BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

DENTAL BOARD OF CALIFORNIA

NOTICE OF MEETING
May 13-14, 2026

Board Members
Lilia Larin, DDS, President
Rosalinda Olague, RDA, Vice President
John Dierking, JD, Public Member, Secretary
Steven D. Chan, DDS
Kevin R. Cheng, JD, Public Member
Robert P. David, Public Member
Alan L. Felsenfeld, MA, DDS
Joni Forge, DDS
Jaskiran K. Grewal, DDS
Angelita Medina, MHS, Public Member
Yogita Thakur, MS, DDS
Ram M. Vaderhobli, MS, DDS
James Yu, MS, DDS

Action may be taken on any item listed on the agenda.

The Dental Board of California (Board) will meet in-person in accordance with Government Code section 11123, subdivision (a), approximately at, but no earlier than, 10:30 a.m., on Wednesday, May 13, 2026, and 8:30 a.m., on Thursday, May 14, 2026, at the following location:

Hilton Anaheim
777 W. Convention Way (Fourth Floor, Huntington Room)
Anaheim, CA 92802
(714) 750-4321 (Hotel)
(916) 263-2300 or (877) 729-7789 (Board Office)

AGENDA

10:30 a.m., Wednesday, May 13, 2026

1. Call to Order/Roll Call/Establishment of a Quorum

2. Public Comment on Items Not on the Agenda **[7]**
   Note: The Board may not discuss or take action on any matter raised during this Public Comment section, except to decide whether to place the matter on the agenda of a future meeting. (Government Code sections 11122.5, 11125, and 11125.3.)

3. Discussion and Possible Action on February 5-6, 2026 Board Meeting Minutes **[8-26]**

4. Board President Report **[27]**

5. Executive Officer Report **[28]**

6. Report on Department of Consumer Affairs (DCA) Activities, which may include updates on DCA's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters **[29]**

7. Report on Purpose Statement and Objectives of Standing and Special Needs Committees **[30-39]**
   a. Access to Care Committee (Special Needs) – Yogita Thakur, MS, DDS, Chair
   b. Anesthesia Committee (Special Needs) – Alan L. Felsenfeld, MA, DDS, Chair
   c. Communications and Editorial Committee (Special Needs) – James Yu, MS, DDS
   d. Enforcement Committee (Standing) – Ram M. Vaderhobli, MS, DDS, Chair
   e. Examination Committee (Standing) – Lilia Larin, DDS, Chair
      i. American Board of Dental Examiners (ADEX) Handout on "Supporting State Boards' Mission to Protect the Public"
      ii. ADEX and the American Dental Association Dental Licensure Examinations Statement
   f. Legislative and Regulatory Committee (Special Needs) – Robert P. David, Chair
   g. Substance Use Awareness Committee (Special Needs) – John Dierking, JD, Chair

8. Dental Assisting Council Meeting Report **[40]**

9. Budget Report **[41-46]**

10. Licensing, Certifications, Permits, and Examinations
    a. Update on Dental Licensure and Permit Statistics **[47-58]**

11. Anesthesia and Sedation
    a. General Anesthesia and Sedation Permits: Inspections and Evaluations Statistics **[59-69]**

12. Enforcement
    a. Review of Statistics and Trends **[70-73]**

13. Substance Use Awareness
    a. Diversion Program Report and Statistics **[74]**

14. Update, Discussion, and Possible Action on Proposed Regulations
    a. Status Update on Pending Regulations **[75]**

i. Update on Rulemaking to Amend California Code of Regulations (CCR), Title 16, Section 1005 Regarding Minimum Standards for Infection Control

b. Discussion and Possible Action to Reconsider Previously Approved Text, and to Consider Initiation of a Rulemaking to Amend CCR, Title 16, Sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and Repeal Sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01 Regarding Applications for Dentist Licensure and Fees **[76-151]**

c. Discussion and Possible Action to Consider Initiation of a Rulemaking to Amend CCR, Title 16, Section 1066 Regarding Vaccine Administration Updates **[152-264]**

15. Presentation on Initiatives to Increase Access to Oral Health Providers – *California Dental Association (CDA)* **[265-291]**

16. Recess Open Session Until May 14, 2026, at 8:30 a.m.

CLOSED SESSION (WILL NOT BE WEBCAST)

17. Convene Closed Session

18. Pursuant to Government Code Section 11126(c)(3), the Board will Meet in Closed Session to Deliberate and Vote on Disciplinary Matters, Including Stipulations and Proposed Decisions

19. Adjourn Closed Session

8:30 a.m., Thursday, May 14, 2026

20. Reconvene Open Session – Call to Order/Roll Call/Establishment of a Quorum

21. Board President's Report on Closed Session Items **[292]**

22. Update, Discussion, and Possible Action on Legislation Impacting the Board, DCA, and/or the Dental Profession
    a. 2026 Tentative Legislative Calendar – Information Only **[293-295]**
    b. Legislation of Interest **[296-340]**
        i. 2026 Legislative Consent Calendar for Board Consideration – Staff Recommendation *SUPPORT*
            A. AB 1670 (Arambula, 2026) Medi-Cal: Dental Care
            B. AB 1671 (Tangipa, 2026) Rural Medical Services Grant Program
            C. AB 2140 (Johnson, 2026) Healing Arts: Reports: Claims Against Licensees
            D. SB 944 (Wiener, 2026) Medi-Cal: Acupuncture
            E. SB 1137 (Valladares, 2026) Personal Income Tax: Deduction: Medical Expenses

F. SB 1146 (Gonzalez, 2026) Advertisement Claims: Health-Related Consumer Products and Services: Digital Replicas and Synthetic Performers
G. SB 1159 (Cabaldon, 2026) Artificial intelligence: Transparency and Governance
H. Senate Resolution (SR) 82 (Pérez, 2026) Relative to Children's Dental Health Month

ii. 2026 Legislative Consent Calendar for Board Consideration – Staff Recommendation *WATCH*
A. AB 1558 (Arambula, 2026) Uniform Emergency Volunteer Health Practitioners Act
B. AB 1563 (Gabriel, 2026) Budget Act of 2026
C. AB 1578 (Jackson, 2026) State/Local Officials: Sexual Harassment Training and Education: Anti-hate Speech Training
D. AB 1629 (Haney, 2026) Dental Coverage
E. AB 1717 (Castillo, 2026) Medi-Cal Dental Reimbursement: House/Extended Care Facility Call
F. AB 1729 (Lee, 2026) State Employment: Telework Programs
G. AB 1775 (Ward, 2026) Veterans
H. AB 1821 (Pacheco, 2026) California Public Records Act: Agency Response Time
I. AB 1900 (Kalra, 2026) Guaranteed Health Care for All
J. AB 1979 (Bonta, 2026) Health Care Services: Artificial Intelligence
K. AB 2029 (Sharp-Collins, 2026) Dental Plan Portal
L. AB 2292 (Ward, 2026) Disability Benefits: Certificates
M. AB 2551 (Elhawary, 2026) Health Care Coverage
N. AB 2668 (Fong, 2026) Acupuncture: License Requirements and Title Protection
O. SB 879 (Laird, 2026) Budget Act of 2026
P. SB 980 (Hurtado, 2026) Access to Medical Records
Q. SB 1150 (Jones, 2026) Cancer Data: Notifications
R. SB 1391 (Wahab, 2026) Department of Consumer Affairs: Retired Category Licenses
S. SB 1416 (Wahab, 2026) Physicians and Surgeons: Dentists: Unprofessional Conduct
T. SB 1422 (Durazo, 2026) Medi-Cal: Eligibility: Immigration Status
U. SB 1433 (Committee on Judiciary, 2026) Maintenance of the Codes

iii. 2025-2026 Two-Year Legislation for Information and Board Consideration
A. AB 280 (Aguiar-Curry, 2025) Health Care Coverage: Provider Directories – Board Position *WATCH*
B. AB 350 (Bonta, 2025) Health Care Coverage: Fluoride Treatments – Board Position *SUPPORT*
C. AB 371 (Haney, 2025) Dental Coverage – Board Position *WATCH (DEAD)*
D. AB 479 (Tangipa, 2025) Criminal Procedure: Vacatur Relief – Board Position *WATCH (DEAD)*

E. AB 485 (Ortega, 2025) Labor Commissioner: Unsatisfied Judgments: Nonpayment of Wages – Board Position *OPPOSE UNLESS AMENDED*
F. AB 667 (Solache, 2025) Professions and Vocations: License Examinations: Interpreters – Board Position *WATCH*
G. AB 787 (Papan, 2025) Provider Directory Disclosures – Board Position *WATCH*
H. AB 837 (Davies, 2025) Ketamine – Board Position *WATCH (DEAD)*
I. AB 872 (Blanca Rubio, 2025) Environmental Health: Product Safety: Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS) – Board Position *WATCH (DEAD)*
J. AB 873 (Alanis, 2025) Dentistry: Dental Assistants – Board Position *SUPPORT IF AMENDED*
K. AB 966 (Carrillo, 2025) Dental Practice Act: Foreign Dental Schools – Board Position *OPPOSE UNLESS AMENDED (DEAD)*
L. AB 1107 (Flora, 2025) Cigarette and Tobacco Products Licensing Act of 2003: Nitrous Oxide: Licensure – Board Position *WATCH (DEAD)*
M. AB 1130 (Berman, 2025) Dentistry: Outreach and Support Program – Board Position *WATCH*
N. AB 1215 (Flora, 2025) Hospitals: Medical Staff Membership – Board Position *WATCH (DEAD)*
O. AB 1298 (Harabedian, 2025) The Department of Consumer Affairs – Board Position *WATCH (DEAD)*
P. AB 1307 (Ávila Farías, 2025) Licensed Dentists from Mexico Pilot Program – Board Position *OPPOSITION WITHDRAWN (WATCH)*
Q. AB 1431 (Tangipa, 2025) Personal Income Taxes: Credit: Medical Services: Rural Areas – Board Position *WATCH (DEAD)*
R. AB 1434 (Michelle Rodriguez, 2025) Health Care Boards: Workforce Data Collection – Board *Position WATCH (DEAD)*
S. AB 1461 (Essayli, 2025) Department of Consumer Affairs: Regulatory Boards – Board Position *WATCH (DEAD)*

iv. 2026 Priority Legislation for Discussion and Board Consideration
A. Assembly Bill (AB) 1760 (Arambula, 2026) Dentistry – *SPONSOR*
B. AB 1952 (Berman, 2026) Dentistry: Dental Hygienists: Licensure – Staff Recommendation *SUPPORT*
C. AB 2625 (Solache, 2026) Dental Practice Act: Foreign Dental Schools – Staff Recommendation *WATCH*
D. Senate Bill (SB) 936 (Blakespear, 2026) Nitrous Oxide: Sales – Staff Recommendation *SUPPORT*
E. SB 1311 (Wahab, 2026) Licensed Professions – Staff Recommendation *SUPPORT*
F. SB 1445 (Committee on Business, Professions and Economic Development, 2026) Healing Arts – Staff Recommendation *SUPPORT*

23. Future Agenda Items and Next Meeting Dates **[341]**

24. Adjournment

Information regarding the meeting is available by contacting the Board at (916) 263-2300 or (877) 729-7789, email: DentalBoard@dca.ca.gov, or send a written request to the Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815. This agenda can be found on the Dental Board of California website at dbc.ca.gov. The time and order of agenda items are subject to change at the discretion of the Board President and may be taken out of order. Items scheduled for a particular day may be moved to an earlier day or later day to facilitate the effective transaction of business. In accordance with the Bagley-Keene Open Meeting Act, all Board meetings are open to the public.

