CARE COSTS

Over the last decade, the cost for individual and family coverage has more than doubled, far exceeding increases in the Consumer Price Index and the Medical Consumer Price Index.

Between 1999 and 2011, average annual premiums for single and family coverage increased approximately 250 percent. Although employers absorbed some of the increase, employee contributions to premiums increased by 168 percent. By comparison, workers' wages increased less than one-third of that amount, by 50 percent.

The impact has been felt most dramatically in the individual and small group insurance markets, which have seen a significant shift towards products with greater member out of pocket cost sharing. From 2006 to 2011, there was more than a four-fold increase in the proportion of insured workers in small employer firms with deductibles of \$2,000 or more, from six percent up to 28 percent.⁴

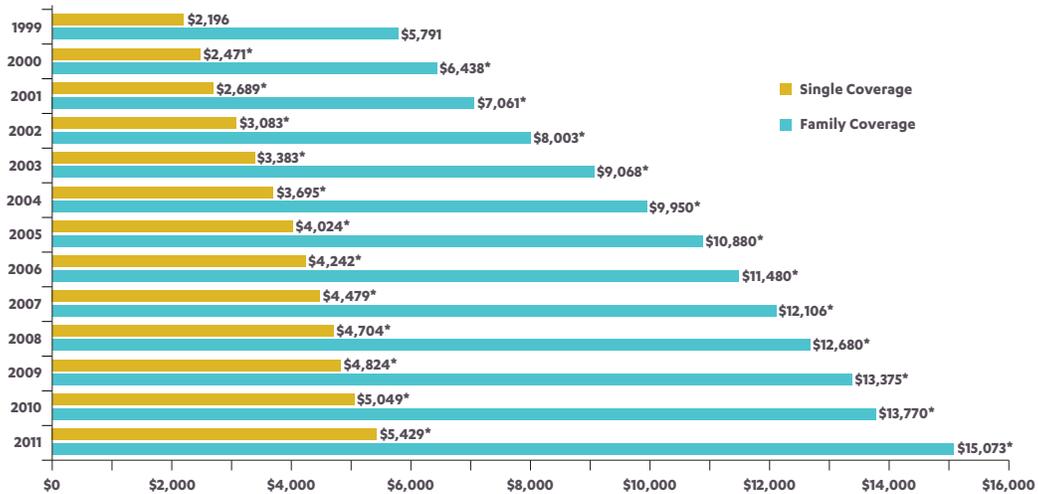
² Thornley, B., Willa, M., Burke, A. (2011) Healthcare and Small Business: Understanding Healthcare Decision Making in California.

³ Source: Kaiser Family Foundation Health Tracking Poll (conducted May 8-14, 2012).

⁴ 2011 Employer Health Benefits Survey, Kaiser Family Foundation/Health Research & Educational Trust, September 2011. Accessed at <http://ehbs.kff.org/>

The following table illustrates the rise in premium levels for individuals and families from 1999 to 2011 in the U.S.

**FIGURE 2: AVERAGE ANNUAL PREMIUMS
FOR SINGLE AND FAMILY COVERAGE, 1999-2011**



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.

The rising costs of premiums put insurance coverage out of reach for many small employers and consumers, especially those with low and moderate incomes. The Affordable Care Act is designed to close the gaps that leave too many Americans, including millions of Californians, without the access to regular health care they need.

SECTION 2

COVERED CALIFORNIA:

A NEW PATHWAY TO AFFORDABLE HEALTH CARE COVERAGE

The Affordable Care Act aims to make it easier for all Americans to get health coverage by changing the law to improve access to coverage, expand coverage options and make insurance more affordable through subsidies and tax credits. A key part of the law is the creation of health benefit exchanges, which are designed to be the vehicle for consumers to access federal tax credits and to make it easier to shop for and enroll in affordable, quality coverage.

Federal law gives states the option to create their own health benefit exchange or allow the federal government to do it for them. Consistent with California's leadership in advancing health reform, state leaders acted six months after passage of the federal Affordable Care Act to enact a law [Chapter 655, Statutes of 2010 (Perez) and Chapter 659, Statutes of 2010 (Alquist)] creating California's Health Benefit Exchange, recently renamed Covered California.

In the law, the California State Legislature declared its intent to:

- Reduce the number of uninsured Californians by creating an organized, transparent marketplace for Californians to purchase affordable, quality health care coverage, to claim available federal tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements imposed under the federal act;
- Strengthen the health care delivery system;
- Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers;
- Require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete based on price, quality, and service, not on risk selection; and
- Meet the requirements of the federal act and all applicable federal guidance and regulations.

Low-income individuals and families will be able to access federal subsidies to offset the cost of premiums, which will make health insurance affordable to millions for the first time.

When California begins offering coverage through Covered California, consumers will have new online tools that allow them to compare for quality, affordable coverage. Lower income individuals and families will be able either to enroll in public programs like Medi-Cal or access subsidies to offset the cost of premiums, which will make health insurance affordable to millions for the first time. Small business owners will find coverage options for employees that did not exist before, and in some cases, those businesses will qualify for tax credits that will help make it easier to provide insurance to their employees.

Shopping for coverage in Covered California will also be easier for consumers because there will be market-wide standards for coverage that will help individuals and small businesses make apples-to-apples comparisons between plans. In addition, insurance companies will be required by law to accept all applicants regardless of their health status rather than competing for only the healthiest consumers. This means that many health consumers who have been locked out of the insurance market due to preexisting conditions will qualify for affordable coverage through Covered California.

LEADERSHIP OF COVERED CALIFORNIA

State law implementing the Affordable Care Act in California created Covered California as an independent state entity governed by a five-member board whose members are appointed by the Governor and Legislature (see Figure 3: Covered California Board Members, on the following page). The Chair is elected annually by the Board pursuant to the law that established the California Health Benefit Exchange.

FIGURE 3: COVERED CALIFORNIA BOARD MEMBERS

MEMBER	APPOINTING AUTHORITY	TERM
<p>DIANA S. DOOLEY Secretary, Health and Human Services Agency and Chair of Covered California. Secretary Dooley began her professional career in public service as an analyst with the State Personnel Board. In 1975, she was appointed to the staff of Governor Edmund G. Brown Jr. where she served as Legislative Secretary and Special Advisor until the end of his term in 1982. Prior to returning to public service in 2011, Ms. Dooley was President and Chief Executive Officer of the California Children’s Hospital Association. She was appointed by Governor Brown to serve as Secretary of the Health and Human Services Agency in 2011.</p>	<p>Ex Officio Voting Member as Secretary of the Health and Human Services Agency</p>	<p>Ex Officio</p>
<p>KIMBERLY BELSHÉ Board Member Ms. Belshé is the Executive Director of First 5 LA (Los Angeles), a child advocacy and grant making organization created by California voters to invest tobacco tax revenue to improve the lives of L.A. County’s young children. Most recently, she was Senior Policy Advisor to the Public Policy Institute of California (PPIC), after having served as Secretary of the California Health and Human Services Agency under Governor Arnold Schwarzenegger. Ms. Belshé was appointed to the Covered California Board by Governor Schwarzenegger in 2010.</p>	<p>Governor</p>	<p>January 2015</p>
<p>PAUL E. FEARER Board Member Mr. Fearer recently retired as a Senior Executive Vice President and Director of Human Resources of UnionBanCal Corporation and its primary subsidiary, Union Bank N.A. He served as the Chair of the Pacific Business Group on Health and has provided strategic leadership on both small group and large employer purchasing for many years.</p>	<p>Assembly Speaker</p>	<p>January 2017</p>
<p>SUSAN P. KENNEDY Board Member Ms. Kennedy served as Chief of Staff to Governor Arnold Schwarzenegger and led Schwarzenegger’s historic health care reform initiative that contained many of the elements of the Affordable Care Act. Previously, she served as Deputy Chief of Staff and Cabinet Secretary to Governor Gray Davis. Ms. Kennedy was appointed to the Covered California Board by Governor Schwarzenegger in 2010.</p>	<p>Governor</p>	<p>January 2015</p>
<p>ROBERT K. ROSS, M.D. Board Member Dr. Ross is President and Chief Executive Officer for The California Endowment, a health foundation established in 1996 to address the health needs of Californians. Previously, Dr. Ross served as Director of the Health and Human Services Agency for the County of San Diego and as Commissioner of Public Health for the City of Philadelphia.</p>	<p>Senate Committee on Rules</p>	<p>January 2016</p>

The Covered California Board met for the first time on April 20, 2011, and has held more than 20 meetings at locations in Sacramento and throughout the state.

COVERED CALIFORNIA VISION, MISSION AND VALUES

Covered California's guiding statements of purpose were developed through an inclusive process that engaged Covered California board members, stakeholders and staff. They were adopted by the Board on October 21, 2011.

The vision of Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care.

The mission is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The Core Values of Covered California are:

CONSUMER-FOCUSED: At the center of Covered California's efforts are the people it serves, including patients and their families, and small business owners and their employees. Covered California will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.

AFFORDABILITY: Covered California will provide affordable health insurance while assuring quality and access.

CATALYST: Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness and reducing health disparities.

INTEGRITY: Covered California will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability and cooperation.

PARTNERSHIP: Covered California welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners and other stakeholders.

RESULTS: The impact of Covered California will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity and lowering costs for all Californians.

With these values in mind, the leadership of Covered California has been working aggressively to put the infrastructure in place to accomplish its mission.

SECTION 3

IMPROVING THE QUALITY OF HEALTH CARE COVERAGE IN CALIFORNIA

Under the Affordable Care Act, health coverage options available to Californians in 2014 will improve due to market reforms that enhance the value of coverage as well as new subsidies and tax credits to offset the cost of insurance.

MARKET REFORMS

While many provisions of the Affordable Care Act have already begun taking effect, many other market reforms will go forward in 2014 that will fundamentally change individual and employer health insurance marketplaces.

HIGHLIGHTS OF INSURANCE MARKET REFORMS UNDER THE AFFORDABLE CARE ACT

Effective Sept. 23, 2010:

- Insurers are prohibited from setting lifetime dollar limits on essential health benefits, such as hospital stays, beginning with new policies issued.
- Insurers are no longer allowed to re-examine a customer's initial application to cancel, or "rescind," their coverage due to unintentional mistakes or minor omissions.
- Dependent children up to age 26 must be offered coverage under a parent's insurance plan.
- Insurers may not exclude children under the age of 19 from coverage due to a pre-existing medical condition.

Effective Jan. 1, 2011:

- Insurance companies are required to spend a specific percentage of premium dollars on medical care and quality improvement activities, and a smaller, limited amount on overhead expenses such as marketing, profits, salaries, administrative costs, and agent commissions. If insurance companies do not meet these new "medical loss ratio" (MLR) standards, they must provide rebates to their customers beginning in 2012.

Effective Jan. 1, 2014:

- Low-income individuals and families between 100 and 400 percent of the federal poverty level will receive federal subsidies to help them buy insurance and cover their out-of-pocket costs. Coverage must be purchased through Covered California to qualify for subsidies.
- Insurance companies must offer the same premium to all applicants of the same age and geographical location regardless of health status, medical conditions, gender or other factors that might predict the use of health services. This provision of the Affordable Care Act, known as "guaranteed issue" is designed to prevent insurance companies from writing policies for only the healthiest individuals.