Members of the public may view a livestream (Webcast) of this meeting at https://thedcapage.blog/webcasts/. Using the Webcast link will allow only for observation with closed captioning. Webcast availability cannot be guaranteed due to resource limitations or technical difficulties. Meeting adjournment may not be Webcast if it is the only item that occurs after a closed session. The meeting will not be cancelled if Webcast becomes unavailable. Members of the public may, but are not obligated to, provide their names or personal information as a condition of attending the meeting. (Government Code section 11124.)

Government Code section 11125.7 provides the opportunity for the public to address each agenda item before or during discussion or consideration by the Board prior to the Board taking any action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Board, but the Board President may, at their discretion, apportion available time among those who wish to speak. Individuals may appear before the Board to discuss items not on the agenda; however, the Board can neither discuss nor take official action on these items at the time of the same meeting (Government Code sections 11122.5, 11125, 11125.3).

The meeting location is accessible to the physically disabled. A person who needs disability-related accommodation or modifications to participate in the meeting may make a request by contacting Bryce W.A. Docherty, MPA, Executive Officer, at Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five (5) business days prior to the meeting will help ensure availability of the requested accommodations. TDD Line: (877) 729-7789

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 2.:** Public Comment on Items Not on the Agenda

Notes

DENTAL BOARD OF CALIFORNIA
MEETING MINUTES
February 5-6, 2026

Pursuant to Government Code section 11123.2, the Dental Board of California (Board) met by teleconference/WebEx Events on February 5-6, 2026, with the following location available for Board and public member participation:

Department of Consumer Affairs
1747 N. Market Blvd., Hearing Room #186
Sacramento, CA 95834

Board Members Present:
Lilia Larin, DDS, President
Rosalinda Olague, PhD(c), RDA, Vice President
John Dierking, JD, Public Member, Secretary
Steven Chan, DDS (remote participant)
Kevin R. Cheng, JD, Public Member
Robert P. David, Public Member
Alan Felsenfeld, MA, DDS
Joni Forge, DDS (remote participant)
Jaskiran Grewal, DDS
Angelita Medina, MHS, Public Member
Yogita Thakur, DDS, MS
Ram M. Vaderhobli, DDS, MS
James Yu, DDS, MS

Staff Present:
Bryce W.A. Docherty, MPA, Executive Officer
Christy Bell, Assistant Executive Officer
Ryan Blonien, Enforcement Chief
Jodi Ortiz, Chief of Licensing and Examination Division
Paige Ragali, Chief of Administration and Compliance
Tina Vallery, Chief of License and Program Compliance and Dental Assisting
Jessica Olney, Anesthesia Unit Manager
Wilbert Rumbaoa, Administrative Services Unit Manager
Brant Nelson, Legislative and Regulatory Specialist
Paul Corbin, Investigator
Juan Pitta, Investigator
Mirela Taran, Administrative Analyst
Joseph Tippins, Investigator

Shelly Jones, Assistant Deputy Director, Board and Bureau Relations, Department of Consumer Affairs (DCA)
Alex Cristescu, Television Specialist, Office of Public Affairs, DCA
David Bouilly, Facilitator and Strategic Business Analyst, Strategic Organizational Leadership and Individual Development (SOLID), DCA
Kristy Schieldge, Regulations Counsel, Attorney IV, Legal Affairs Division, DCA
Tara Welch, Board Counsel, Attorney IV, Legal Affairs Division, DCA

10:30 a.m., Thursday, February 5, 2026

Agenda Item 1: Call to Order/Roll Call/Establishment of a Quorum
The Board President, Lilia Larin, DDS, called the meeting to order at 10:31 a.m. Board Members Joni Forge, DDS, and Steven Chan, DDS, participated remotely and confirmed there were no individuals 18 years of age or older present in the room at their remote locations in compliance with Government Code section 11123.2, subdivision (j)(4).

The Board Secretary, John Dierking, JD, called the roll; 13 Board Members were present, and a quorum was established.

Agenda Item 2: Public Comment on Items Not on the Agenda
President Larin called for public comment on items not on the agenda. The Board received the following public comments.

Dr. Sheetal Patil, Legislative Chair for the California Association of Orthodontists (CAO), congratulated President Larin and the Board's Executive Officer, Bryce Docherty, for their new leadership roles and noted that CAO looks forward to working closely with them both in the years ahead. She conveyed that CAO represents approximately 1,500 participating orthodontists across California and regularly engage with the Board and the legislature on issues impacting orthodontic practices and patient care. Ms. Patel thanked the Board for its ongoing stakeholder engagement particularly around updating the table of duties and aligning the statue with the regulation. Additionally, she thanked Board Chief of Licensing and Program Compliance and Dental Assisting Tina Vallery for her continued engagement and frequent communication with CAO, as her efforts have helped CAO work productively with the Board.

Agenda Item 3: Discussion and Possible Action on Board Meeting Minutes

a. November 5, 2025

Motion/Second/Call the Question (M/S/C) (Yu/Medina) to approve the November 5, 2025 meeting minutes.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: David.
Absent: None.
Recusals: None.

The motion passed.

b. November 6-7, 2025

(M/S/C) (Chan/Cheng) to approve the November 6-7, 2025 meeting minutes as amended on page 12, Agenda Item 15, to strike and replace “Ms. Bell received three nominations for 2026 Board President: Board Member Yu, who accepted the nomination; Secretary Larin, who accepted the nomination; and President Chan, who accepted the nomination” with “Ms. Bell received three nominations for 2026 Board President: Board Member Yu, who accepted the nomination; Secretary Larin, who accepted the nomination; and President Chan, who expressed reluctance on the nomination for President due to uncertainty of reappointment”.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 4: Board President Report

President Larin congratulated the Board Members, Angelita Medina, Joni Forge, Steven Chan, Rosalinda Olague, and herself, on being reappointed to the Board by Governor Newsom. She noted that Vice President Olague and herself have been holding informative weekly meetings with Board Executive Officer Bryce Dochety and look forward to continuing this collaboration. On January 27, 2026, she had the pleasure of

delivering a motivational address to the Sandy Saunders NYU Langone Health pediatric residents focusing on leadership and resilience. President Larin announced the Board's 2026 committee appointments and mentioned that for 2026 her goal is to create more opportunities for Board members to actively be involved in committee work and other Board activities. This will allow everyone to contribute their expertise and collaborate on meaningful projects. She added that at the next Board meeting, which will take place in May, there will be a more detailed update on committee plans and activities.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 5: Executive Officer Report

Mr. Docherty reported that he has instituted weekly one-on-one check-in meetings with each of his direct report staff and meets weekly with President Larin and Vice President Olague. He, along with Board Assistant Executive Officer Christy Bell, attends monthly meetings with DCA Acting Director Christine Lally and Deputy Director of Board and Bureau Relations Lucia Saldivar. Mr. Docherty mentioned that he and Ms. Bell, alongside Board Administrative Services Unit Supervisor Wilbert Rumbaoa and his team, have been keeping a strategic watchful eye on the Board's organizational chart and all personnel matters. He reported that the Board has a healthy retention rate and only a 6% vacancy rate. Furthermore, the Board currently has almost 15 months of operating reserves and that a healthy reserve balance is typically six to nine months. Mr. Docherty reported that in his capacity as Executive Officer of the Board, he has attended some additional noteworthy meetings and engagement since the last Board meeting. On December 6, 2025, he met with the Dental Hygiene Board of California Executive Officer Anthony Lum, at Dental Board headquarters to discuss ongoing strategic alliances and the tradition of attending each other's board meetings. On December 9, 2025, he along with Board Member Chan attended the DCA Board Leadership meeting hosted by former and now retired DCA Director Kimberly Kirchmeyer. On December 17, 2025, he and Board Member Chan attended the DCA Health Board Controlled Substance Joint Forum hosted by the California State Board of Pharmacy at Sacramento State University. On December 19, 2025, and January 8, 2026, he attended DCA Executive Officer Onboarding workshops at DCA headquarters. With a background in legislative advocacy, his 30-year experience in and around the state capitol, Mr. Docherty reported that he has been spending a considerable amount of time assessing the status of Board positions and priorities on several legislative matters. Additionally, he has been reintroducing himself to members of the California Legislature and legislative staff in his new capacity as Executive Officer of the Board.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 6: Report on Department of Consumer Affairs (DCA) Activities, which may include updates on DCA's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative,

Regulatory, and Policy Matters
Shelly Jones provided a departmental update, which included the following.

Ms. Jones reported that DCA Chief Deputy Director Christine Lally has been named the Acting Director of DCA. On January 8, 2026, Governor Newsom delivered his final State of the State address, reaffirming California's role as a national beacon for democracy and an economic engine with conscience, pushing back against federal overreach while boldly investing in jobs, education, affordability, climate action, and recovery from the Los Angeles wildfires. The following day on January 9, 2026, he delivered his proposed State Budget for 2026/27. Ms. Jones communicated that the budget is balanced for the coming fiscal year (FY), reflecting a surge in state revenues, forecasting more than $42 billion higher than projected at last year's enacted budget. The budget does not include new significant spending proposals. Instead, it builds on prior policy successes and continues to implement critical investments in priorities such as education, affordability, small businesses, wildfire mitigation, and more.

Ms. Jones provided updates on the Governor’s Reorganization Plan, travel, Form 700 Statement of Economic Interests filings, and Board member trainings.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 7: Presentation, Discussion, and Possible Action on 2026 – 2029 Strategic Plan
Mr. Docherty provided the report, which is available in the meeting materials.

Board Member Alan Felsenfeld requested an amendment on page 4 of the Strategic Plan to strike “dental” from “The Board issues many types of permits to administer dental anesthesia and sedation, as well as orthodontic assistant and dental sedation assistant permits” and replace it with “general”.

(M/S/C) (Felsenfeld/Chan) to approve the amendment to the 2026-2029 Strategic Plan.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (David/Medina) to approve the 2026-2029 Strategic Plan.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 8: Dental Assisting Council February 5, 2026, Meeting Report
Dental Assisting Council (DAC) Chair, Jeri Fowler, provided a verbal report on the February 5, 2026 DAC meeting. Ms. Fowler advised the Board regarding DAC discussion of DAC meeting agenda items.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 9: Discussion and Possible Action Regarding Appointment of Dental Assisting Council Members
Mr. Docherty provided the report, which is available in the meeting materials.

(M/S/C) (David/Felsenfeld) to reappoint Jessica Gerlach to the DAC.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.

Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Chan/Cheng) to reappoint Cara Miyasaki to the DAC.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 10: Budget Report
Mr. Rumbaoa provided a report on the Board's budget for FY 2025/2026. He conveyed that to date, the Board's appropriation is $20.4 million, and the Board is expected to expend roughly $18.6 million for this FY, with $10.9 million in personnel and $7.7 million in operating equipment and expenses. Based on that report, the Board is expected to revert $1.9 million for the FY, which provides the Board with approximately 14.9 months in reserve for FY 25/26.

Board Member Vaderhobli inquired whether the $1.9 million accrues interest. Mr. Rumbaoa responded that $1.9 million will go back to the Board's fund at the end of the FY, and that the amount that did collect interest was the General Fund (GF) Loan of $5 million. He added that the Board collected approximately $132,000 in interest on that loan.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 11: Licensing, Certifications, Permits, and Examinations
Agenda Item 11.a.: Update on Dental Licensure and Permit Statistics
Board Chief of Licensing and Examination Division Jodi Ortiz provided the report, which is available in the meeting materials.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 12.: Presentation on California State Loan Repayment Program and Scholarship Programs for Oral Health Professionals – *Department of Health Care Access and Information (HCAI)*
Jalaunda Granville, Federal Policy and State Special Projects Section Chief, HCAI, provided an overview on California State Loan Repayment Program and Scholarship Programs for Oral Health Professionals.

Board Member Chan voiced that in 2001 when the California Dental Association (CDA) debuted its foundation, among its debut was a pilot prototype program for a loan repayment on student debt for dentists serving in shortage areas. He stated that in 25 years they must have a lot of history on what was the return on investment of having the shortfall of those areas in shortage areas and how they treated. Additionally, he conveyed that dental students across the country have anywhere from $250,000 to $500,000 in student debt and noted that should be put into the equation on the recruitment to go to those areas.

Board Member Robert David noted that for the state loan repayment program to only have $333,000 in state funding and no federal match available is not going to help anyone.

President Larin requested public comment on this item. The Board received public comment.

Ariane Terlet asked whether the $333,000 is the money that the state will distribute. Ms. Granville responded that the loan repayment is up to $50,000, where $25,000 would come from the state and the other $25,000 would come from the employer. In terms of HRSA (Health Resources and Services Administration) and other loan repayment programs, Ms. Terlet inquired whether this is taxable to the person who is receiving the money. Ms. Granville responded that it depends on the individual, but that is something that one can bring up and ask for as a part of the application cycle. She added that it is her understanding that it is on a case-by-case basis.

At 12:09 p.m., the Board recessed for a break.

At 1:15 p.m., the Board reconvened.

Agenda Item 13: Elective Facial Cosmetic Surgery (EFCS) Permit Credentialing Committee January 14, 2026, Meeting Report
Agenda Item 13.a.: Discussion and Possible Action on Recommendations on EFCS Permit Application
Ms. Ortiz provided the report, which is available in the meeting materials.

(M/S/C) (Chan/Felsenfeld) to deny the Application of O.N., DDS, for a Category 3 EFCS Permit.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 14: Anesthesia and Sedation
Agenda Item 14.a.: General Anesthesia and Sedation Permits: Inspections and Evaluations Statistics
Board Anesthesia and Customer Service and Support Unit Manager Jessica Olney provided the report, which is available in the meeting materials. Ms. Olney noted that on December 10, 2025, she and Board Member Felsenfeld provided an evaluator calibration course that was done virtually. Ms. Olney added that they had 230 people in attendance who were current evaluators for both the moderate sedation and general anesthesia programs. Additionally, new permit holders who would like to sign up to become evaluators were invited. Since then, the Board has had about 40 new evaluators who have joined.

Board Member Felsenfeld inquired whether it has been easier to schedule evaluations since one evaluator is enough on a secondary evaluation. Ms. Olney responded that the Board requires two evaluators when an individual is being evaluated for their first time or in the event that there is a failure. She conveyed that for every subsequent evaluation moving forward, there is only one evaluator required. Therefore, it has helped being able to schedule the evaluations quickly.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 15: Substance Use Awareness
Agenda Item 15.a.: Diversion Program Report and Statistics

Board Chief of Administration and Compliance Paige Ragali provided the report, which is available in the meeting materials. Ms. Ragali noted that the next quarterly Diversion Evaluation Committee meeting is scheduled for February 11, 2026.

Board Member David stated that while a lot of the probationers are on probation because of substance abuse, there are so few people in the Diversion Program. Ms. Ragali responded that the Board has Uniform Standards, which essentially are criteria that the Board looks at for determining whether an individual is considered a substance abusing licensee. She added that a lot of the licensees who go through disciplinary action have either criminal convictions or substance abuse issues, but they do not all reach that criteria of being considered a substance abusing licensee, which would then have them fall under the Uniform Standards, which dictates the certain terms and conditions that the Board would apply to their probationary terms.

Ms. Ragali noted that there are different reasons why they could have provided rehabilitation, and it is different mitigating criteria that Board staff reviews when they are determining the probation terms of the licensees, which is the reason as to why there are not many participants. She mentioned that it is also because Board staff want to ensure the probationers are successful. Therefore, the goal of probation is to rehabilitate the licensees, not be punitive. She added that Board staff are trying to evaluate and determine what the best course of action would be in order for them to rehabilitate the licensees; not all of the cases are extreme enough for them to be within the Uniform Standards, which would require participation in Diversion.

Board Member Chan requested that the Board have a presentation by the Diversion Evaluation Committee Chair.

President Larin requested public comment on this item. The Board received public comment.

Dr. Guy Acheson, representing the California Academy of General Dentistry, requested that when the presentation by the Diversion Evaluation Committee Chair is made, that real world examples be used of multiple people who are considered for the Diversion program but did not make the grade.

Agenda Item 16: Discussion of and Possible Action Regarding Government Code Section 11340.6 Petition to Adopt, Amend, or Repeal Regulations Regarding Complaint Intake, Review, Evaluation, and Closure Procedures

Board Counsel Tara Welch provided the report, which is available in the meeting materials.

(M/S/C) (David/Chan) to deny the Petition and approve the proposed Decision as drafted in Attachment 2 to be sent to the Petitioner and for filing and publication in the California Regulatory Notice Register.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Board Regulations Counsel Kristy Schieldge noted that the procedure after this is that the Decision will be sent to the Petitioner but also is required to be published in the California Notice Register. She reported that the attachment that the Board approved would be published, and then the Petitioner has 60 days to appeal and ask the Board to reconsider its Decision.

Agenda Item 17: Recess Open Session Until February 6, 2026, at 9:00 a.m.
President Larin recessed Open Session at 1:50 p.m.

Agenda Item 18: Convene Closed Session
At 2:00 p.m., the Board convened Closed Session.

Agenda Item 19: Pursuant to Government Code Section 11126(c)(3), the Board will Meet in Closed Session to Deliberate and Vote on Disciplinary Matters, Including Stipulations and Proposed Decisions
The Board convened in Closed Session to discuss disciplinary matters.

Agenda Item 20: Adjourn Closed Session
President Larin adjourned Closed Session at 2:31 p.m.

9:00 a.m., Friday, February 6, 2026

Agenda Item 21: Reconvene Open Session – Call to Order/Roll Call/Establishment of a Quorum
President Larin called the meeting to order at 9:02 a.m. Board Members Forge and Chan participated remotely and confirmed there were no individuals 18 years of age or older present in the room at their remote locations in compliance with Government Code section 11123.2, subdivision (j)(4).

Secretary Dierking called the roll; 13 Board Members were present, and a quorum was established.

Agenda Item 22: Board President's Report on Closed Session Items
President Larin provided a verbal report regarding Closed Session items. She reported that the Board met in closed session and granted one petition for consideration.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 23: Enforcement
Agenda Item 23.a. Presentation of "Attorney General's Annual Report on Accusations Prosecuted for Department of Consumer Affairs Client Agencies, Business and Professions Code Section 312.2, January 1, 2026" – *Carl Sonne, Senior Assistant Attorney General, Office of the Attorney General, Department of Justice*
Carl Sonne, Senior Assistant Attorney General, Office of the Attorney General (OAG), Department of Justice, provided a verbal update and presentation on the OAG Annual Report.

Board Member David asked how the Board compares the 260 days accusations filed to settlement of the Board with other healthcare licensing boards. Mr. Sonne responded that there are a lot of different considerations that goes into every case and noted that agencies that may usually be referred to them that do not require expert testimony may go faster, and agencies that have some additional complexity may take longer.

Board Member Vaderhobli asked how many staff Mr. Sonne has on his team. Mr. Sonne responded that in the licensing section, they have about 115 attorneys and paralegals who work on the Board cases and for all of their other client agencies.

Secretary Dierking stated that when a case goes to the Administrative Law Judge (ALJ) for a proposed decision at the hearing, what the Board very often sees is a more developed history of an individual licensee involved in the underlying misconduct, and that usually includes aggravating and mitigating factors and sometimes there is quite a robust discussion of that, which helps facilitate a decision in some of these cases. He noted that when the Board sees stipulations offered up for consideration, the Board sometimes sees something more on a summary side and something more on a narrative side. Secretary Dierking inquired what the Board can do to facilitate a more comprehensive understanding of the rational basis for the terms of the settlement which would then be agreed to by the respondent or licensee.

Mr. Sonne responded that the process of settlement usually involves a dialogue with their client representatives in which they have a discussion regarding the terms and conditions that are being offered. When they provide a recommendation letter to adopt a settlement, there is also a desire not to provide too much information such that if in fact the Board were not to adopt the settlement, it has already heard more evidence that

should properly be the subject of a hearing. Mr. Sonne stated that they try to characterize the value of the settlement to the Board, and they do that so they can facilitate the adoption of a settlement. He added that there is always that type of tension where they are not going to try the case so to speak to the Board when they are conducting a settlement. They have to be mindful of the interests of the respondent in case the settlement is not agreed to.

Secretary Dierking inquired whether the Board could move forward indicating if there is a letter of support and if there is not; it is his understanding that these support letters are entitled to very little weight. Therefore, in the case of support letters offered when an individual is being accused or there is a statement of issues, Secretary Dierking asked what the Board can do to this particular point to ensure that it is included in the memorandum. Mr. Sonne responded that they typically do not attach those letters themselves, and it can vary from case to case. He added that one has to assume that the deputy has evaluated all those letters, and at the end of the day, the deputy is recommending the settlement to the Board. If in fact the Board is ever feeling like they have not received sufficient information or that the letters do not provide clarity, the Board has the ability to reject the settlement and choose to go to hearing and see what these individuals actually say when they are called to testify at the hearing. Mr. Sonne conveyed that regarding the recommendation to adopt letters, they usually try to keep them fairly brief so that the Board has a focus on it rather than trying to present the entire case. The accusation itself is sort of the operative document that is before the Board to be settled. Therefore, the letter along with the accusation itself and the terms of the stipulated settlement are the material considerations that the Board needs to evaluate in order to determine whether to adopt, reject, or sometimes even come up with counter terms to refer back to the OAG to negotiate another term that the Board wants to see included.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 23.b: Review of Statistics and Trends
Ryan Blonien provided the report, which is available in the meeting materials.

Board Member Felsenfeld noted that it looks like dentists have averaged about 3,000 complaints a year, and yet in the first 6 months of this year, it looks like the Board is already almost at that number. Mr. Blonien responded that a big cause to that is attributed to social media and conveyed that when a dentist makes a controversial statement and it goes in the media, the trend has been that it generates complaints.

Board Member David expressed that regarding investigative case aging where 23 percent of the cases are two to three years old, he hopes the Board is able to put some effort into clearing those up, as that is the number that the Legislature tears their hair out over about licensing boards. Mr. Blonien responded that the more staff he has, the more those cases can be moved.

President Larin inquired on the Board complaint process. Mr. Blonien responded that individuals can go online and file a complaint against anybody for anything. A complaint is evaluated in the intake unit and if it is a viable complaint, Board staff will attempt to collect records and have those records looked at by a dental consultant, who will provide them with areas of concern that the Board should focus on for the treatment. Afterwards, the case is assigned to either a special investigator or a sworn investigator, who will organize the file, determine what records they have, what records they may need to collect, and who needs to be interviewed. Once the interviews are all done and the records are all there, Board staff will send that to a dental expert, who is now the expert witness in the case. Board staff will then use that expert testimony in the report to move the case forward and determine next steps.