Effective Jan. 1, 2014 (continued):

- Insurance issuers must offer a comprehensive set of health benefits known as Essential Health Benefits in any health insurance policy (see next section for further discussion).
- Insurance issuers will no longer be permitted to select enrollees based on risk. Several mechanisms in the Affordable Care Act will support this transition by stabilizing premiums starting in 2014, including:
 - **Risk Adjustment** — The Affordable Care Act seeks to end the incentive for issuers to avoid the sick and market only to the healthy by transferring excess payments from plans with lower risk enrollees to plans with higher risk enrollees. Health plans and insurance issuers who experience lower-than-average actuarial risk among enrollees will face assessments, while those who have higher-than-average risk among enrollees will qualify for state payments;
 - **Reinsurance** — The Affordable Care Act establishes a transitional reinsurance program to even out the health insurance market and moderate premium increases during the years that Exchanges are being established. For any plan beginning in the three-year period starting Jan. 1, 2014, insurers must pay into a reinsurance fund. Plans that experience very high claims will qualify for reimbursement from this fund; and,
 - **Corridors** — Under a program of risk corridors set up for calendar years 2014, 2015 and 2016, qualified health plans offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Qualified Health Plan issuers with costs that are three percent less than the issuers' costs projections will remit charges for a percentage of those savings to the U.S. Department of Health and Human Services, while qualified health plan issuers with costs greater than three percent of cost projections will receive payments from the department to offset a percentage of those losses.
- Large employers with at least 50 full-time employees who do not provide affordable health insurance will be required to pay a fee if their employees receive premium tax credits to buy their own insurance in the Exchange.
- Small businesses will be eligible for tax credits aimed at offsetting the cost of credits up to 50 percent of the cost of insurance if they pay for at least half the cost of employee coverage, pay average annual wages below \$25,000 and employ fewer than 10 full-time workers. The credit decreases as company size and average wage rise until it is phased out for employers with 25 or more full-time workers and average annual wages of \$50,000 or more.
- The Affordable Care Act requires all individuals to be enrolled in a health insurance plan that meets minimum standards or pay an assessment, except in cases of very low income individuals who cannot afford insurance or other limited exceptions.

The wide-ranging reforms to the health insurance system will increase competition based on comparative value, reduce “gaming” based on underwriting strategies, and ensure maximum participation — all of which will improve the overall quality of coverage.

Covered California has begun laying the groundwork to implement provisions of federal law and open the new health insurance marketplace in 2014.

ESSENTIAL HEALTH BENEFITS IN CALIFORNIA

The following minimum benefits are enumerated in the Affordable Care Act.

ESSENTIAL HEALTH BENEFITS

- Ambulatory patient services
- Prescription drugs
- Emergency services
- Rehabilitative and habilitative services and devices
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services and chronic disease management
- Mental health and substance use disorder services, including behavioral health treatment
Pediatric services, including oral and vision care

Based on federal guidance, states have some flexibility in defining the essential health benefits that will become the “benchmark” plan for coverage in the state. In California, the Legislature adopted AB 1453 by Assemblyman Bill Monning and SB 951 by Senator Ed Hernandez, which designates the Kaiser Foundation Health Plan Small Group HMO 30 plan, as it was offered during the first quarter of 2012, as the state’s benchmark plan for essential health benefits. On Sept. 30, 2012, Gov. Jerry Brown signed the bills into law.

To make it easier for consumers to compare products on an “apples-to-apples” basis, carriers who offer Qualified Health Plans through Covered California in the individual marketplace and SHOP will be required to sell those same plans outside Covered California. Further, all carriers in the individual and small group markets, including those not in Covered California, will still be required to include in their offerings one product that matches Covered California’s standardized benefit designs. Requiring health plans to match the coverage and price of plans sold inside and out of the Covered California marketplace reduces the likelihood of plans segmenting individuals and small employee groups by risk characteristics and “dumping” riskier, higher-cost populations into Covered California plans. This requirement, along with the federal Affordable Care Act’s risk reduction mechanisms, is designed to protect Covered California plans from adverse risk selection. These and other reforms are intended to shift the focus of the insurance industry to value rather than risk avoidance.

COVERAGE OFFERED IN UNIFORM CATEGORIES

Policies offered through Covered California and in the individual and small employers insurance marketplaces at large will be organized into categories of coverage, making it easier for individuals and small business owners to compare coverage options and tradeoffs.

Every insurance policy offered inside and outside the Covered California marketplace will be given a “metal rating” — platinum, gold, silver or bronze — based on “actuarial value” calculations. This rating indicates the share of costs paid by the plan for health benefits and the share paid by the consumer. For example, a consumer with a bronze-level plan would pay on average 40 percent of the cost of healthcare expenses through features like deductibles and coinsurance, while a consumer with a higher-premium platinum plan would pay only 10 percent.

Consumers will be given the information they need to better understand the tradeoffs inherent in purchasing health insurance coverage. Some may decide they prefer to pay more each month for a plan that covers more of their healthcare costs and helps keep their out-of-pocket costs low. Others may decide their top priority is the lowest monthly premium possible, and they may be willing to accept the risk of paying significantly more when they access care. It will be essential for Covered California to educate consumers about these tradeoffs so they fully understand the choices they are making and the potential overall costs of health care associated with the coverage they select.

While federal law requires a carrier to offer plans rated silver and gold in each Exchange, California state law goes further, requiring plans in Covered California to offer each of the four metal levels as well as a fifth product known as a catastrophic plan. A catastrophic plan is a high-deductible health plan offered through Covered California for mostly individuals under age 30 that features lower premiums for higher deductibles.

FIGURE 4: METAL TIERS BY SHARE OF COST

	SHARE OF COST PAID BY PLAN	SHARE OF COST PAID BY INDIVIDUAL/CONSUMER
BRONZE	60%	40%
SILVER	70%	30%
GOLD	80%	20%
PLATINUM	90%	10%

QUALIFIED HEALTH PLANS

Consistent with its authorizing legislation, the board has determined that Covered California will be an active purchaser in the health insurance marketplace, meaning it will use its purchasing power and clout to negotiate health plan products that have the best value for its enrollees.

California law implementing the Affordable Care Act authorizes Covered California to establish and use a competitive process to select participating health plans. The law enacted in 2010 also requires Covered California to set minimum requirements for participating carriers as well as the standards and criteria for selecting qualified health plans to “provide health care coverage choices that offer the optimal combination of choice, value, quality and service.”

Covered California has established a certification process for these plans, known as Qualified Health Plans. Qualified Health Plans must be offered by “health insurance issuers” who are “licensed and in good standing with the state.” In California, issuers (carriers) may be either licensed as health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 administered by the Department of Managed Health Care, or obtain a certificate of authority as an insurer from the California Department of Insurance.

In early 2012, Covered California embarked on a broad outreach effort to inform the development of its health plan strategy. In February and March 2012, Covered California convened in-person stakeholder group sessions in Los Angeles, Redding, Sacramento, San Diego and San Francisco to gather input on plan selection and design issues. Covered California staff has met regularly with consumer groups, providers and potential health plan partners ranging from the largest carriers in the state to small regional and Medi-Cal managed care plans. In addition, the Covered California Board heard from three panels of stakeholder experts on issues related to health plan selection and promoting delivery reform. Written input was submitted by 47 stakeholder organizations in response to more than 30 questions posed by Covered California relating to qualified health plans, benefit design and promoting healthcare delivery system reform. That input was summarized and presented at the Covered California board meeting on June 19, 2012 titled *The California Path to Achieving Effective Health Plan Design and Selection and Catalyzing Delivery System Reform Stakeholder Input on Key Strategies*.⁵

Covered California selected PricewaterhouseCoopers (PwC) to assist in developing standards and processes for the certification and competitive selection of its plans. This also includes an ongoing program of certification, recertification and decertification,

⁵ http://www.healthexchange.ca.gov/BoardMeetings/Documents/III-B_HBEX-QHPStakeholderReport_5-18-12.pdf

performance measurement, quality monitoring and compliance for participating health plans. PwC was also asked to recommend strategies for Covered California programs or activities that might improve the broader healthcare delivery system in the state. Covered California engaged in data collection and research to identify and compare products in the California market including benefits, premiums and enrollment through review of plan descriptions, evidence of coverage documents and cost sharing summaries.

The Board considered and adopted principles consistent with Covered California's core values to guide the selection and oversight of the plans and benefit designs it would offer based on stakeholder input, and then refined the principles based on that input. These principles include:

- Promoting affordability for the consumer and small employer — both in terms of premium and at point of care;
- Assuring access to quality care for consumers presenting with a range of health statuses and conditions;
- Facilitating informed choice of health plans and providers by consumers and small employers;
- Promoting wellness and prevention;
- Reducing health disparities and fostering health equity;
- Working to reform the health care delivery system while being mindful of Covered California's impact on and role in the broader health care delivery system; and
- Operating with speed and agility and using resources efficiently in the most focused possible way.

Guided by these principles, the Board in August 2012 adopted a comprehensive 260-page set of recommendations⁶ on health plan selection, certification and contracting covering a wide range of issues such as certification requirements, plan and network design issues, accreditation and reporting, administrative simplification, alignment with state programs, dental and vision benefits, and partnerships with plans to promote enrollment. Among the policy recommendations adopted, Covered California intends to:

- Assure that plans in Covered California have sufficient providers to meet the needs of enrollees, and in initial years use and monitor existing regulatory mechanisms to assess this capacity (described as “network adequacy”).
- Assure broad choice of offerings (e.g. four or five different issuers) in all geographic regions of the state, in every metal level choice (platinum, gold, silver, bronze) to facilitate coverage choices and stimulate competition while making clear to certain consumers at lower income levels the value of choosing a Silver-level plan;
- Allow innovation in the SHOP with benefit designs that encourage and reward healthy behaviors through out-of-pocket costs, financial rewards or improved clinical support for avoidance or management of chronic disease;
- Assure participation of safety net providers who have historically served low-income and Medi-Cal populations;
- Encourage inclusion of Federally Qualified Health Centers (FQHCs) in Qualified Health Plan networks and require payment at fair compensation by the Qualified Health Plan defined as rates no less than the generally applicable rates of the issuer;
- Broaden the definition of Essential Community Providers to include physicians, clinics and hospitals which have demonstrated service to the Medi-Cal, low-income, and medically underserved populations;
- Establish a standard for health plan accreditation with a minimum level of quality reporting and transparency than current proposed federal requirements, while also specifying a transitional path for newly organized plans and regional carriers to meet requirements. The accreditation standard would apply for the first two to three years, with the expectation that Covered California will consider more rigorous accreditation standards in later years as it becomes established in the market;

⁶ http://www.healthexchange.ca.gov/BoardMeetings/Documents/August_23_2012/IX_FinalBRB-QHPPoliciesandStrategies_8-23-12.pdf

- Require health plans to provide a health risk assessment tool to enrollees;
- Establish requirements for plan-offered wellness programs in the SHOP;
- Coordinate and align coverage with state health care programs and commercial plans given the expected regular migration in and out of public and private coverage; and
- Collect information and work with its contracted plans to promote changes in how care is paid for and delivered to a catalyst for promoting better care, improved health and lower costs for Californians both inside and outside of Covered California.

In November 2012, Covered California released its qualified health plan solicitation and proposed regulations which reflected these policy decisions. Over thirty health insurers have expressed interest in participating in the new marketplace. Covered California will conduct its selection and certification process for plans that will be offered through the individual and SHOP Covered California markets in early 2013.

SECTION 4

IMPROVING THE AFFORDABILITY OF HEALTH CARE COVERAGE IN CALIFORNIA

FEDERAL SUPPORT FOR LOW AND MODERATE INCOME CALIFORNIANS

For eligible low- and moderate-income individuals and families, Covered California will play a critical role by helping them find out if they are eligible for public programs or obtain federal advance tax credits that will defray premiums in order to make coverage more affordable. The tax credits are based on income and applied on a sliding scale basis to individuals and families earning between 138 and 400 percent of the federal poverty level (approximately \$35,000 to \$94,000 a year for a family of four). The credits are available only for health insurance purchased through Covered California.

Although actual premiums will be based on age, geography and family size the chart below illustrates what an average family of four with varying income levels could expect to pay based on the tax credits that will be offered by Covered California.