Board Member Vaderhobli voiced that since there is data that shows a stark difference between Northern and Southern California, whether there is a need to rebalance resources. Mr. Blonien responded that Board staff have taken a little bit of that southern area to help out.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 24: Update, Discussion, and Possible Action on Proposed Regulations
Agenda Item 24.a.: Status Update on Pending Regulations
Board Legislative and Regulatory Specialist Brant Nelson provided the report, which is available in the meeting materials.

Mr. Docherty conveyed there are five regulatory packages that will be coming before the Board this year. He noted that once the regulations are promulgated and published according to the Office of Administrative Law (OAL) and the Administrative Procedure Act, the Board will have 12 months by which to get that language and those regulations approved by the OAL. Although there are only five rulemaking packages that will come before the Board this year, that will leave 10 for next year.

President Larin requested public comment on this item. There were no public comments made on this item.

Agenda Item 25: Update, Discussion, and Possible Action on Legislative Proposals
Agenda Item 25.a.: Discussion and Possible Action to Amend Business and Professions Code (BPC) Sections 1621, 1628, 1633, 1635.5, 1638.1, 1724, 1750.1, 1753, 1753.5, 1754.5, and 1755, and Repeal BPC Section 1632.6 Regarding Dentistry
Mr. Nelson provided the report, which is available in the meeting materials.

(M/S/C) (David/Thakur) to approve for submission to the California State Legislature the legislative proposal in Attachment 1 to amend BPC sections 1621, 1628, 1633, 1635.5,

1638.1, 1724, 1750.1, 1753, 1753.5, 1754.5, and 1755, and repeal BPC Section 1632.6 regarding dentistry.

President Larin requested public comment before the Board acted on the motion. The Board received public comment.

Tooka Zokaie, representing the California Dental Association (CDA), reiterated that CDA is looking forward to seeing this language submitted as one package with the committee. Additionally, they are also continuing to offer stakeholder input, especially with the 8-hour infection control course, which is a big priority for CDA members. As it has been a challenge for the last year, they look forward to the language to offer this course virtually so CDA can ensure it is accessible and that it meets the standards of the Board. Ms. Zokaie indicated that they will continue to monitor this language and give their input.

Susan McLearan, California Dental Hygienists Association (CDHA), stated that she supports Ms. Zokaie's comments about their interest in the infection control aspect of the bill. She noted that they support the virtual option but are concerned about the time frame in which the dental assistant would need to take the course. She added that they would like to see it taken before any contact with any potentially infectious material and therefore will look forward to that bill and its content.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 25.b.: Legislative Proposal to Amend BPC Sections 1684.5, 1741, 1750, 1750.1, and 1752.4 Regarding Dental Auxiliaries
DAC Member Gerlach alongside Ms. Vallery provided the report, which is available in the meeting materials.

Board Member David asked whether this proposal is considered non-substantive. Ms. Vallery responded that the main things that Board staff did was reorder and clarify things from regulation into statute. At the moment, the Board has allowable duties in regulation that have been there for a very long time, and the statute was approved more recently. However, in order to make things clearer, Board staff are moving the language that needs discussion into statute and then with the hopes of repealing the regulations

that have the allowable duties. Ms. Vallery voiced that there were no changes made to this section other than some very minor verbiage clarification added and reordering. Therefore, there should be no controversy.

President Larin requested public comment on this item. The Board received public comment.

Ms. McLearan, representing CDHA, commended the working group for a fabulous job in doing this major task.

(M/S/C) (Dierking/Medina) to move the legislative proposal in Attachment 1 for submission to the California State Legislature to amend BPC sections 1684.5, 1741, 1750, 1750.1, and 1752.4 regarding dental auxiliaries.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 25.c.: Legislative Proposal to Amend BPC Sections 1628.7, 1686, 1718.2, and 1718.3 Regarding Probationary Licenses, Petitions for Reinstatement, Termination, or Modification of Penalty, and Cancelled Licenses and Permits
Ms. Ragali provided the report, which is available in the meeting materials.

(M/S/C) (Yu/Cheng) to approve for submission to the California State Legislature the legislative proposal in Attachment 1 to amend BPC sections 1628.7, 1686, 1718.2, and 1718.3 to clarify the probationary license, petition for reinstatement, termination, or modification of penalty, and cancelled license and permit processes and requirements.

President Larin requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Larin called for the vote on the motion. Secretary Dierking took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Dierking, Felsenfeld, Forge, Grewal, Larin, Medina, Olague, Thakur, Vaderhobli, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 26: Update, Discussion, and Possible Action on Legislation Impacting the Board, DCA, and/or the Dental Profession
Agenda Item 26.a.: 2026 Tentative Legislative Calendar – Information Only
Mr. Nelson provided an overview of the 2026 Tentative Legislative Calendar, which is available in the meeting materials.

President Larin requested public comment on this item. There were no public comments made on this item.

At 10:37 a.m., the Board recessed for a break.

At 10:47 a.m., the Board reconvened.

Agenda Item 26.b.: Legislation of Interest
Mr. Nelson provided the report, which is available in the meeting materials.

President Larin requested public comment on this item. The Board received public comment.

Dr. Acheson stated that it is his understanding that Assembly Bill (AB) 873 (Alanis, 2025) was intended mainly to address unregistered dental assistants, specifically the ones that come in basically to learn on the job training, and the concern that they have an adequate education in infection control before they actually participate in working with patients. He expressed that this bill basically, as the way it is written, is merging all infection control requirements with this specific goal. Dr. Acheson noted that paragraph five of the bill states that the bill would instead make the employer responsible for ensuring that the dental assistant has successfully completed the course in infection control on or before 60 days from the date of first employment at the dental office. The bill would also authorize a dental assistant to comply with this requirement by taking a Board-approved course provided by a Board-approved registered dental assisting educational program.

Shari Becker, representing the Alliance, noted that regarding AB 873, part of the concern is regarding the 60 days that would be applicable to the unlicensed dental assistant to take the infection control course 60 days after employment. She added that the Senate Bill (SB) 1453 (Ashby, Chapter 483, Statues of 2024) language did pass,

and it states “prior to exposure.” Therefore, she stated that the Alliance supports the language that was passed in SB 1453. Ms. Becker added that also of concern in AB 873 is the virtual option for the lab portion taking away any live hands-on lab. She indicated that the Alliance does not support the virtual option that is being offered in place of in-person.

Melodi Randolph, representing the Alliance, expressed a concern at the top of page 240 of the meeting materials regarding the increase in fees for approved courses. She communicated that currently the fee is $300, and although they recognize that it is grossly insufficient to cover costs of approving these courses, to increase them to a maximum of $8,000 per course is prohibitive for these course providers to pay that much money for approval. She noted that the cost of those fees would be transferred to the students taking the course and absorbed by the students, which therefore would impact the availability of courses as a lot of providers will either choose not to apply and pay that astronomically increased fee or pass that fee along to the students. Ms. Randolph expressed that they would support an increase, but a reasonable increase in the fees.

Ms. Zokaie, representing CDA, mentioned that considering the language of AB 873 and how that may change through a new vehicle of the new Board's cleanup language and with the Senate Business, Professions and Economic Development Committee, if the language will continue to be the 8-hour infection control course before exposure to blood and saliva, then CDA believes that is why the online course needs to be available and accessible and fully online because dentists want to be able to hire dental assistants and their teams to be able to train them in appropriate infection control and then be able to work with it being before exposure to blood and saliva. Ms. Zokaie noted that the course needs to be accessible, especially for rural dental clinics that may not have an in-person portion accessible to them.

Leslie Canham expressed that she supports Ms. Randolph's comments about the fee being exorbitant for an 8-hour infection control provider. As she is a standalone provider, it would be a cost she would pass on to the assistants, which would have an impact on the workforce shortage. As she travels to outreach areas and to rural areas to the training, she indicated that there is really no excuse not to reach out to the providers that do travel to the dental clinics and the offices that are in these outlying areas to get this training completed.

Agenda Item 27: Future Agenda Items and Next Meeting Dates

Mr. Docherty provided a report on future agenda items and Board meeting dates for the rest of the year.

President Larin requested public comment on this item. The Board received public comment.

Ms. McLearan, representing CHA, applauded the Board for asking HCAI for details on how they incentivize dental practices in shortage areas. She noted that HCAI is currently doing their deep dive into the oral health workforce, including dentists, dental assistants, and dental hygienists. It is her understanding that their data will come from license renewal data. She suggested that the Board ask HCAI how it plans to track the unlicensed dental assistant population who also play an integral part in the delivery of oral care.

Agenda Item 28: Adjournment
President Larin adjourned the meeting at 11:18 a.m.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 4.:** Board President Report

Background

Dr. Lilia Larin, President of the Dental Board of California, will provide a verbal report.

Action Requested

No action is requested.

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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 5.:** Executive Officer Report

Background

Bryce W.A. Docherty, MPA, Executive Officer of the Dental Board of California, will provide a verbal report.

Action Requested

No action requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 6.:** Report on Department of Consumer Affairs (DCA) Activities, which may include updates on DCA's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters

Background

The Department of Consumer Affairs Board and Bureau Relations will provide a verbal report.

Action Requested

No action requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 30, 2026
TO	Members of the Dental Board of California
FROM	Bryce W.A. Docherty, MPA, Executive Officer Dental Board of California
SUBJECT	**Agenda Item 7.:** Report on Purpose Statement and Objectives of Standing and Special Needs Committees

Background

Dr. Lilia Larin, President of the Dental Board of California (Board), will provide a verbal report.

Pursuant to Business and Professions Code (BPC) section 1601.1 and the Board Administrative Policy and Procedure Manual, the Board shall be organized into standing committees pertaining to examinations, enforcement, and other subjects the Board deems appropriate.

Committees meet when they have issues to be considered and make recommendations to the full Board.

Committee Updates

A verbal report from the following Board committees will be provided:

a. Access to Care Committee (Special Needs) – Yogita Thakur, MS, DDS, Chair
b. Anesthesia Committee (Special Needs) – Alan Felsenfeld, MA, DDS, Chair
c. Communications and Editorial Committee (Special Needs) – James Yu, MS, DDS
d. Enforcement Committee (Standing) – Ram Vaderhobli, MS, DDS, Chair
e. Examination Committee (Standing) – Lilia Larin, DDS, Chair
f. Legislative and Regulatory Committee (Special Needs) – Robert David, Chair
g. Substance Use Awareness Committee (Special Needs) – John Dierking, JD, Chair

Below are the Purpose Statements and Objectives of the Board's Standing and Special Needs Committees:

a. Access to Care Committee:

Members: Yogita Thakur, MS, DDS (Chair); Angelita Medina, MHS

Purpose Statement: The Access to Care Committee identifies barriers that limit access to safe dental care and proposes recommendations to eliminate such barriers.

Objectives:

- Gather data internally and from key stakeholders on ways to improve access to care.
- Evaluate current licensing requirements to identify and potentially reduce barriers for practitioners entering the California dental workforce.
- Collaborate with the California Department of Public Health Office of Oral Health; California Department of Health Care Services *Smile, California*; California Department of Health Care Access and Information; and others on efforts to increase access to oral health professionals.
- Review best practices of other state licensing boards that increase access to care.
- Provide recommendations on legislation impacting access to care to the Board and the Legislative and Regulatory Committee.

b. Anesthesia Committee:

Members: Alan L. Felsenfeld, MA, DDS (Chair); Steven Chan, DDS

Purpose Statement: The Anesthesia Committee of the Dental Board of California monitors the use of systemic sedation and anesthesia by dentists and other providers to ensure safety in the provision of these services to the public.