FIGURE 5: SAMPLE TAX CREDIT FOR PURCHASE IN COVERED CALIFORNIA

PERCENT OF FPL*	ANNUAL INCOME	UNSUBSIDIZED ANNUAL PREMIUM	TAX CREDIT	ANNUAL PREMIUM AFTER CREDIT	MONTHLY PREMIUM AFTER CREDIT
150	\$35,137	\$14,245	\$12,840	\$1,405	\$117
200	\$46,850	\$14,245	\$11,294	\$2,952	\$246
300	\$70,275	\$14,245	\$7,569	\$6,676	\$556
400	\$93,700	\$14,245	\$5,344	\$8,901	\$742

Example based on family of four headed by a 45-year-old policyholder using 2014 projected incomes, assuming a "silver" plan covering 70 percent of expected medical utilization costs. These figures do not reflect actual premiums and are estimates.

* Federal Poverty Level

In addition to premium subsidies, cost-sharing reductions will reduce point-of-service costs for individuals with incomes between 100 and 250 percent of the federal poverty level in the silver plan. These federal subsidies effectively cap out-of-pocket expenditures, such as deductibles, copays, and coinsurance, at a lower level for individuals in this income range in order to help ensure that both premiums and the cost of accessing care remains affordable for lower income Californians.

The case studies below show how premium reductions and cost-sharing subsidies will make health insurance coverage more affordable for lower income Californians.

CASE STUDY #1

A 29-year-old with asthma who earns \$20,000 a year as a self-employed painter (179% of the federal poverty level)*

BEFORE THE AFFORDABLE CARE ACT

- unable to buy health insurance due to his medical condition
- asthma treated irregularly and ineffectively
- makes regular high-cost trips to the emergency room
- loses wages due to his intermittent inability to work

AFTER THE AFFORDABLE CARE ACT

- buys health insurance for the first time
- obtains regular care from a physician for his asthma
- pays \$89/month in premiums because the \$280 monthly premium for insurance is offset by a federal subsidy of \$191*
- pays a maximum of \$2,017/year in co-pays or deductibles due to provisions of the ACA that cap on out-of-pocket costs for individuals at his income level
- works without interruption and enjoys a better quality of life because his asthma is under control

CASE STUDY #2

A family of four with parents age 33 and 35, one of whom earns \$35,000/year as a window washer (152% of the federal poverty level)*

BEFORE THE AFFORDABLE CARE ACT

- attempted to buy insurance coverage on the individual market and found the monthly premium of \$760 unaffordable
- learned that many of the policies offered did not include benefits they needed such as maternity care
- one family member continued to gain 20 pounds/year, leading to adult-onset diabetes
- began seeking acute care in the emergency room, with costs shifted to the government and others who have insurance

AFTER THE AFFORDABLE CARE ACT

- purchased health coverage for the entire family for the first time
- pays a monthly premium of \$119 due to a \$640 subsidy offsetting the \$760 monthly premium
- paid a maximum of \$4,033 in copays and deductibles due to provisions of the ACA that cap out-of-pocket costs for families at their income level (152% of the federal poverty level)
- established relationships with physicians and began getting regular medical care, learning of the dangers of diabetes and undertaking lifestyle changes to prevent the disease
- began weight loss program to improve health with support from physicians and insurers
- improved overall health and avoided trips to the emergency room, reducing costs to the health care system

* Source for premium/subsidy information: UC Berkeley Labor Center Health Policy Calculator, based on the Affordable Care Act and premium estimates from the Congressional Budget office, adjusted for inflation and age rating, 2012.

HELP FOR SMALL BUSINESS OWNERS

Small businesses will get help from Covered California through an innovative new program known as the Small Business Health Options Program (SHOP), which will make it easier to provide a broader array of health coverage options for employees.

With the market-wide reforms in the small employer insurance market, all insurers — both inside and outside of Covered California — will be part of one combined “risk pool.”

By participating in the SHOP, small employers will be able to provide their employees with the choice of health plans that generally has only been available to large employers.

Certain small businesses — those with 25 or fewer full-time equivalent employees paid an average annual wage of less than \$50,000 — will be eligible to receive a 50 percent federal tax credit for coverage purchased through the SHOP, with an estimated 375,000 small employers in the state qualifying for the tax credit.

Similar to quality standards for individual coverage, the SHOP will offer coverage certified as meeting quality standards.

Covered California intends a phased approach for implementing the SHOP. To facilitate the launch phase, Covered California plans to initially contract for establishment and operational services for SHOP. After 2015, this approach would be evaluated to consider the potential of transitioning the administration of the SHOP functions to in-house operations.

The proposed contract for SHOP administrative services would exclude several SHOP business functions that are considered “core” operational and policy functions. “Core” functions that will be internal to Covered California include:

- **Governance, policy development and quality assurance:** Covered California will retain ultimate governance and policy-making authority and ensure that contractors are meeting contractual quality standards;
- **Health plan management:** Covered California will retain control over health plan selection, certification and ongoing management of plan relationships for the SHOP;
- **Marketing:** Covered California will lead the SHOP marketing efforts and will maintain direction of marketing campaigns and outreach; and
- **Legal:** Covered California will manage legal issues internally.

Covered California issued a solicitation for the administration of the SHOP operations. This solicitation⁷ was published in late September 2012 with the intent to contract with the vendor by the end of 2012.

⁷ <http://www.healthexchange.ca.gov/Solicitations/Pages/HBEX11.aspx>

SECTION 5

ENROLLMENT THAT MAKES THE COMPLEX EASY

Individual consumers and small businesses interested in finding out what the coverage options are will have access to a Web-based portal that will provide a modern, new way to learn about their health insurance options and enroll in coverage. The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) aims to make the process of finding what is affordable and shopping for insurance easy.

With CalHEERS, consumers will have access to online tools that will help them compare coverage, learn about subsidies and determine both the costs of their premium but also their potential out-of-pocket responsibility when they get care. Small business owners will be able to shop with the same purchasing power as large employers to find coverage for their employees. The CalHEERS portal will offer eligibility determinations for both Medi-Cal and federally subsidized Covered California coverage. It will also allow enrollment through multiple access points including mail, phone and in-person applications. This “no wrong door” policy is intended to ensure the maximum number of Californians obtain coverage appropriate to their needs.

In December 2011, Covered California issued a draft solicitation for the design and development of CalHEERS. In response to the request for stakeholder feedback, more than 1,300 specific responses and suggestions were provided to Covered California from the broad stakeholder community, including consumer advocates, providers, health plans, agents and IT vendors. This feedback was used to guide the development of the final solicitation⁸, which was released in January 2012. The procurement evaluation team ranked proposals in five areas: 1) corporate qualifications; 2) project management staffing; 3) functional approach; 4) technical approach; and 5) cost.

Following an extensive review process, Accenture was hired for the design, development and deployment of CalHEERS. The contract includes approximately \$183 million for the initial development and implementation of the system, supported primarily by federal Affordable Care Act implementation funding. After the CalHEERS system becomes operational, the contract provides \$176 million for continued development and operating costs over a period of approximately three and a half years.

⁸ <http://www.healthexchange.ca.gov/Solicitations/Pages/HBEX4.aspx>

Because CalHEERS is serving as the single streamlined eligibility and enrollment system for both Medi-Cal and Covered California plans, the entire design and implementation effort has been built through a close partnership between Covered California and the California Department of Health Care Services which jointly oversee CalHEERS, and the Office of Systems Integration (OSI), which have executed a memorandum of understanding to jointly oversee CalHEERS with OSI providing project management. In addition to the partnerships between Covered California and the Department of Health Care Services, the development and build of CalHEERS has reflected close partnership efforts with federal agency partners who are providing financial support (Center for Consumer Information and Insurance Oversight and Center for Medicare and Medicaid Services), other parts of the State Administration (particularly the Department of Social Services, Department of Finance and California Technology Agency), and counties which implement Medi-Cal program's eligibility and case management function for the State.

CalHEERS is expected to be operational by October 1, 2013 when Californians will be able to enroll for coverage which begins in January 2014. Building a new eligibility and enrollment system for the new opportunities offered by the Affordable Care Act would be challenging under any circumstances, but are particularly so because of the tight timeframe we are operating in. Covered California and the Department of Health Care Services have recognized this fact and sought to build mechanisms will assure success, including:

- Developing a clear governance process that assures needed decisions get made quickly;
- Selecting the most essential components to launch in October and planning for future enhancements that reflect feedback obtained after the initial open enrollment period is completed;
- Testing each version of the software rigorously before it is released;
- Building in iterative opportunities for stakeholder feedback through the requirements validation and design sessions, as well as through webinars, educational panels and focus groups;
- Including substantial external, independent review processes;
- Establishing privacy and security standards to meet federal, state and industry requirements;

- Designing the usability of the system with the consumer view in mind from the start, to minimize the need for time-consuming changes after the system is launched; and
- Setting clear benchmarks and review processes, including by federal oversight agencies.

Covered California and the California Department of Health Care Services plan to have a prototype of the CalHEERS system — the online portal to the new marketplace and public coverage programs — that will go through a period of testing before it goes live. This will provide the CalHEERS team sufficient time to subject the system to various customer enrollment scenarios to ensure it will perform as expected and address any problems identified during the test phase.

SECTION 6

CONNECTING WITH CALIFORNIA'S DIVERSE COMMUNITIES

AN OPPORTUNITY TO EXPAND COVERAGE TO MILLIONS OF CALIFORNIANS

The success of Covered California will depend on connecting with California's diverse communities in a wide variety of ways to increase awareness of new options for health coverage, and provide the support individuals need to enroll. Covered California is committed to an aggressive education, outreach and marketing effort beginning in 2013. As part of these efforts, Covered California has been developing its plans in consultation with the California Department of Health Care Services. In addition, Covered California will make sure that trained personnel are available in person, online and through toll free call centers to help individuals and small business owners get the support they need to select from options and enroll in coverage.

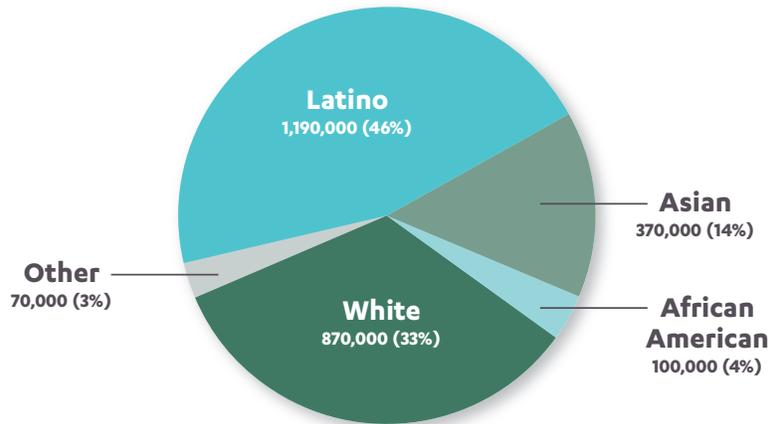
MARKETING, OUTREACH AND EDUCATION

The expansion of health coverage under the Affordable Care Act has the potential to improve the lives of millions of Californians. The number of Californians who stand to benefit from the expanded coverage options from the Affordable Care Act is large and reflects the rich diversity of our State. As of 2014, when the Affordable Care Act's new

The success of Covered California will depend on connecting with California's diverse communities in a wide variety of ways to make them aware of new options for health coverage, help them sort out their options and give them the support they need to enroll.