Objectives:

- Monitor dental anesthetic complications data and make recommendations to the Board for potential solutions if significant negative trends emerge.
- Periodically review the statutory and regulatory standards for anesthesia and sedation providers and the algorithms used in office evaluation examinations.
- Evaluate permit holders who fail multiple office evaluations and recommend potential corrective actions and solutions to the Board.
- Be aware of and monitor legislation that impacts anesthesia and sedation.
- Consider the use of dental sedation assistant permit examinations used by other recognized agencies and make recommendations to the Board.

c. Communications and Editorial Committee:

Members: James Yu, MS, DDS (Chair); Joni Forge, DDS

Purpose Statement: The Communications and Editorial Committee of the Dental Board of California reviews and recommends Board communication strategies to ensure quality customer service to Board licensees and stakeholders.

Objectives:

- Review and update BreEZe functionality for an improved user experience.
- Develop an Outreach and Communication Plan to promote transparency and increase stakeholder awareness of the Board's activities and processes.
- Increase internal and external communication to improve transparency and knowledge of processes and provide better customer service.

d. Enforcement Committee[i]:

Members: Ram M. Vaderhobli, MS, DDS (Chair); Kevin R. Cheng, JD

Purpose Statement: The Enforcement Committee of the Dental Board of California advances public protection by providing governance-level oversight to improve efficiency, consistency, and accountability of the Board's enforcement program, while identifying opportunities for licensee violations prevention to ensure consumer protection.

Objectives:

- Efficiency and Process Modernization: Evaluate opportunities to reduce case processing timelines, including a review of how the transition to a paperless process can help streamline operations and reduce backlog.
- Consistency and Transparency: Review disciplinary outcomes to ensure equitable and standardized enforcement and assess how the Board communicates its enforcement actions to the public to enhance transparency and trust.
- Prevention Through Trend Analysis: Identify the most common violation categories and emerging trends to explore targeted preventive education opportunities that address root causes and reduce future complaints.

e. Examination Committee[ii]:

Members: Lilia Larin, DDS (Chair); Rosalinda Olague, RDA

Purpose Statement: The Examinations Committee of the Dental Board of California monitors licensing examinations to ensure licensee competency and consumer protection by supporting timely access to the dental workforce while maintaining high licensure standards. Furthermore, it evaluates exam validity and fairness, reviews

performance data, assesses methodologies, such as American Board of Dental Examiners (ADEX) and the California Law and Ethics Examination, and provides recommendations to the Board for regulatory improvements.

Objectives:

- Maintain and strengthen stakeholder trust by ensuring examination processes are transparent and equitable, and aligned with current clinical and professional standards.
- Leverage data-driven insights to evaluate exam validity and reliability and identify opportunities for ongoing improvement.
- Review and recommend to the Board statutory and regulatory changes that reflect current dental practice.
- Evaluate dental assisting licensure requirements for any barriers to entry and license portability across states.
- Assess exams and factors that potentially impact pass rates to ensure fairness, validity, comprehensiveness, and relevance.

f. Legislative and Regulatory Committee:

Members: Robert P. David (Chair); Jaskiran K. Grewal, DDS

Purpose Statement: The Legislative and Regulatory Committee of the Dental Board of California works with Board staff to educate Board members on key legislation and regulations impacting consumer protection, patient access, and quality of dental care in California.

Objectives:

- Assist Board members in conducting at least one annual meeting in the district with their local State Assemblymember and State Senator.
- Plan, coordinate, and execute an annual “Board Legislative Day” at the State Capitol the day before the first Board meeting of the year.
- Provide subject matter expertise and strategic insights to Board staff on legislative bill positions and priorities and proposed rulemaking packages under consideration by the Board.
- Coordinate with Board staff and other Board committees on educating Board members, licensees, and the public on issues impacting dental consumers of California.

g. Substance Use Awareness Committee:

Members: John Dierking, JD (Chair); Rosalinda Olague, RDA

Purpose Statement: The Substance Use Awareness Committee of the Dental Board of California supports consumer protection by advancing education, oversight, and policy recommendations related to substance use, diversion, and safe prescribing practices within dentistry.

Objectives:

- Promote licensee awareness and education on substance use risks, prevention, and safe prescribing practices.
- Monitor Board Diversion Program activity and provide input to Board staff to increase program participation.
- Support alignment with statewide and Board-led initiatives focused on opioid misuse and substance use prevention.
- Inform Board discussions on regulatory, enforcement, and continuing education efforts related to substance use.

Action Requested

No action is requested.

[i] Statutory Committee
[ii] Statutory Committee

AMERICAN BOARD of DENTAL EXAMINERS

SUPPORTING **STATE BOARDS'** MISSION TO **PROTECT THE PUBLIC**

- Accepted or required by law in 51 U.S. states and territories
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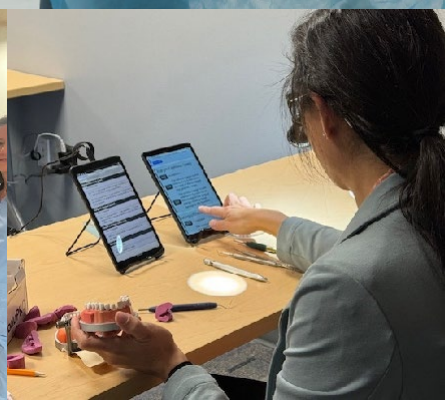
- Exams accessible to all dental & dental hygiene candidates
- Nationally coordinated scoring and quality assurance



Who We Are

The American Board of Dental Examiners (ADEX) is a national, non-profit organization dedicated to protecting the public through close collaboration with state dental boards. Together, we develop and administer evidence-based licensure assessments that support safe and competent dental practice.

ADEX upholds the highest standards of fairness, validity, and reliability through uniform computer-based and clinical manikin hand skills examinations, trusted by state boards to evaluate candidates' readiness for licensure. Today, ADEX examinations are accepted across nearly all U.S. jurisdictions and are utilized by the vast majority of dental and dental hygiene candidates.

ADEX administers a comprehensive portfolio of clinical examinations used by dental boards across the United States and internationally. The Council on Examinations, representing every U.S. state and territory, continuously reviews and refines these assessments to ensure clinical relevance, fairness, and accuracy.

Our organization is led by a national network of state dental board and educator-examiners, united by a shared commitment to integrity, consistency, and public protection.

Our Mission

Assess
Deliver psychometrically sound clinical examinations in dental and dental hygiene licensure. ADEX delivers more than 24,000 assessments annually.

Support
Support state regulatory agencies in standardizing and evaluating candidate competence.

Strengthen
Strengthen public trust in the licensure process while enabling portability for professionals.

WHY **BECOME** AN **EXAMINER?**

State dental board members play a critical role by participating in the examination administration process. Participation in the American Board of Dental Examiners allows regulators to uphold public protection and contribute to national consistency in dental and dental hygiene competency standards. Engagement ensures that the licensure pathways align with real-world practice, regulatory priorities, and evolving standards of care.

Examine

All members of state boards may participate in administering ADEX examinations at 400+ sites nationwide as available.

Lead

Opportunity to serve on the ADEX board of directors or other committees.

Develop

States select representatives to the Council on Examinations, participating in exam development and policy.

Connect

Represent your state board at meetings, conferences, and regulatory summits.

ADEX
AMERICAN BOARD of DENTAL EXAMINERS

QUICK FACTS
FOR PROSPECTIVE EXAMINERS

Honorarium and travel reimbursement

Training and calibration offered on demand

Professional development opportunities

PURSUE **EXCELLENCE** IN **LICENSURE**

Offering trusted, reliable examinations backed by professional expertise and a collaborative governance model, the American Board of Dental Examiners provides regulators with the tools they need to determine readiness for practice and standards for licensure.

Ask your Executive Director to get started.

JOIN TODAY

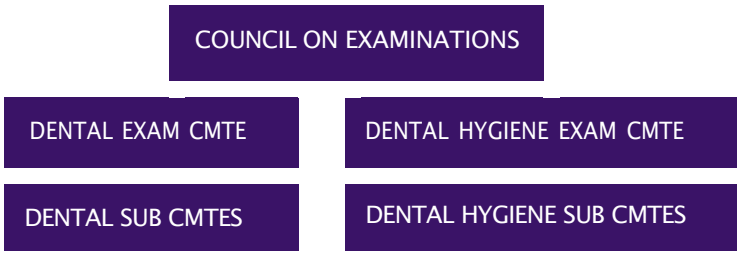
WHAT **IS** THE **COUNCIL ON EXAMINATIONS?**

State dental board members play a critical role in the examination process. Through participation with the American Board of Dental Examiners, regulators directly support public protection while serving as stewards of a consistent, national standard for dental and dental hygiene licensure.

Examiner engagement provides the opportunity to collaborate with fellow state board members and respected professionals from across jurisdictions, fostering shared insight and alignment. It also ensures that licensure pathways remain grounded in real-world clinical practice, aligned with regulatory priorities, and responsive to evolving standards of care.

Council Appointment Eligibility & Term Length

Each state is asked to appoint a dentist and dental hygienist to the Council to serve three year terms. Persons who are current members of their state dental board, or have served within the past five years, are eligible to be appointed to the Council. Appointees will onboard with ADEX to access materials, information and be invited to examine. Active ADEX participation of five years or more is required to hold an office on the Council.



Council Member Commitments & Expectations

The Council will meet in person during the ADEX Annual Meeting. Exam Committees will meet virtually in advance and may gather in person at the Annual Meeting event as well. Virtual meetings typically last one to two hours. The time requirement can vary slightly depending on what (if any) subcommittees the person is appointed to serve.

Participation in the examining process, and the Council on Examinations provides state board members insight into how their service protects the public, firsthand. Ask for a presentation to your board to learn more.

Contact:
ADA:
mediarelations@ada.org

ADEX:
communications@adextesting.org

American Dental Association and American Board of Dental Examiners Advance Dental Licensure Examinations Through New Agreement

ADEX to incorporate the Dental Licensure Objective Structured Clinical Examination (DLOSCE) into the ADEX Dental Examination no later than Aug. 1, 2026

CHICAGO, April 14, 2026 – The American Dental Association (ADA) and the American Board of Dental Examiners (ADEX) have finalized an agreement to license the ADA's Dental Licensure Objective Structured Clinical Examination (DLOSCE) for incorporation into the ADEX Dental Examination, marking a significant step forward in modernizing dental licensure and advancing patient safety.

The agreement benefits public health, dental licensure candidates, the dental profession, and licensing boards to help ensure dentists enter the profession with proven competence and uphold the highest standards for patient safety.

The integration of the ADA's DLOSCE simplifies licensure pathways and supports licensure portability, benefiting candidates seeking to practice in 48 states and other jurisdictions—including Washington, D.C., Puerto Rico, Jamaica, and the U.S. Virgin Islands — that currently accept or require the ADEX Dental Examination.

"This agreement represents an important milestone for the dental profession," said Dr. Richard Rosato, D.M.D., president of the ADA. "By aligning pathways to licensure and advancing candidate assessment, we are strengthening licensure portability, supporting a more mobile and responsive workforce, and ensuring that patient safety remains paramount. The ADA has long championed solutions that modernize licensure while protecting the public, and this collaboration reflects our commitment to shaping a strong, sustainable future for dentistry in service to public health."

The ADEX Dental Examination with its DLOSCE component represents a modernized, evidence-based approach to evaluating clinical competence and readiness for practice. The ADEX Dental Examination will continue to assess candidates' clinical hand skills alongside their treatment-planning and decision-making abilities. Through inclusion of the DLOSCE, the ADEX Dental Examination will benefit from the DLOSCE's extensive use of images and 3D models that allow candidates to demonstrate their clinical judgment in scenarios that closely mirror real-world practice.

"ADEX has long served state dental boards to support licensure processes that reflect both public protection and clinical competence," said Dr. Mark Armstrong, Chair of ADEX. "This agreement

continues that work by strengthening alignment across assessment components while preserving the clinical hand-skills evaluation that remains central to licensure in most U.S. jurisdictions."

The agreement follows extensive collaboration among the ADA, ADEX, the Joint Commission on National Dental Examinations (JCNDE), and the ADA Council on Dental Education and Licensure (CDEL) that began in 2025. In March 2026, the ADA Board of Trustees and ADEX Board of Directors voted to approve the general terms that led to this joint agreement.

Central to discussions was a shared commitment to ensuring that dental licensure assessments continue to evolve in step with advancements in clinical education, technology, and patient care. Both organizations emphasized the importance of strengthening public protection while also enhancing the portability of dental licensure for candidates navigating an increasingly mobile profession.

ADEX will sunset its DSE OSCE no later than Aug. 1, 2026. Upon sunset of the DSE OSCE, all ADEX Dental Examination administrations will include the DLOSCE.

The DLOSCE will no longer be offered or administered as a standalone examination to new DLOSCE candidates, except in conjunction with the ADEX Dental Examination, after August 1, 2026. All standalone administrations of the DLOSCE will cease after October 9, 2026.

###

About the American Dental Association

The not-for-profit ADA is the nation's largest dental association, representing more 152,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859. The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance has long been a valuable and respected guide to consumer dental care products. *The Journal of the American Dental Association* (JADA), published monthly, is the ADA's flagship publication and the best-read scientific journal in dentistry. For more information about the ADA, visit ADA.org. For more information on oral health, including prevention, care and treatment of dental disease, visit the ADA's consumer website MouthHealthy.org.

About the American Board of Dental Examiners

The American Board of Dental Examiners (ADEX) is a not-for-profit organization dedicated to supporting dental boards in their mission to protect the public through the licensure of qualified oral health professionals. Established in 1969, ADEX administers independent competency examinations developed and approved by representatives of state dental boards. ADEX examinations are accepted or required by law in 51 U.S. jurisdictions and serve as the initial licensure pathway for 98% of dental and 85% of dental hygiene candidates nationwide. Through ongoing collaboration with dental boards and educators, ADEX continues to advance innovative, evidence-based assessment methods that uphold the highest standards of fairness, clinical competence, and public protection. Learn more at adextesting.org.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 8.:** Dental Assisting Council Meeting Report

Background

Ms. Jeri Fowler, Chair of the Dental Assisting Council, will provide a verbal report on the May 13, 2026, meeting.

Action Requested

No action requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	April 10, 2026
TO	Members of the Dental Board of California
FROM	Yvette Ramirez, Budget and Contract Analyst Dental Board of California
SUBJECT	**Agenda Item 9.:** Budget Report

Background

The Dental Board of California (Board) administers the State Dentistry Fund (Fund), which derives revenues (primarily) through licensing-related fees to fund the Board's administrative, licensing, and enforcement activities.

The Board receives the legislated annual budget appropriation upon the chaptering of the Budget Act. The Board is statutorily required to remain within its appropriation spending limit and to ensure the Fund's ongoing solvency.

Action Requested

The following chart provides an overview of the Governor's Budget for the Dental Board of California.

2026-27 Governor's Budget: Fiscal Year 2025-26		
Fund	**Revenue**	**Expenditures***
State Dentistry Fund	$20,420,000	$20,362,000

*$283,000 (net) reimbursements – probation monitoring and fingerprints

Analysis of Fund Condition Statement (See Attachment 3):

The attached fund condition statement (FCS) is based on the 2026-27 Governor's Budget. It has been updated with 2025-26 expenditure and revenue projections, which resulted in a fund balance reserve of $27.0 million (14.8 months).

Revenues (See Attachments 2 & 3) – The Board began 2025-26 with a fund balance of $26.4 million and is projected to collect $20.5 million in revenues with $3.5 million from initial license fees and $15.3 million from license renewals.

Expenditures (See Attachment 1 & 3) – The Board's 2025-26 appropriation is $20.4 million and expenditures are projected to be $18.7 million. The FCS projects ongoing expenditures in the future with a three percent (growth factor) increase per year. The FCS also shows the Board fully expending its appropriation ongoing which has not been the trend in recent years. To the extent the Board does not fully expend its appropriation, any savings remains in the Fund for future use.

Overall expenditures are projected to increase in future years, with the most significant growth driven by personnel services, investigation costs, and statewide contributions.

The Board notes, future legislation or other events could require the Board to request additional resources through the annual budget process. If that happens, it could place more financial pressure on the Fund.

General Fund (GF) Loan – Item 1111-011-0741, Budget Act of 2020, authorized a $5 million loan transfer from the Fund to the GF, with an interest rate of .67%.

The loan was repaid on June 30, 2025, with an earned interest of $131,000.

Fund Balance Months in Reserve – The fund balance reserve reports the dollar amount remaining in the Fund at the end of any given fiscal year. This is used to calculate the Months in Reserve balance based on projected expenditures for the next fiscal year. Typically, a healthy fund has about 6 to 9 months in reserve.

The fund balance reserve is currently stable but does show a declining balance in future years due to a structural imbalance caused by the fund's revenues projected to stay stationary, and the fund's expenditures to increase by 3%. The fund should remain healthy through 2028-29, although, unforeseen expenditures can cause this to change.

Structural Imbalance – A structural imbalance occurs when projected revenues are less than anticipated expenditures.

Action Required (future) – The Board will continue to monitor the Fund and work with DCA Budget Office to ensure solvency.

As of April 2026, the Board has a 10% vacancy rate.

The Board further notes, most existing license fee types are currently being assessed below their statutory maximums. These fees could be increased through regulatory action and/or statutory amendments, which could address the existing structural imbalance. Regulatory fee changes typically take 18 to 24 months to complete the promulgation process.

Board staff will be working with the DCA Budget Office to identify possible actions to reduce or eliminate the structural imbalance to ensure the Board remains solvent and able to fully meet its licensing and enforcement mandates.

Board staff will present the findings and recommendations at future board meetings to allow for public input and Board Member consideration.

Action Requested

This item is informational only. No action requested.

Attachment 1

Department of Consumer Affairs

Expenditure Projection Report

Dental Board of California
Reporting
Structure(s):
Fiscal Month: 8
Fiscal Year: 2025 - 2026
Run Date: 03/23/2026

PERSONAL SERVICES

Fiscal Code	Line Item	PY Budget	PY FM13	Budget	Current Month	YTD	Encumbrance	YTD + Encumbrance	Projections to Year End	Balance
5100	PERMANENT POSITIONS	$7,109,000	$6,608,324	$7,374,000	$552,710	$4,375,601	$0	$4,375,601	$6,615,922	$758,078
5100	TEMPORARY POSITIONS	$284,000	$236,372	$228,000	$17,924	$304,476	$0	$304,476	$281,871	-$53,871
5105-5108	PER DIEM, OVERTIME, & LUMP SUM	$130,000	$17,625	$130,000	$400	$11,000	$0	$11,000	$158,251	-$28,251
5150	STAFF BENEFITS	$3,854,000	$3,490,045	$4,302,000	$317,866	$2,617,549	$0	$2,617,549	$3,857,909	$444,091
	PERSONAL SERVICES	$11,377,000	$10,352,366	$12,034,000	$888,900	$7,308,625	$0	$7,308,625	$10,913,952	$1,120,048

OPERATING EXPENSES & EQUIPMENT

Fiscal Code	Line Item	PY Budget	PY FM13	Budget	Current Month	YTD	Encumbrance	YTD + Encumbrance	Projections to Year End	Balance
5301	GENERAL EXPENSE	$375,000	$127,592	$377,000	$12,486	$42,983	$10,433	$53,416	$139,320	$237,680
5302	PRINTING	$75,000	$151,617	$75,000	$11,306	$21,711	$117,407	$139,119	$162,975	-$87,975
5304	COMMUNICATIONS	$36,000	$23,216	$36,000	$2,868	$18,356	$0	$18,356	$29,595	$6,405
5306	POSTAGE	$54,000	$87,056	$54,000	$58	$49,501	$5,174	$54,675	$77,768	-$23,768
5308	INSURANCE	$2,000	$18,850	$2,000	$0	$10,487	$0	$10,487	$10,487	-$8,487
53202-204	IN STATE TRAVEL	$102,000	$83,598	$102,000	$13,088	$67,659	$0	$67,659	$96,000	$6,000
53206-208	OUT OF STATE TRAVEL	$0	$1,000	$0	$0	$0	$0	$0	$1,000	-$1,000
5322	TRAINING	$12,000	$5,606	$12,000	$573	$1,758	$2,300	$4,058	$5,300	$6,700
5324	FACILITIES	$716,000	$726,088	$716,000	$61,812	$486,106	$240,170	$726,276	$739,561	-$23,561
5326	UTILITIES	$1,000	$0	$1,000	$0	$0	$0	$0	$0	$1,000
53402-53403	C/P SERVICES (INTERNAL)	$2,457,000	$2,299,532	$2,457,000	$180,944	$1,307,217	$4,225	$1,311,442	$2,340,164	$116,836
53404-53405	C/P SERVICES (EXTERNAL)	$1,275,000	$912,743	$1,082,000	$65,244	$477,598	$39,321	$516,919	$730,567	$351,433
5342	DEPARTMENT PRORATA	$3,287,000	$3,098,158	$3,259,000	$0	$2,478,000	$0	$2,478,000	$3,259,000	$0
5342	DEPARTMENTAL SERVICES	$186,000	$231,238	$186,000	$1,276	$69,800	$0	$69,800	$208,746	-$22,746
5344	CONSOLIDATED DATA CENTERS	$42,000	$44,674	$42,000	$0	$0	$0	$0	$46,908	-$4,908
5346	INFORMATION TECHNOLOGY	$32,000	$47,132	$32,000	$3,193	$32,085	$9,608	$41,692	$47,423	-$15,423
5362-5368	EQUIPMENT	$89,000	$323,371	$173,000	$747	$52,083	$1,724	$53,806	$73,612	$99,388
5390	OTHER ITEMS OF EXPENSE	$5,000	$72,227	$5,000	$2,665	$29,819	$0	$29,819	$56,007	-$51,007
54	SPECIAL ITEMS OF EXPENSE	$0	$4,816	$0	$1,716	$1,716	$0	$1,716	$3,021	-$3,021
	OPERATING EXPENSES & EQUIPMENT	$8,746,000	$8,258,514	$8,611,000	$357,974	$5,146,878	$430,361	$5,577,239	$8,027,452	$583,548

OVERALL TOTALS	$20,123,000	$18,610,880	$20,645,000	$1,246,874	$12,455,503	$430,361	$12,885,865	$18,941,404	$1,703,596
FINGERPRINT REPORTS	-$66,000		-$66,000					-$66,000	
EXTERNAL/PRIVATE/GRANT	-$217,000	$508,136	-$217,000					-$217,000	
OVERALL NET TOTALS	$19,840,000	$19,119,016	$20,362,000	$1,246,874	$12,455,503	$430,361	$12,885,865	$18,658,404	$1,703,596
									8.37%

Attachment 2

Department of Consumer Affairs

Revenue Projection Report

Reporting Structure(s):
Fiscal Month: 8
Fiscal Year: 2025 - 2026
Run Date: 03/23/2026