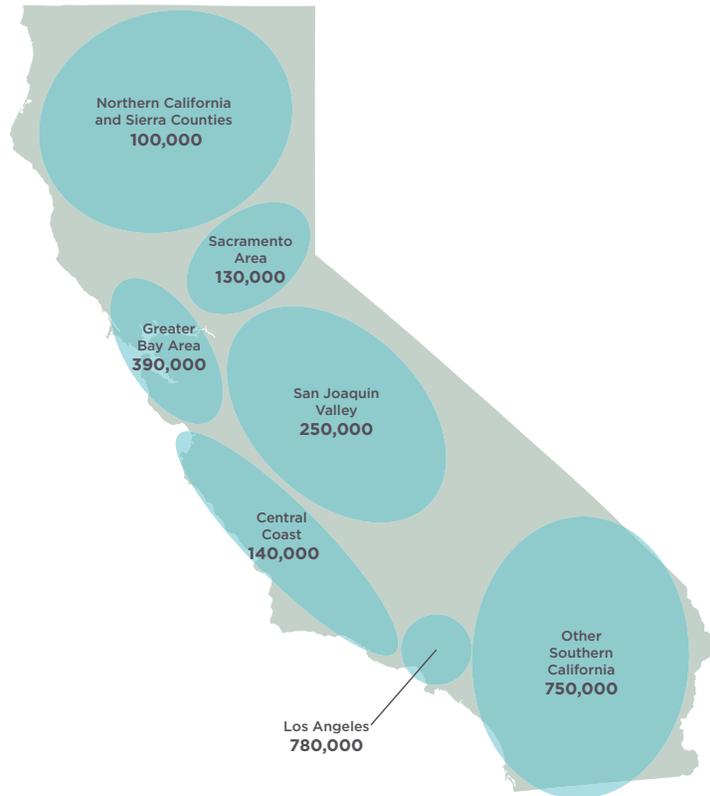
coverage provisions take effect, more than 5.3 million Californians will be Covered California's main target audience. Of that audience, 2.6 million qualify for subsidies through Covered California, and 2.7 million would benefit from guaranteed health coverage and will be able to enroll inside or outside of Covered California. The Marketing, Outreach and Education efforts must reach all those who may be eligible, including California's diverse cultures and multiple languages (see Figure 6: Ethnic Mix of Exchange Subsidy Eligible Californians, on the following page).

FIGURE 6: ETHNIC MIX OF EXCHANGE SUBSIDY ELIGIBLE CALIFORNIANS



California is a diverse state geographically. CalSIM modeling indicates that those who are eligible for health insurance coverage through Covered California with subsidies live in every part of the state (See Figure 7: California’s Exchange Subsidy Eligible Individuals by Region, below.).

FIGURE 7: CALIFORNIA’S EXCHANGE SUBSIDY ELIGIBLE INDIVIDUALS BY REGION



Source: CalSIM Version 1.8

Covered California is directed under state law to carry out efforts “to market and publicize the availability of health care coverage and federal subsidies through the Exchange.”

The law also requires the Board to “undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and re-enrolling in Covered California in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.”

After an extensive competitive selection process, Covered California chose Ogilvy Public Relations and Ogilvy & Mather to develop specific outreach and communication strategies to reach the large and diverse population of California. Those strategies have been guided by comments and suggestions received at stakeholder sessions in Fresno, Los Angeles, Oakland, Rocklin (Placer County), Sacramento, San Bernardino, San Diego, San Francisco and San Mateo. Covered California received input from 31 organizations in response to more than 50 questions. That input was summarized in a report⁹ and presented to the Covered California Board in March 2012. Covered California also conducted focus group research to gain a deeper understanding of the concerns and needs of potential enrollees.

Covered California adopted the following principles for outreach and education:

- Promote maximum enrollment of individuals in coverage — including subsidized coverage in Covered California’s Individual Marketplace and Small Business Health Option Program (SHOP), as well as for individuals who can purchase coverage without subsidies;
- Build on and leverage existing resources, networks and channels to maximize enrollment into health care coverage, including close collaboration with state and local agencies, community organizations, businesses and other stakeholders with common missions and visions;
- Consider where eligible populations live, work and play and select tactics and channels that are based on research and evidence of how different populations can best be reached and encouraged to enroll and, once enrolled retain coverage;

⁹ <http://www.healthexchange.ca.gov/BoardMeetings/Documents/Exchange%20-%20Achieving%20Health%20Care%20Coverage%20Success%20in%202014%20and%20Beyond.pdf>

- Use marketing and outreach strategies that reflect and target the mix and diversity of those eligible for coverage; and
- Promote retention of existing insurance coverage in public programs and the individual market, as well as in employer-based coverage.

Given that Covered California represents an entirely new health insurance marketplace, a comprehensive, multiphase marketing, outreach and education effort will be needed.

Covered California, in consultation with the Department of Health Care Services, has developed a comprehensive marketing, outreach and education plan that incorporates a wide variety of tools including research, targeted mass, social and paid media, public relations and partnerships with a wide array of community, faith, labor, industry, health care, business and other organizations.

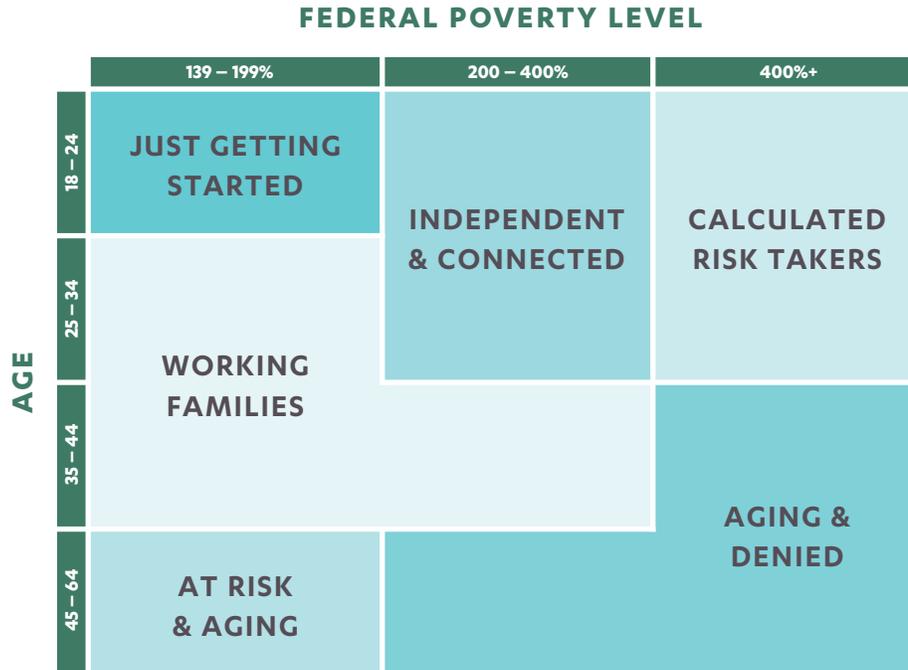
Specifically, the marketing strategy seeks to define and position Covered California as a one-stop marketplace offering financial help for low and moderate income Californians a wide choice of affordable coverage options. It will help build Covered California as a trusted provider of insurance products and a place to comparison shop for quality insurance options. In addition, it will work to foster and build on the desire to have good health through good health insurance coverage.

TARGET AUDIENCES

As mentioned earlier in this section, the primary audience of Covered California's marketing and outreach efforts include more than 5.3 million California residents as of 2014. Of that total, 2.6 million qualify for federal subsidies only available through Covered California, and 2.7 million who may not qualify for federal subsidies but will benefit from guaranteed coverage whether or not enrolling through Covered California's new marketplace.

Covered California is prioritizing its outreach based on the following target segments which very frequently overlap and intersect. Members of the following segments may have different needs and motivations, and therefore require different messages and delivery methods to prompt them to seek health insurance coverage.

FIGURE 8: AUDIENCE PROFILES



Within each of the segments identified in Figure 8, additional research was conducted to further understand the demographic mix of Californians within the target group.

They include:

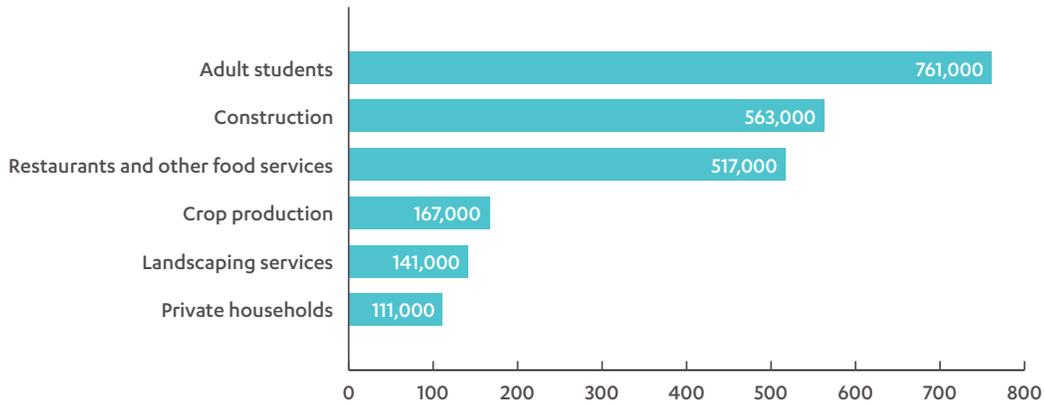
- **Latinos:** Studies show that the majority of California’s uninsured and nearly half of coverage-eligible uninsured are Latino. Reaching Latinos will be critical to the success of Covered California;
- **Additional Ethnic/Racial Populations:** Low-income African-Americans, Asian and Pacific Islanders, and Native Americans are disproportionately represented among the uninsured and will require targeted, culturally sensitive outreach efforts and messaging;
- **Women:** Based on current data, women will be a critical target for this effort. The target group is age 18-49. Single mothers and working women representing multiple ethnic groups provide additional micro-targeting in the female group, but Latinos make up a large portion of this target;
- **Young Adults:** Data shows that the young adult target is disproportionately male. While many programs will be designed to reach young men and young women, young men (age 18-34) will be a core target group. This subgroup is multiethnic.

This group may be under the age of 26 or just off parental health coverage (which, under the Affordable Care Act, now extends to 26 year old individuals). Many working people may be hourly, part-time or temporary employees without benefits. Our data shows that 23 percent of all college students are uninsured;

- **Older Adults:** Another broad target group is adults ages 35-64. While this group includes a balance of men and women, the data shows that older adults are disproportionately single. Again, this target group is made up of multiple ethnic groups. This group may include working poor or individuals who have experienced layoffs/loss of insurance in the past several years;
- **Influencers:** The marketing plan will also target influencers of uninsured Californians such as health care providers, faith-based organizations, state agencies, community leaders and others;
- **“Hard to Move”:** Another critical audience target are those individuals who, for whatever reason, are not inclined to purchase insurance, even if they can afford it, or enroll in public coverage. Some have referred to the first group as the “invincibles” — those people, primarily young men who do not see the value of insurance and do not believe they can afford coverage. Research will help determine what messages may move these individuals to seek coverage; and
- **California Small Businesses (2-50 Employees) and other Employers:** Small business owners and entrepreneurs are another important target as majorities of the uninsured are employed by small businesses. Currently, just 46 percent of firms with fewer than 50 employees offer health insurance. Educating small business owners about the Small Employer Health Options Program (SHOP) is crucial. Small business enrollment and use of Covered California is critical for success, but just as important will be reaching out to small businesses as a way to find the uninsured.

Marketing strategies also will include targeting industries with significant numbers of uninsured workers. Current marketplace data (2010 ACS) shows that there are significant numbers of the uninsured in particular areas of employment (e.g. construction, restaurant/food service, crop production, college students).

FIGURE 9: CALIFORNIA'S UNINSURED: WORKERS AND ADULT STUDENTS



The plan includes both broad outreach targeting the Covered California eligible individuals and small business, as well as targeted industry, trade, union and other communications to reach these large uninsured categories. One key challenge to Covered California's marketing will be to consistently support the continued and expanded coverage of insurance through employers. At the same time, Covered California needs to reach out through these venues to make sure uninsured workers and their families receive the benefits of the Affordable Care Act.

The first phase of the marketing, outreach and education effort was recently completed, which included the development of the Covered California brand. This involved qualitative research, which was conducted in Los Angeles, San Diego and Sacramento among uninsured California adults (men and women) with a variety of incomes from the 138–399 percent and 400+ percent federal poverty level ranges in English, Spanish and other languages. Four groups were also used to both shape the messaging for marketing and outreach and to refine targeting.

Beginning in January 2013, Covered California will step up its work with community-based organizations and partners by offering grants to help inform consumers about the coming benefits. The board approved requesting, as part of its establishment grant, funds for a \$43 million grant program (over 2013 and 2014) to establish and facilitate the outreach and education grant program. The program will engage organizations and entities with trusted relationships with California's uninsured markets to increase awareness and understanding of health coverage options, promote a culture of coverage, motivate Californians to take the next step to enroll and remove barriers to enrollment. Of the \$43 million total, \$3 million will be focused on education and outreach to small businesses. Covered California also is seeking to develop partnerships with retail stores, social media outlets, providers and others to be sure that all Californians understand the opportunities available to them and their new responsibilities as we approach 2014.

These efforts will be reinforced through paid media that will begin in the summer of 2013, just prior to the open enrollment period that begins October 1, 2013 and extends through March 1, 2014.

The marketing, outreach and education effort will rely on measures to evaluate success and course correct as needed, increasing some campaign efforts while reducing others that are less effective. Messaging will emphasize the need to both obtain and retain coverage.

The specific enrollment targets for the marketing, outreach and education effort are as follows:

- By 2015, **1.4 MILLION** Californians enrolled in subsidized coverage in Covered California or eligible to purchase in the individual market without subsidies;
- By 2016, **1.9 MILLION** Californians enrolled in subsidized coverage in Covered California or eligible to purchase in the individual market without subsidies; and
- By 2017, **2.3 MILLION** Californian’s enrolled in subsidized coverage in Covered California or eligible to purchase in the individual market without subsidies.

Effective marketing and outreach will be critical to the success of reform. For Covered California, encouraging enrollment is about selling a service, which may be a financial challenge for many households even with the federal subsidy. Helping consumers understand the choice that is right for them will often require a discussion with an expert on the phone or even an in-person session in their community. Covered California is setting up capacity to meet both of those needs.

HELP A PHONE CALL AWAY

Friendly and responsive experts working at customer service centers will be critical to achieving the goal of maximizing enrollment of eligible individuals and small employers and reducing the number of uninsured Californians. These customer service representatives will answer specific questions from consumers or assisters, refer consumers to resources, such as local in person assisters, or offer Web-based “chat” advice to consumers on-line.

Many individuals who turn to Covered California will need assistance sorting through complex insurance options so they can make choices that are right for them.

Our goal is to make the enrollment process as easy as possible, but we know that many consumers — especially during the initial Covered California enrollment phase — will need more than the “self-service” of the CalHEERS Web portal due to the complexity of their individual circumstances or specific needs. Covered California has developed five principles for the operation of Service Centers, including:

- Provide first-class customer service;
- Offer comprehensive, integrated and streamlined services;
- Be responsive to consumers and stakeholders;
- Assure cost-effectiveness; and
- Optimize best-in-class staffing to support efficient eligibility and enrollment functions.

Covered California has been working closely with the Administration, counties and other stakeholders to develop a strategy to serve the needs of those newly eligible for health care coverage while relying where possible on existing capacity and skills to support

eligibility and enrollment in Medi-Cal.

Based on this work, Covered California Board approved a centralized model¹⁰ for providing customer service at its August 23, 2012 meeting. That model includes a design dividing the work so that consumers potentially eligible for Medi-Cal can be helped by the existing pool of county workers. The centralized model provides for a primary state service center, with the potential of having another site that would be operated under contract with a county.

Covered California is designing a customer service center to support consumers by using the best-in-class technology with staff who speak 12 languages. Friendly and responsive experts working at customer service centers will be critical to achieving the goal of maximizing enrollment of eligible individuals and small employers and reducing the number of medically uninsured Californians.

¹⁰ http://www.healthexchange.ca.gov/BoardMeetings/Documents/August_23_2012/X_CHBE-BRB_ServiceCenterOptions_8-23-12.pdf

IN PERSON HELP WHEN NEEDED — COMPENSATED ASSISTERS ENTITIES, ASSISTERS AND AGENTS

Beyond getting help on the phone, many individuals who turn to Covered California will need assistance sorting through complex insurance options so they can make choices that are right for them. To fulfill this role, Covered California will rely on Certified Enrollment Assistants and licensed insurance agents who receive specialized training.

Working together with the Department of Health Care Services and the Managed Risk Medical Insurance Board, Covered California adopted the following principles for in-person assistance in California:

- Assistants must reflect the cultural and linguistic diversity of the target audiences and result in successful relationship and partnerships; and
- Assistants must be equipped with the information and expertise needed to successfully educate and enroll individuals in appropriate coverage.

Based on a review of reports, research, stakeholder input and lessons learned by California and other states, the Board adopted a strategy for implementing navigation services along with training, compensation, eligibility and standards and assistant recruitment.

Among the key elements of the strategy:

- The Assistants program will include Certified Enrollment Assistants trained, certified and registered with Covered California, responsible for enrolling consumers in Covered California products and programs. Only those Certified Enrollment Assistants who are trained and employed for appropriate entities will be compensated by Covered California. Other Certified Enrollment Assistants, including health insurance agents, hospitals and providers, will be required to complete all training and become certified but will not be compensated by Covered California;
- Compensation will be \$58 per successful enrollment in Covered California based product (individual or family);
- Compensation will be \$25 per successful annual re-determination of enrollment in Covered California based product (individual or family);
- Certified Enrollment Assistants will be required to complete education, eligibility, and enrollment activities and will be sufficiently trained to assist individuals in completing eligibility requirements for all Covered California coverage;

- Assisters will have the option to target specific markets or populations (e.g. low income, cultural and linguistic groups, or other segments);
- Eligible Certified Enrollment Assisters must be affiliated with an enrollment entity. Individual assisters are not eligible for enrolling individuals in Covered California products;
- Certified Enrollment Assisters, will be certified through Covered California after completing required trainings;
- All certified enrollment entities and their assisters will sign a code of conduct relating to confidentiality and assister guidelines; and
- All assisters will be trained and required to complete the eligibility process required for potential enrollment in Medi-Cal and support the individual’s enrollment in plans or options relevant to their eligibility.

Health insurance agents have historically played a key role in helping employers and consumers enroll in health coverage by guiding them through options and helping them find appropriate plans based on their needs. Covered California recognizes that agents should play an important role in promoting Covered California products in the individual market.

The Affordable Care Act prohibits Covered California from directly compensating agents for enrollment assistance if they are also paid by health plans. Covered California therefore adopted a compensation policy for agents certified by Covered California that would allow for participating health plans to pay agents directly under their own commission arrangements. In this approach, agents are incentivized to help enroll consumers into Covered California products. However, while agents may be paid by plans, Covered California will establish and enforce strict policies which will assure that assisters — whether they be agents or other types of assisters — do not steer consumers to particular health plans.

SECTION 7

WORKING WITH STAKEHOLDERS

One of Covered California's core values is to act in partnership with stakeholders and Californians from all walks of life.

Consumers, health plans and providers, large and small businesses, labor unions, community leaders and organizations, philanthropic organizations, and many other organizations have come together to share their vision, values, energy and resources. The policy expertise, hands-on experience with California's communities and informed recommendations about how Covered California should proceed has strengthened the decision-making process.

To date, the leadership of Covered California has met with hundreds of stakeholders throughout California and has received and reviewed tens of thousands of pages of written input on a wide range of issues on strategic, tactical and operational decisions before them.

The Covered California's approach to gathering stakeholder input includes:

- Inviting feedback at board meetings, where stakeholders are offered opportunities to make presentations to the Board on policy issues under consideration and comment on any agenda item;
- Receiving reports and comment letters;
- Sharing program updates with stakeholders via e-mail (stakeholders can subscribe to the distribution list through a link on Covered California homepage);
- Holding focus groups and informal stakeholder group meetings to solicit comment from health care consumers enrolled in health plans, individuals and entities with experience in facilitating enrollment in health plans, representatives of small businesses and self-employed individuals and advocates for enrolling hard-to-reach populations;
- Meeting with individual stakeholder groups and making presentations at stakeholder conferences and webinars;

- Convening work groups with consumer advocates, providers, health plans, counties, labor, brokers and small businesses to advise Covered California, Department of Health Care Services and the Managed Risk Medical Insurance Board on eligibility and enrollment issues;
- Holding ad hoc statewide meetings and webinars to gather input on marketing, outreach and education, grant application, enrollment and qualified health plan issues; and
- Soliciting website responses to specific, detailed questions on policy issues before the Board.

The leadership of Covered California has met with hundreds of stakeholders throughout California and has received and reviewed tens of thousands of pages of written input on a wide range of issues.

During 2012, Covered California engaged in planning for the first consultation with Indian Tribes as required by the Affordable Care Act. The goal of the consultation is to address Covered California policies and actions that have tribal implications so that the state and Tribes can share information that leads to mutual understanding and informed decision-making. That process had led to the Board adopting a formal tribal consultation policy and forming a standing advisory group.

To promote stakeholder transparency and input, Covered California has established a public website at www.hbex.ca.gov and is continually adding new and updated content.

In September 2012, Covered California elected to convene three stakeholder advisory groups to collect input on specific topics beginning in January 2013. They include:

- The Plan Management Advisory Group for Qualified Health Plan selection, monitoring, re- and de-certification, quality rating and ongoing benefit design issues;
- The Marketing, Outreach and Education and Enrollment Assistance Advisory Group for marketing strategies by target population and media channel (e.g., digital, television, print), effective community outreach strategies, and strategies for providing in person assistance with enrollment in insurance affordability programs; and

- The Small Employer Health Options Program (SHOP) Advisory Group for strategies to raise interest in the SHOP and ensure that it provides value for small employers.

The composition of each advisory group will be tailored to the scope of the group, and up to two Board members may participate in each advisory group. Advisory groups would be limited to 12-15 members in order to ensure meaningful participation by all members. Representatives of state partner departments will be invited to participate as ex-officio members. Advisory group meetings will be open to the public, with opportunities for public comment at designated times during the meetings. The advisory group committee calendar will be set early in the calendar year to facilitate public participation. Agendas and meeting materials will be posted in advance of the meetings.

SECTION 8

COVERED CALIFORNIA OPERATIONS AND FUNDING: A COMMITMENT TO TRANSPARENCY, ACCOUNTABILITY AND COLLABORATION

Twenty months ago, Covered California had no office space, no furniture or computer equipment, and no staff. Over time, it has grown to include a dedicated team tasked with tackling the administrative, legal and technical responsibilities required to launch Covered California. Covered California staff reflects the diversity of the state and the diversity of expertise and perspectives that are needed for Covered California to succeed, including individuals with deep experience in government, private insurance plans, health policy, finance and operations.

TRANSPARENCY AND COLLABORATION

Covered California is governed by the state's Bagley-Keene Open Meeting Act, which requires all meetings of state boards and commissions be publicly noticed with an agenda at least 10 days before the meeting and that the public have opportunity to provide comment at the meeting. On average, board meetings draw 150 attendees with public comment provided by one-fourth of all participants. In addition, all board meetings are webcast with opportunities for phone participants to ask questions or comment. Board meeting minutes, agendas, meeting materials and stakeholder comments are posted on the Covered California website, www.hbex.ca.gov. In addition, board meetings are held throughout the state to engage local communities in the discussions.