Revenue

Fiscal Code	Line Item	Budget	July	August	September	October	November	December	January	February	Year to Date	Projection To Year End
Delinquent Fees		$373,000	$25,730	$26,756	$25,909	$32,793	$25,531	$28,747	$34,665	$25,856	$225,985	$347,000
Other Regulatory Fees		$501,000	$32,605	$29,536	$43,431	$28,373	$31,745	$43,392	$41,391	$42,980	$293,453	$417,221
Other Regulatory License and Permits		$3,888,000	$410,636	$276,350	$267,067	$289,709	$230,792	$220,515	$252,904	$313,205	$2,261,178	$3,475,998
Other Revenue		$815,000	$465	$625	$1,696	$307,626	$9,582	$1,275	$312,807	$912	$634,987	$931,457
Renewal Fees		$14,843,000	$1,298,858	$1,238,001	$2,159,796	$2,449,690	$1,173,080	$1,200,190	$1,393,545	$1,219,756	$12,132,916	$15,288,729
Revenue		$20,420,000	$1,768,293	$1,571,267	$2,497,900	$3,108,191	$1,470,729	$1,494,119	$2,035,311	$1,602,709	$15,548,519	$20,460,405

Reimbursements

Fiscal Code	Line Item	Budget	July	August	September	October	November	December	January	February	Year to Date	Projection To Year End
Scheduled Reimbursements		$0	$2,107	$1,225	$1,568	$2,107	$1,172	$1,523	$1,862	$1,977	$13,541	$24,719
Unscheduled Reimbursements		$0	$49,027	$65,294	$57,155	$50,094	$50,094	$38,954	$23,903	$29,087	$363,609	$559,807
Reimbursements		$0	$51,134	$66,519	$58,723	$52,201	$51,266	$40,477	$25,765	$31,064	$377,150	$584,525

Attachment 3

0741 - Dental Board of California Fund Analysis of Fund Condition
(Dollars in Thousands)
2026-27 Governor's Budget With FM 8 Projections

Prepared 3.24.2026

	Actuals 2024-25	CY 2025-26	BY 2026-27	BY +1 2027-28	BY +2 2028-29
BEGINNING BALANCE	$ 19,224	$ 26,439	$ 27,040	$ 26,200	$ 24,689
Prior Year Adjustment	$ 398	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 19,622	$ 26,439	$ 27,040	$ 26,200	$ 24,689
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS					
Revenues					
4121200 - Delinquent fees	$ 372	$ 347	$ 377	$ 377	$ 377
4127400 - Renewal fees	$ 15,129	$ 15,289	$ 15,090	$ 15,090	$ 15,090
4129200 - Other regulatory fees	$ 438	$ 417	$ 481	$ 481	$ 481
4129400 - Other regulatory licenses and permits	$ 3,916	$ 3,476	$ 3,938	$ 3,938	$ 3,938
4143500 - Miscellaneous Services to the Public	$ 1	$ -	$ 15	$ 15	$ 15
4150500 - Interest Income from Interfund Loans	$ 131	$ -	$ -	$ -	$ -
4163000 - Income from surplus money investments	$ 1,213	$ 914	$ 1,104	$ 1,041	$ 946
4171400 - Escheat of unclaimed checks and warrants	$ 9	$ 9	$ 12	$ 12	$ 12
4172500 - Miscellaneous revenues	$ 12	$ 8	$ 2	$ 2	$ 2
Totals, Revenues	$ 21,221	$ 20,460	$ 21,019	$ 20,956	$ 20,861
Transfers to/from Other Funds					
Loan Repayment from General Fund (0001) to State Dentistry Fund (0741) per Item 1111-011-0741, Budget Act of 2020	$ 5,000	$ -	$ -	$ -	$ -
Totals, Transfers and Other Adjustments	$ 5,000	$ -	$ -	$ -	$ -
TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS	$ 26,221	$ 20,460	$ 21,019	$ 20,956	$ 20,861
TOTAL RESOURCES	$ 45,843	$ 46,899	$ 48,059	$ 47,156	$ 45,550
Expenditures:					
1111 Department of Consumer Affairs (State Operations)	$ 18,103	$ 18,356	$ 20,270	$ 20,878	$ 21,504
9892 Supplemental Pension Payments (State Operations)	$ 71	$ -	$ -	$ -	$ -
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	$ 1,230	$ 1,503	$ 1,589	$ 1,589	$ 1,589
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	$ 19,404	$ 19,859	$ 21,859	$ 22,467	$ 23,093
FUND BALANCE					
Reserve for economic uncertainties	$ 26,439	$ 27,040	$ 26,200	$ 24,689	$ 22,456
Months in Reserve	16.0	14.8	14.0	12.8	1.0

NOTES:
1. Assumes workload and revenue projections are realized in CY and ongoing.
2. Expenditure growth projected at 3% beginning BY.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

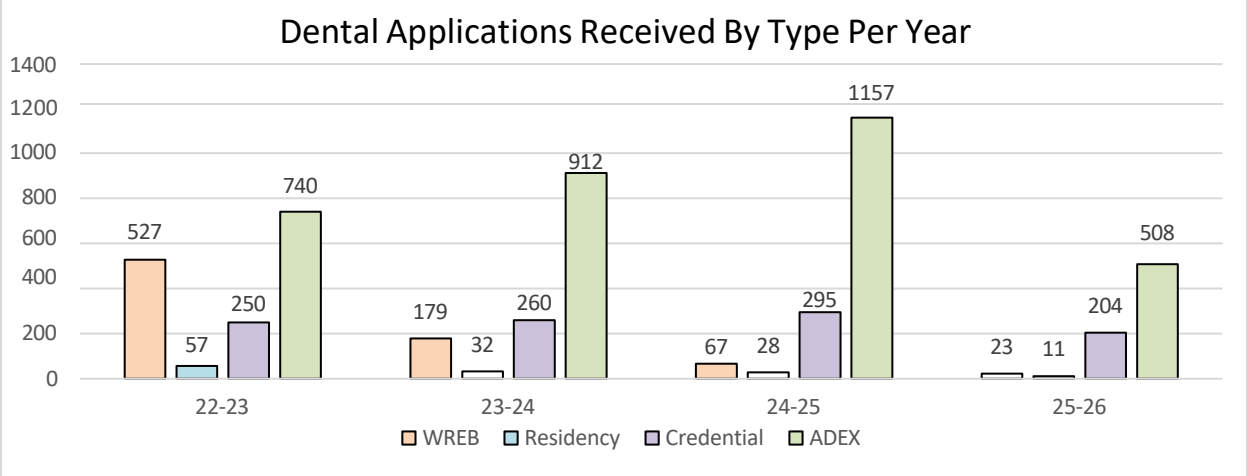
DATE	April 3, 2026
TO	Members of the Dental Board of California
FROM	Jodi Ortiz, Chief of Licensing and Examination Unit Dental Board of California
SUBJECT	**Agenda Item 10.a.:** Update on Dental Licensure and Permit Statistics

Year Over Year Dental License Application Statistics

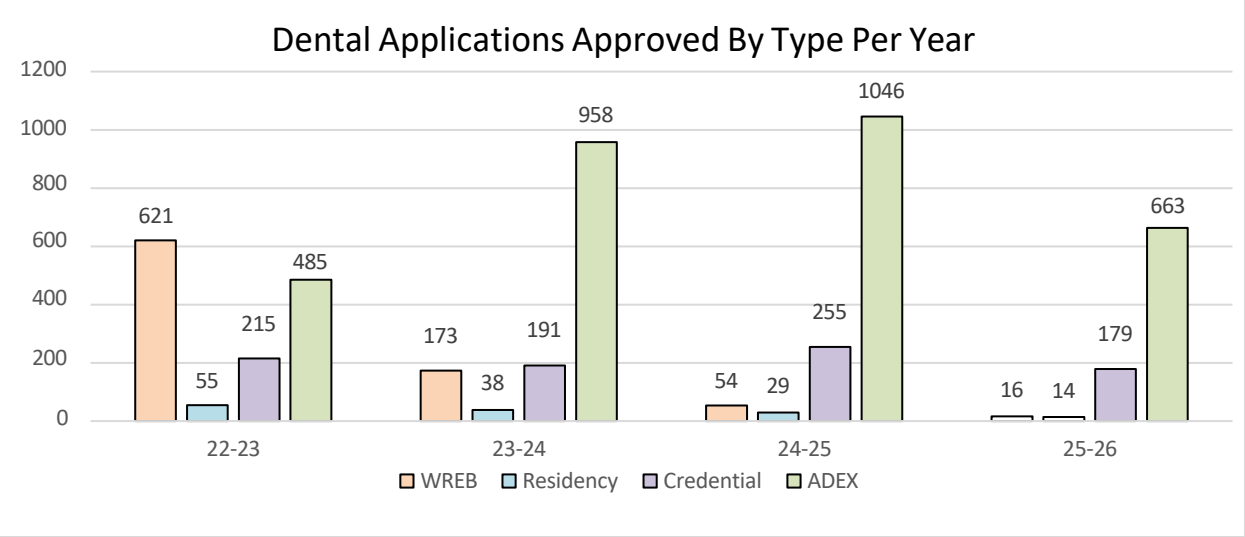
The following are monthly dental license application statistics by pathway for fiscal year 2022–23, 2023-24, 2024-25 and 25-26 as of March 31, 2026.

***NOTE:** Portfolio application information will no longer be included in the reports as this pathway was repealed. Portfolio information can be found in prior Board meeting materials.*

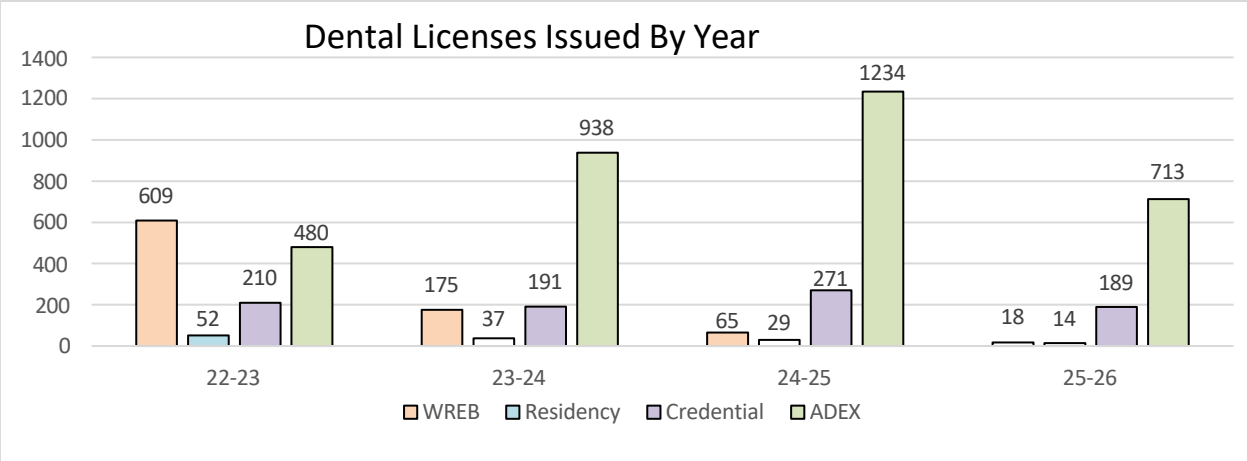
Dental Applications Received by Year					
	22-23	23-24	24-25	25-26	**Yearly Totals**
WREB	527	179	67	23	**796**
Residency	57	32	28	11	**128**
Credential	250	260	295	204	**1,009**
ADEX	740	912	1,157	508	**3,317**
Total	**1,576**	**1,385**	**1,548**	**746**	**5,255**