The Board, staff and contractors of Covered California are subject to appropriate provisions of the California Political Reform Act and Conflict of Interest Code provisions adopted by the California Fair Political Practices Commission. The Covered California Board has adopted a separate conflict of interest code consistent with its authorizing legislation and specific to the duties and activities of Covered California. The Board also developed organizational bylaws for Covered California consistent with state and federal laws applicable to Covered California operations, outlining board membership, powers and duties, committees, meeting procedures and other operational aspects of Covered California.

Covered California staff actively collaborates with the Department of Health Care Services as required by its authorizing legislation as well as other state health program administrators and key regulators including the California Department of Insurance and

the Department of Managed Health Care. Key areas of collaboration include development of joint vendor solicitations where appropriate, joint responses to proposed federal regulations, shared stakeholder consultation strategies and forums, and collaborative analysis of federal statute and implementing regulations compared to state law. In addition, executives from Covered California, the Department of Health Care Services, the Managed Risk Medical Insurance Board, the California Department of Insurance, the Department of Managed Health Care and any other parts of the Brown administration meet regularly to discuss common efforts, assign staff and discuss key policy issues.

FUNDING

Covered California's authorizing statute bars the use of California General Fund money to either establish or operate California's exchange. Covered California receives all of its start-up funding from the federal government as part of the support to states implementing the Affordable Care Act. Those start-up funds will support Covered California through 2014, the first full year of individuals being enrolled. From 2015 Covered California must be wholly self-sufficient with funding derived from participation fees on health plans in the Covered California marketplace. Since affordability is "job one" for Covered California, keeping its own costs down is a constant imperative.

Since September 2010, Covered California has received \$236.5 million in federal planning grants from the Department of Health and Human Services for implementation of the Affordable Care Act, including:

- A \$1 million planning grant to establish the Board and recruit key staff; analyze insurance markets, gather public and stakeholder input, collect data on projected insurance markets and develop multiyear plans;
- A \$39 million Level 1 Establishment grant work plan supporting robust, comprehensive strategic, business and operational planning, including information-technology analysis and system design from August 15, 2011 to August 15, 2012; and
- A \$196.5 million Level 1.2 Establishment grant request awarded August 23, 2012 to support background research and evaluation, stakeholder consultation, program integration, qualified health plan management, establishment of SHOP, eligibility and enrollment, consumer outreach, marketing and assistance; information technology (accounting for the bulk of the funding request — \$153 million), a customer service center, operations and financial management. This grant supports work from August 15, 2012 to June 15, 2013.

FIGURE 10: TOTAL EXCHANGE EXPENDITURES - PROGRAM AREA
8/2011 - 10/2012

Functional Area	Total Funding*	Total Expenses	Encumbrances**	Balance
Program Operations	27,542,318	4,139,807	3,388,899	20,013,612
Health Plan Management	7,341,160	1,407,332	384,619	5,549,209
SHOP	1,328,091	155,656	24,182	1,148,253
Service Center	2,040,821	732,165	-	1,308,656
CalHEERS	151,637,782	27,604,821	85,080,097	38,952,865
Eligibility & Enrollment	17,949,908	68,765	530,000	17,351,144
Marketing, Outreach & Education	28,060,929	970,915	601,998	26,488,017
TOTAL	\$ 235,901,009	\$ 35,079,461	\$ 90,009,795	\$ 110,811,753

* Funds approved in Federal Level 1.1 and 1.2 grants

** Encumbrances reflect executed purchase orders and contracts as of October 2012

In November 2012, Covered California submitted a Level 2.0 funding request to the federal government for \$706 million to provide funding for 2013 and 2014.

Covered California also submitted to the federal government its “Blueprint” for operating a state-based insurance exchange in December 2012. The federal government must approve this plan before designating Covered California as a state-based exchange.

Part of the Blueprint plan is a requirement that a state exchange must demonstrate that it will be self-sustaining with sufficient funding to support ongoing operations beginning January 1, 2015. Consistent with this requirement, Covered California’s authorizing statute requires Covered California to assess a charge on qualified health plans participating in Covered California that is reasonable and necessary to support the development, operations, and prudent cash management. The statute also mandates Covered California maintain health plan enrollment and expenditures to ensure that expenditures do not exceed revenues and to maintain fiscal solvency.

Covered California has developed and maintains routine internal financial and accounting systems, protocols, and policies to monitor and track grants, revenues and expenditures with accounting and administrative support from the California Department of Social Services. The Department assists Covered California in adhering to federal Department of Health and Human Services financial monitoring activities and establishing a financial and management structure with experienced staff and ability to respond to federal audits. Covered California has initiated internal policies and procedures to comply with state and federal requirements related to Covered California operations.

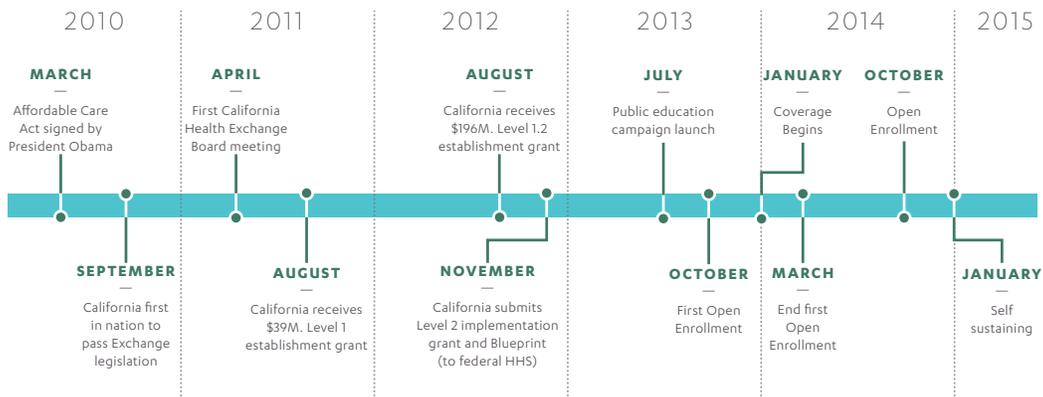
SECTION 9

COUNTDOWN TO ENROLLMENT

The federal Affordable Care Act promises enormous reform that will change the lives of millions of Californians. At the same time, it sets in motion ambitious timelines that require swift action to achieve success.

In less than 12 months — on October 1, 2013 — open enrollment will begin, giving Californians their first opportunity to select among a range of new health care options, including the Exchange-based products.

FIGURE 11: TIMELINE OF MAJOR COVERED CALIFORNIA MILESTONES



Covered California is completing work on its marketing, outreach and education plan in order to be prepared to implement the plan beginning in 2013. At that time, Covered California will have finalized key marketing tasks such as selecting a brand name for the Exchange, key marketing messages communicating the benefit and value of purchasing health coverage through the Exchange, and selecting optimum communication channels and media. The goal of outreach and marketing activities in 2013 is to maximize awareness of Covered California and its value in advance of the October 1, 2013 initial enrollment date in order to enroll as many Californians and small businesses as possible. Attracting a robust pool of healthy individuals to Covered California will help ensure the success and affordability of health coverage for all Californians, both in and out of Covered California.

Covered California will also spend a period of time leading up to October 2013 making sure that those who help Californians enroll have the training they need to be successful. Whether consumers seek help online, in person or through a toll free number to enroll

in Covered California-based coverage, they will need to connect with someone who thoroughly understands the coverage options available and can answer detailed questions about how subsidies and tax credits will work for a consumer's specific circumstances. Moreover, the training must also ensure that those who are trained are ready to advise Californians from diverse cultures who may have limited understanding of health insurance and/or limited English proficiency.

With continued focus, engagement of government partners, stakeholders and the broader public, Covered California is poised to be a key part of enabling California to take a giant step in January 2014 to reduce the number of people living without health insurance coverage. Covered California will work vigorously in the coming months and years to help make quality health care more affordable so Californians can access the care they need and have the tools to live healthier lives.



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February 13, 2013 **Media Line:** (916) 205-8403

No Gimmicks, No Surprises – Standard Benefits

Covered California Announces Standard Benefit Plans for Consumers

BOARD MEMBERS

Diana S. Dooley, Chair
Kimberly Belshé
Paul Fearer
Susan Kennedy
Robert Ross, MD

EXECUTIVE DIRECTOR

Peter V. Lee

SACRAMENTO, Calif. – Californians who must pay for their own health insurance are getting their first detailed look at what health care reform will truly offer. Covered California, the state run program that oversees implementation of the Affordable Care Act, is releasing the standards for benefit plans that will be made available to California citizens who do not rely on employer provided insurance or Medi-Cal for health care coverage.

“The most important aspect of these benefits is they are standardized and they are adjusted according to income to lower costs for those with lower incomes,” said Peter V. Lee, Executive Director of Covered California. “Standardization is a game changer. It lets consumers shop from one insurance provider to the next, knowing that the benefits are the same. This is about removing barriers to care; about changing the focus of health insurance on prevention and on taking care of the sick.”

“Covered California is leading the way for consumers to make apples to apples comparisons when choosing health coverage,” said James Guest, President and CEO of Consumers Union. “Not only can consumers no longer be denied due to pre-existing conditions, they know there will be no surprises or gimmicks, and the benefits are the same from one carrier to the next.”

Consumers have four levels of plans from which to choose – Bronze, Silver, Gold and Platinum. Households earning less than 250 percent of the federal poverty level can receive financial help if they enroll in a Silver plan; the less income they earn, the more financial assistance they can receive. For example, individuals earning between 150 to 250 percent of the federal poverty level can expect to pay \$20 to see their primary care physician, while those earning 100 to 150 percent would pay \$4.

“California has clearly learned from our experience. Massachusetts launched its health insurance exchange without standardizing benefits, but changed course after recognizing that allowing consumers to make apples-to-apples comparisons among plan options is critical to their ability to make informed decisions about what health plan satisfies their needs and meets their budget.” said Jean Yang, Executive Director of Massachusetts Health Connector.

-continued-

To be eligible for financial support, consumers must purchase plans from Covered California's marketplace. The State of California is leading the health care innovation process by requiring that all carriers offer these same standard designs to all individuals and small businesses – whether inside or outside of Covered California. While higher income individuals choosing one of these plans would not be eligible for financial help, they would be assured that the plan contains the same essential health benefits offered, and the exact same benefit design so they can make true comparisons.

Examples of benefits, their costs, and typical premium costs are available on the newly launched Covered California website, www.CoveredCA.com. The website will deliver up-to-date information for consumers, and access to resources during the lead up to the open enrollment period this fall for coverage that starts January 1, 2014. The website currently includes seven fact sheets, in both English and Spanish, and additional fact sheets are soon to be added, as well as translation of the material in 11 more languages.

Covered California also announced it has launched a social media presence on Facebook, Twitter, YouTube and Google+.

Critical next steps in the launch of Covered California include the selection of insurance carriers that will be allowed to participate in Covered California, and determination of the plan pricing.

About Covered California

California is the first state to create a health benefit exchange following the passage of federal health care reform. Covered California is charged with creating a new insurance marketplace that allows individuals and small businesses to purchase competitively priced health plans using federal tax subsidies and credits. Coverage starts in 2014.

Covered California is overseen by a five-member board appointed by the Governor and Legislature; the California Health and Human Services Secretary serves as an ex officio voting member and is its current Chair.

For more information on Covered California, please visit www.CoveredCA.com.

###

What People are Saying

About Covered California's standard benefit plans

James Guest

Consumers Union, President and CEO

"At Consumer Reports, our stock and trade is translating complex information into standardized formats for easy apples-to-apples comparisons. By standardizing its benefit designs, Covered California is leading the way in uniform products that allow valid comparisons of health insurance policies, taking the pain out of the dreaded experience of shopping for health insurance. For the first time, consumers without employer-based coverage will be able to readily assess what they are getting, what they are not getting, and the true value of various health insurance options. That's just plain common sense -- but in the health insurance world it's revolutionary. Bravo, Covered California, for holding consumer needs for understandable information at the forefront."

Jean Yang

State of Massachusetts, Health Connector Executive Director

"California has clearly learned from our experience. Massachusetts launched its health insurance exchange without standardizing benefits, but changed course after recognizing that allowing consumers to make apples-to-apples comparisons among plan options is critical to their ability to make informed decisions about what health plan satisfies their needs and meets their budget."

Pam Kehaly

Anthem Blue Cross, President

"Anthem Blue Cross applauds Covered California for their continued partnership with all stakeholders and their consumer-focused approach in developing benefit plans that will make comparing and choosing plans easier than ever before."

Paul Markovich

Blue Shield of California, CEO & President

"With the establishment of this standardized benefit package, Covered California has achieved a major milestone toward the launch of the new, reformed health insurance marketplace. As important as the result was the intensely collaborative process that produced it. Covered California's diligence in hearing all voices bodes well for its success in meeting the many tough challenges that lie ahead."

Bill S. Wehrle

Kaiser Permanente, Vice President, Health Insurance Exchanges

"We applaud Covered California for its leadership in making the health coverage marketplace simpler for consumers. Consumer choice is a powerful tool, especially when it can be unleashed to reward quality, service, and price, and not be held back by complexity or other artificial barriers. Kaiser Permanente has strongly supported simplifying consumer choice in the new marketplace, and today's announcement is a big step toward making it happen."

###

**Covered California
Standard Benefit Plan Designs
Summary of Benefits and Coverage**

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	Platinum Coinsurance Plan	Platinum Copay Plan
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$4,000	\$4,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$25		\$25	
	Specialist visit	\$50		\$50	
	Other practitioner office visit	\$25		\$25	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$25		\$25	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%			
Need immediate attention	Emergency room services (waived if admitted)	\$150		\$150	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$50		\$50	
Hospital stay	Facility fee (e.g., hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25		\$25	
	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
	Substance use disorder outpatient services	\$25		\$25	
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days	
Pregnancy	Prenatal and postnatal care	\$25		\$25	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%		
Help recovering or other special health needs	Home health care	10%		\$25	
	Rehabilitation services	\$25		\$25	
	Habilitation services	\$25		\$25	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment	
	Dental Basic Services				
Dental Restorative and Orthodontia Services					

Notes:

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 6) Glasses benefit limited to \$100 per year.
- 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

**Covered California
Standard Benefit Plan Designs
Summary of Benefits and Coverage**

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	Gold Coinsurance Plan	Gold Copay Plan
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45	
	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$45		\$45	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Generic drugs	\$25		\$25	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%			
Need immediate attention	Emergency room services (waived if admitted)	\$250		\$250	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g., hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45		\$45	
	Mental/Behavioral health inpatient services	20%		\$600 per day up to 5 days	
	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal and postnatal care	\$45		\$45	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%		
Help recovering or other special health needs	Home health care	20%		\$45	
	Rehabilitation services	\$45		\$45	
	Habilitation services	\$45		\$45	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment	
	Dental Basic Services				
Dental Restorative and Orthodontia Services					

Notes:

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 6) Glasses benefit limited to \$100 per year.
- 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

**Covered California
Standard Benefit Plan Designs
Summary of Benefits and Coverage**

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$500	\$500
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45		
	Specialist visit	\$65		\$65		
	Other practitioner office visit	\$45		\$45		
	Preventive care/ screening/ immunization	No cost share		No cost share		
Tests	Laboratory Tests	\$45		\$45		
	X-rays and Diagnostic Imaging	\$65		\$65		
	Imaging (CT/PET scans, MRIs)	20%	X	\$250		
Drugs to treat illness or condition	Generic drugs	\$25		\$25		
	Preferred brand drugs	\$50	X	\$50	X	
	Non-preferred brand drugs	\$70	X	\$70	X	
	Specialty drugs	20%	X	20%	X	
Outpatient surgery	Facility fee (e.g., ASC)	20%	X	20%	X	
	Physician/surgeon fees	20%				
Need immediate attention	Emergency room services (waived if admitted)	\$250	X	\$250	X	
	Emergency medical transportation	\$250	X	\$250	X	
	Urgent care	\$90		\$90		
Hospital stay	Facility fee (e.g., hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45		\$45		
	Mental/Behavioral health inpatient services	20%	X	20%	X	
	Substance use disorder outpatient services	\$45		\$45		
	Substance use disorder inpatient services	20%	X	20%	X	
Pregnancy	Prenatal and postnatal care	\$45		\$45		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care	20%		\$45		
	Rehabilitation services	\$45		\$45		
	Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
	Hospice service	No cost share		No cost share		
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%		
	Glasses	1 pair per year		1 pair per year		
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment		
	Dental Basic Services					
Dental Restorative and Orthodontia Services						

Notes:

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- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 7) Glasses benefit limited to \$100 per year.
- 8) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

**Covered California
Standard Benefit Plan Designs
Summary of Benefits and Coverage**

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	SHOP	SHOP
	Silver Coinsurance Plan	Silver Copay Plan
	71.2%	71.0%
	N/A	N/A
Overall deductible		
Other deductibles for specific services		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45		
	Specialist visit	\$65		\$65		
	Other practitioner office visit	\$45		\$45		
	Preventive care/ screening/ immunization	No cost share		No cost share		
Tests	Laboratory Tests	\$45		\$45		
	X-rays and Diagnostic Imaging	\$65		\$65		
	Imaging (CT/PET scans, MRIs)	20%	X	\$250		
Drugs to treat illness or condition	Generic drugs	\$25		\$25		
	Preferred brand drugs	\$50	X	\$50	X	
	Non-preferred brand drugs	\$70	X	\$70	X	
	Specialty drugs	20%	X	20%	X	
Outpatient surgery	Facility fee (e.g., ASC)	20%	X	20%	X	
	Physician/surgeon fees	20%				
Need immediate attention	Emergency room services (waived if admitted)	\$250	X	\$250	X	
	Emergency medical transportation	\$250	X	\$250	X	
	Urgent care	\$90		\$90		
Hospital stay	Facility fee (e.g., hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45		\$45		
	Mental/Behavioral health inpatient services	20%	X	20%	X	
	Substance use disorder outpatient services	\$45		\$45		
	Substance use disorder inpatient services	20%	X	20%	X	
Pregnancy	Prenatal and postnatal care	\$45		\$45		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care	20%		\$45		
	Rehabilitation services	\$45		\$45		
	Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
	Hospice service	No cost share		No cost share		
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%		
	Glasses	1 pair per year		1 pair per year		
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment		
	Dental Basic Services					
Dental Restorative and Orthodontia Services						

Notes:

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- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 7) Glasses benefit limited to \$100 per year.
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Actuarial Value SUBJECT TO FINAL FEDERAL RULES

Individual & SHOP

Silver HSA Plan

Overall deductible	\$1500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	20%	X	
	Specialist visit	20%	X	
	Other practitioner office visit	20%	X	
	Preventive care/ screening/ immunization	No cost share		
Tests	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Generic drugs	20%	X	
	Preferred brand drugs	20%	X	
	Non-preferred brand drugs	20%	X	
	Specialty drugs	20%	X	
Outpatient surgery	Facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
Need immediate attention	Emergency room services (waived if admitted)	20%	X	
	Emergency medical transportation	20%	X	
	Urgent care	20%	X	
Hospital stay	Facility fee (e.g., hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20%	X	
	Mental/Behavioral health inpatient services	20%	X	
	Substance use disorder outpatient services	20%	X	
	Substance use disorder inpatient services	20%	X	
Pregnancy	Prenatal and postnatal care	20%	X	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care	20%	X	
	Rehabilitation services	20%	X	
	Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
	Hospice service	No cost share	X	
Child needs dental or eye care	Eye exam (deductible waived)	0%		
	Glasses	1 pair per year		
	Dental check-up - Preventive and Diagnostic	See attachment		
	Dental Basic Services			
Dental Restorative and Orthodontia Services				

Notes:

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- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
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- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 7) Glasses benefit limited to \$100 per year.
- 8) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

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Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$4		\$20	
	Specialist visit	\$6		\$25	
	Other practitioner office visit	\$4		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$6		\$20	
	X-rays and Diagnostic Imaging	\$10		\$25	
	Imaging (CT/PET scans, MRIs)	10%		15%	X
Drugs to treat illness or condition	Generic drugs	\$4		\$8	
	Preferred brand drugs	\$7		\$18	X
	Non-preferred brand drugs	\$10		\$27	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	X
	Physician/surgeon fees	10%		15%	
Need immediate attention	Emergency room services (waived if admitted)	\$25		\$75	X
	Emergency medical transportation	\$25		\$75	X
	Urgent care	\$8		\$40	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee	10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$4		\$20	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	\$4		\$20	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal and postnatal care	\$4		\$20	
	Delivery and all inpatient services	Hospital	10%	15%	X
		Professional	10%	15%	
Help recovering or other special health needs	Home health care	10%		15%	
	Rehabilitation services	\$4		\$20	
	Habilitation services	\$4		\$20	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment	
	Dental Basic Services				
Dental Restorative and Orthodontia Services					

Notes:

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- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

**Silver Coinsurance Plan
200%-250% FPL**

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

73.9%

Overall deductible

N/A

Other deductibles for specific services

Medical

\$1,500

Brand Drugs

\$500

Dental

See attachment

Out-of-pocket limit on expenses

\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$45		
	Specialist visit	\$55		
	Other practitioner office visit	\$45		
	Preventive care/ screening/ immunization	No cost share		
Tests	Laboratory Tests	\$45		
	X-rays and Diagnostic Imaging	\$55		
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Generic drugs	\$20		
	Preferred brand drugs	\$30	X	
	Non-preferred brand drugs	\$50	X	
	Specialty drugs	20%	X	
Outpatient surgery	Facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%		
Need immediate attention	Emergency room services (waived if admitted)	\$250	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$90		
Hospital stay	Facility fee (e.g., hospital room)	20%	X	
	Physician/surgeon fee	20%		
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45		
	Mental/Behavioral health inpatient services	20%	X	
	Substance use disorder outpatient services	\$45		
	Substance use disorder inpatient services	20%	X	
Pregnancy	Prenatal and postnatal care	\$45		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care	20%		
	Rehabilitation services	\$45		
	Habilitation services	\$45		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
	Hospice service	No cost share		
	Eye exam (deductible waived)	0%		
Child needs dental or eye care	Glasses	1 pair per year		
	Dental check-up - Preventive and Diagnostic	See attachment		
	Dental Basic Services			
	Dental Restorative and Orthodontia Services			

Notes:

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- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
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**Covered California
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$4		\$20	
	Specialist visit	\$6		\$25	
	Other practitioner office visit	\$4		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$6		\$20	
	X-rays and Diagnostic Imaging	\$10		\$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat illness or condition	Generic drugs	\$4		\$8	
	Preferred brand drugs	\$7		\$18	X
	Non-preferred brand drugs	\$10		\$27	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	X
	Physician/surgeon fees				
Need immediate attention	Emergency room services (waived if admitted)	\$25		\$75	X
	Emergency medical transportation	\$25		\$75	X
	Urgent care	\$8		\$40	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$4		\$20	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	\$4		\$20	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal and postnatal care	\$4		\$20	
	Delivery and all inpatient services	10%	Hospital Professional	15%	X
Help recovering or other special health needs	Home health care	\$4		\$20	
	Rehabilitation services	\$4		\$20	
	Habilitation services	\$4		\$20	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic				
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				
		See attachment		See attachment	

Notes:

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

**Silver Copay Plan
200%-250% FPL**

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

73.6%

Overall deductible

N/A

Other deductibles for specific services

Medical

\$1,500

Brand Drugs

\$500

Dental

See attachment

Out-of-pocket limit on expenses

\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$45	
	Specialist visit	\$55	
	Other practitioner office visit	\$45	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	\$45	
	X-rays and Diagnostic Imaging	\$55	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$20	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees		
Need immediate attention	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
	Urgent care	\$90	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee		
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	\$45	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal and postnatal care	\$45	
	Delivery and all inpatient services	Hospital Professional 20%	X
Help recovering or other special health needs	Home health care	\$45	
	Rehabilitation services	\$45	
	Habilitation services	\$45	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic		
	Dental Basic Services		
	Dental Restorative and Orthodontia Services		See attachment

Notes:

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- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

	Bronze Plan	Bronze HSA Plan
Overall deductible	\$5000 integrated Med/Rx Ded	\$4500 integrated Med/Rx Ded
Other deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$60	After 1st 3 non-preventive visits	40%	X	
	Specialist visit	\$70	X	40%	X	
	Other practitioner office visit	\$60	X	40%	X	
	Preventive care/ screening/ immunization	No cost share		No cost share		
Tests	Laboratory Tests	30%	X	40%	X	
	X-rays and Diagnostic Imaging	30%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X	
Drugs to treat illness or condition	Generic drugs	\$25	X	40%	X	
	Preferred brand drugs	\$50	X	40%	X	
	Non-preferred brand drugs	\$75	X	40%	X	
	Specialty drugs	30%	X	40%	X	
Outpatient surgery	Facility fee (e.g., ASC)	30%	X	40%	X	
	Physician/surgeon fees	30%	X	40%	X	
	Emergency room services (waived if admitted)	\$300	X	40%	X	
Need immediate attention	Emergency medical transportation	\$300	X	40%	X	
	Urgent care	\$120	After 1st 3 non-preventive visits	40%	X	
Hospital stay	Facility fee (e.g., hospital room)	30%	X	40%	X	
	Physician/surgeon fee	30%	X	40%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60	X	40%	X	
	Mental/Behavioral health inpatient services	30%	X	40%	X	
	Substance use disorder outpatient services	\$60	X	40%	X	
	Substance use disorder inpatient services	30%	X	40%	X	
Pregnancy	Prenatal and postnatal care	\$60	After 1st 3 non-preventive visits	40%	X	
	Delivery and all inpatient services	Hospital	30%	X	40%	X
		Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care	30%	X	40%	X	
	Rehabilitation services	30%	X	40%	X	
	Habilitation services	30%	X	40%	X	
	Skilled nursing care	30%	X	40%	X	
	Durable medical equipment	30%	X	40%	X	
	Hospice service	No cost share	X	No cost share	X	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%		
	Glasses	1 pair per year		1 pair per year		
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment		
	Dental Basic Services					
Dental Restorative and Orthodontia Services						

Notes:

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- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 7) Glasses benefit limited to \$100 per year.
- 8) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/12/2013

Actuarial Value SUBJECT TO FINAL FEDERAL RULES

Catastrophic Plan

Overall deductible	\$6400 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	0%	After 1st 3 non-preventive visits	
	Specialist visit	0%	X	
	Other practitioner office visit	0%	X	
	Preventive care/ screening/ immunization	No cost share		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Generic drugs	0%	X	
	Preferred brand drugs	0%	X	
	Non-preferred brand drugs	0%	X	
	Specialty drugs	0%	X	
Outpatient surgery	Facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
Need immediate attention	Emergency room services (waived if admitted)	0%	X	
	Emergency medical transportation	0%	X	
	Urgent care	0%	After 1st 3 non-preventive visits	
Hospital stay	Facility fee (e.g., hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0%	X	
	Mental/Behavioral health inpatient services	0%	X	
	Substance use disorder outpatient services	0%	X	
	Substance use disorder inpatient services	0%	X	
Pregnancy	Prenatal and postnatal care	0%	After 1st 3 non-preventive visits	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care	0%	X	
	Rehabilitation services	0%	X	
	Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
	Hospice service	No cost share	X	
Child needs dental or eye care	Eye exam (deductible waived)	0%		
	Glasses	1 pair per year		
	Dental check-up - Preventive and Diagnostic	See attachment		
	Dental Basic Services			
Dental Restorative and Orthodontia Services				

Notes:

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.
- 5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits, specified in another benefit category.
- 6) Glasses benefit limited to \$100 per year.
- 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.



FACT SHEET

Covered California Standard Benefits Announcement Frequently Asked Questions

February 13, 2013

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SACRAMENTO, CA
95814
www.hbex.ca.gov

BOARD MEMBERS

Diana S. Dooley, Chair
Kimberly Belshé
Paul Fearer
Susan Kennedy
Robert Ross, MD

EXECUTIVE DIRECTOR

Peter V. Lee

1) What is significant about today's announcement?

Today Covered California is the first state exchange in the nation to announce what individuals can expect to get in the health plans offered under the Affordable Care Act starting 2014. These benefits must be offered in the individual and small group markets both inside and outside of Covered California's marketplace. More than 2.6 million Californians eligible for subsidies will know both their monthly cost for coverage and their out-of-pocket costs including cost per visit, medication costs, and annual maximum expenses.

Since individuals who are eligible for a subsidy have their monthly premium cost set as a percent of income, they don't have to wait for plan bids to come in to know what they will pay. With this announcement, California is leading the nation as we prepare for the largest change in health care coverage since Medicare.

Covered California also announced the launch of its consumer website – CoveredCA.com. The site will help inform Californians about the changes in health care and health insurance coverage options starting on January 1, 2014. The site – in English and Spanish – includes a cost calculator that will help consumers estimate the potential financial support they are eligible for and ultimately the estimated cost of health insurance. It will continually be updated to bring consumers more information and resources as the process continues.

Covered California is also on Facebook, Twitter (in English and Spanish), Google+ and YouTube: [facebook.com/CoveredCalifornia](https://www.facebook.com/CoveredCalifornia), twitter.com/CoveredCA, (@CoveredCA), twitter.com/CoveredCA_ES (@CoveredCA_es) [youtube.com/CoveredCA](https://www.youtube.com/CoveredCA) and gplus.to/CoveredCalifornia.

2) What are standard benefits?

Standard benefits are those benefits that must be offered by every plan that sells health insurance through Covered California. Under California law, since the Board of Covered California decided to establish standard benefit designs, those designs must be offered by all health plans in the individual and small group markets starting in January 2014. Standard designs help consumers compare the full array of what each plan will feature. This announcement means that 2.6 million Californians can know their 2014 premium costs and the exact benefits they can purchase when they can enroll. The only missing piece is which health plan they will select to be their insurer. An additional 2.7 million Californians – those who will

not be eligible for sliding scale financial help, but will now be assured health plans must offer them coverage – can know the standard designs that will be available to them.

Think of it this way: If health insurance under Covered California were a car, the platinum, gold, silver and bronze models would offer the exact same features no matter what dealer you purchase it from. Costs may vary, but the product is exactly the same, making apples to apples comparison shopping easy for consumers. And, for those who get sliding scale financial assistance, they know what it will cost them.

3) What do you mean by platinum, gold, silver and bronze plans?

The “metal levels” – platinum, gold, silver and bronze – define the level of coverage you pay as a patient compared to what the plans pay. The metal levels were defined by the Affordable Care Act as:

Coverage Levels		
Metal Level	% Paid by Health Plan	% Paid by You
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

4) How will people who don't receive financial help benefit from these standard benefits?

First, if you are in the individual or small employer market, you will benefit by being able to make apples to apples comparisons. If you have employer-based coverage, you can keep your coverage. But all families, employers and parts of the government that pay for health care stand to benefit. If all 2.6 million Californians eligible were to take advantage of subsidized coverage, it is estimated that California would receive more than \$11.5 billion in annual federal funding to support our health care delivery system. Because Californians will be able to access health care when they need it – not just in an emergency – and also take advantage of preventive care, we will have a healthier California with lower overall health care costs.

5) How will the standard benefit plans remove barriers to access and care?

What consumers pay out-of-pocket can be a barrier for many to receiving their needed care. When consumers know what their health plans are going to cost and what benefits they can count on they are more likely to seek preventive care and address health issues before they become an emergency. And taking advantage of doctor visits and recommended medications will keep them out of emergency rooms.

In addition, in focus groups, Covered California heard over and over again that Californians without coverage lived in constant fear of a big medical expense. Announcing today what millions of Californians can expect moves us from a culture of coping to a culture of security and coverage.

6) How are California's benefits different than other states?

California is one of a very few number of states in the nation to offer standard benefits. This will allow consumers to make apples to apples comparisons and mean lower administrative costs because each of the plans must be uniform. In addition, our benefit plans will allow for

innovation as health plans may propose alternative designs that benefit consumers and increase access.

7) *If I have employer-based health insurance, what does this mean for me?*

Nothing will change, but you will be able to compare plans and it will give you peace of mind that you can still be covered if you lose or change jobs.

8) *What plans will be offered and what's next?*

The advocates at Covered California will now negotiate with the health plans that will then offer our standard benefits at the four levels. Thirty-three plans have already expressed interest. We will work with these plans so that we can offer them through our marketplace. Then comes the big job: telling the public about the coverage, educating them and enrolling the 2.6 million that are eligible for subsidized care.

For more information on Covered California, please visit www.CoveredCA.com

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MEMORANDUM

DATE	January 17, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	Agenda Item 10: Discussion and Possible Action Regarding Changing the Dates and Locations of Dental Board Meetings in 2013

At the August 2012 meeting, the Dental Board voted on the following dates and locations for its meetings in 2013:

Winter	February 28 – March 1	San Diego
Spring	May 16 – 17	San Francisco
Summer	August 15 – 16	Sacramento
Fall	November 7 – 8	Los Angeles

Due to conflicts in scheduling, new dates will need to be considered for the August and November meetings.

Additionally, in order to accommodate interviews for the Executive Officer position, if necessary, staff recommends switching locations for the May and August meetings. May would move to Sacramento and August would be held in San Francisco.

Spring	May 16-17	Sacramento (new location)
Summer	August 22-23 or 29-30 (new dates)	San Francisco (new location)
Fall	November 21-22 (new dates)	Los Angeles

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21 M L King Day	22	23	24	25	26
27	28	29	30	31		

March

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1 DBC	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16 ADEA → Seattle
17 ADEA → Seattle	18	19	20	21	22	23
24	25	26	27	28	29	30
31 Easter						

February

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18 President Day	19	20	21	22	23
24	25	26	27	28 DBC San Di		

April

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11 CDA → Anaheim	12	13
14	15	16	17	18	19	20
21 AADB Chicago	22	23	24	25	26	27
28	29	30				

2013

May

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12 Mothers Day	13	14	15	16 DBC Sacto.?	17 DBC	18
19	20	21	22	23	24	25
26	27 Memorial Day	28	29	30	31	

July

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

2013

June

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16 Father's Day	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

August

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22 DBC ?	23 DBC ?	24
25	26	27	28	29 DBC ?	30 DBC ?	31

2013

September

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 Labor Day	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

November

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1 ADA → Delegate →	2
3 ADA →	4	5	6	7 DBC	8 DBC	9
10	11 Veterans Day	12	13	14	15 CDA → House of Delegate →	16
17 →	18	19	20	21 DBC ?	22 DBC ?	23
24	25	26	27	28 Thanksgiving	29	30

2013

October

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31 ADA → New Orleans		

December

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25 Christmas	26	27	28
29	30	31				

2013