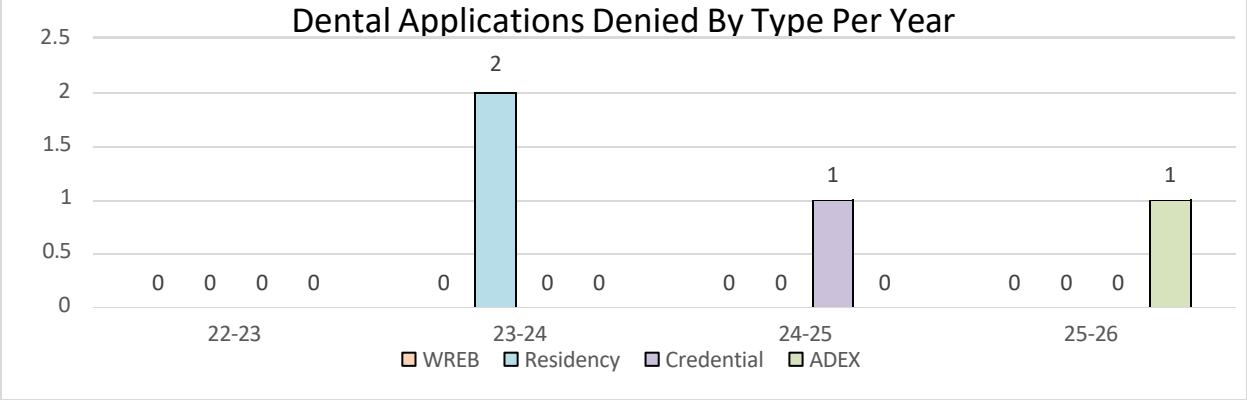
Dental Applications Approved by Year					
	22-23	23-24	24-25	25-26	**Yearly Totals**
WREB	621	173	54	16	**864**
Residency	55	38	29	14	**136**
Credential	215	191	255	179	**840**
ADEX	485	958	1,046	663	**3,152**
Total	**1,376**	**1,360**	**1,384**	**872**	**4,992**



Dental Licenses Issued by Year					
	22-23	23-24	24-25	25-26	**Yearly Totals**
WREB	609	175	65	18	**867**
Residency	52	37	29	14	**132**
Credential	210	191	271	189	**861**
ADEX	480	938	1,234	713	**3,365**
Total	**1,351**	**1,341**	**1,599**	**934**	**5,225**



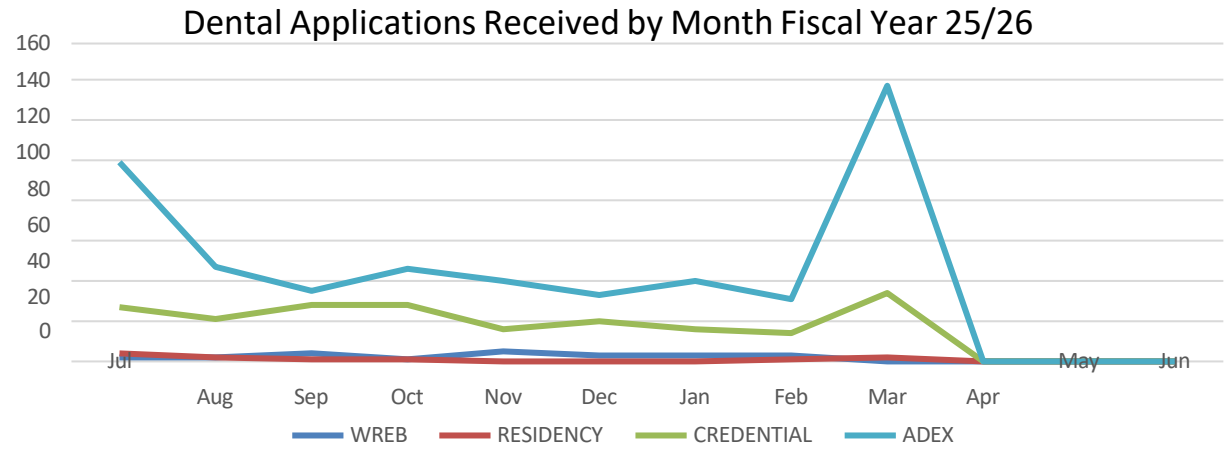
Dental Applications Denied by Year					
	22-23	23-24	24-25	25-26	**Yearly Totals**
WREB	0	0	0	0	**0**
Residency	0	2	0	0	**2**
Credential	0	0	1	0	**1**
ADEX	0	0	0	1	**1**
Total	**0**	**2**	**1**	**1**	**4**



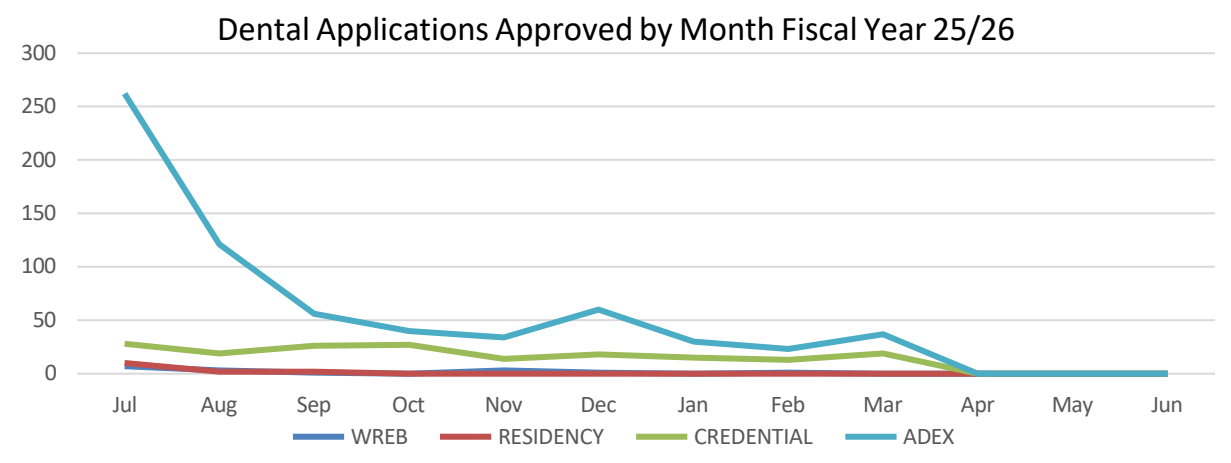
Monthly Dental License Application Statistic Graphs

The following graphs represent monthly dental license application statistics by pathway for fiscal year 2025-26 as of March 31, 2026.

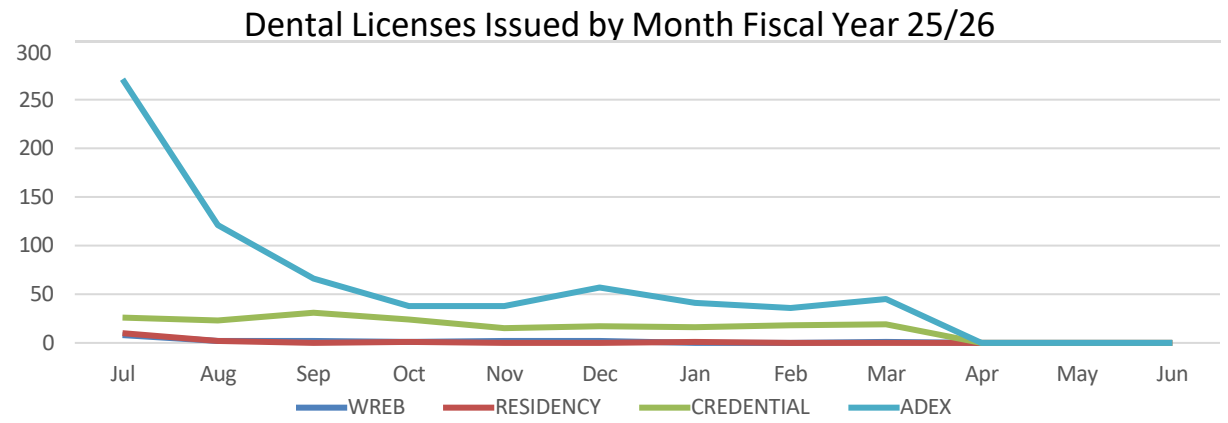
Dental Applications Received by Month													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Yearly Totals
WREB	2	2	4	1	5	3	3	3	0	0	0	0	23
Residency	4	2	1	1	0	0	0	1	2	0	0	0	11
Credential	27	21	28	26	16	20	16	14	34	0	0	0	202
ADEX	99	47	35	46	40	33	40	31	137	0	0	0	508
Total	**132**	**72**	**68**	**76**	**61**	**56**	**59**	**49**	**173**	**0**	**0**	**0**	**746**



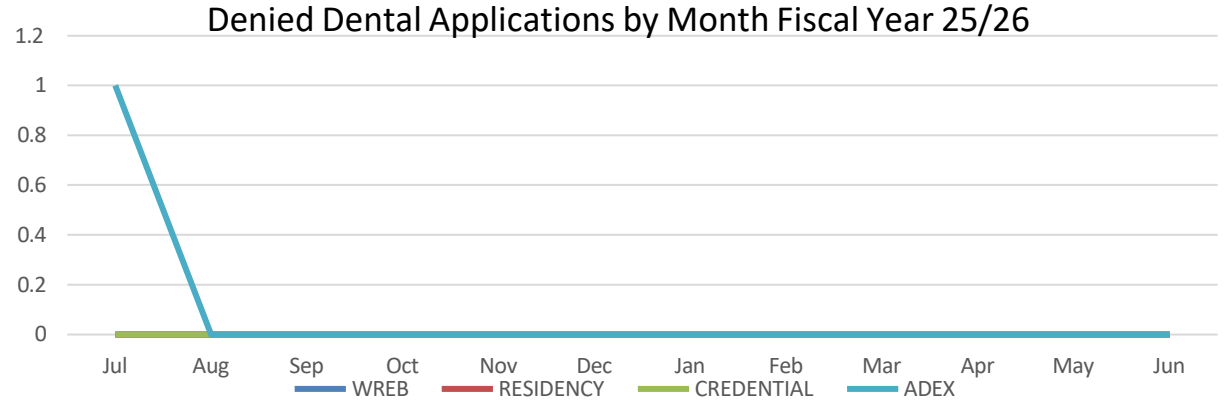
Dental Applications Approved by Month													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Yearly Totals
WREB	7	3	1	0	3	0	0	1	0	0	0	0	15
Residency	10	2	2	0	0	0	0	0	0	0	0	0	14
Credential	28	19	26	27	14	18	15	13	19	0	0	0	179
ADEX	262	121	56	40	34	60	30	23	37	0	0	0	663
Total	**307**	**145**	**85**	**67**	**51**	**79**	**45**	**37**	**56**	**0**	**0**	**0**	**872**



Dental Licenses Issued by Month													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Yearly Totals
WREB	8	2	2	1	2	2	0	0	1	0	0	0	18
Residency	10	2	0	1	0	0	1	0	0	0	0	0	14
Credential	26	23	31	24	15	17	16	18	19	0	0	0	189
ADEX	271	121	66	38	38	57	41	36	45	0	0	0	713
Total	**315**	**148**	**99**	**64**	**55**	**76**	**58**	**54**	**65**	**0**	**0**	**0**	**934**



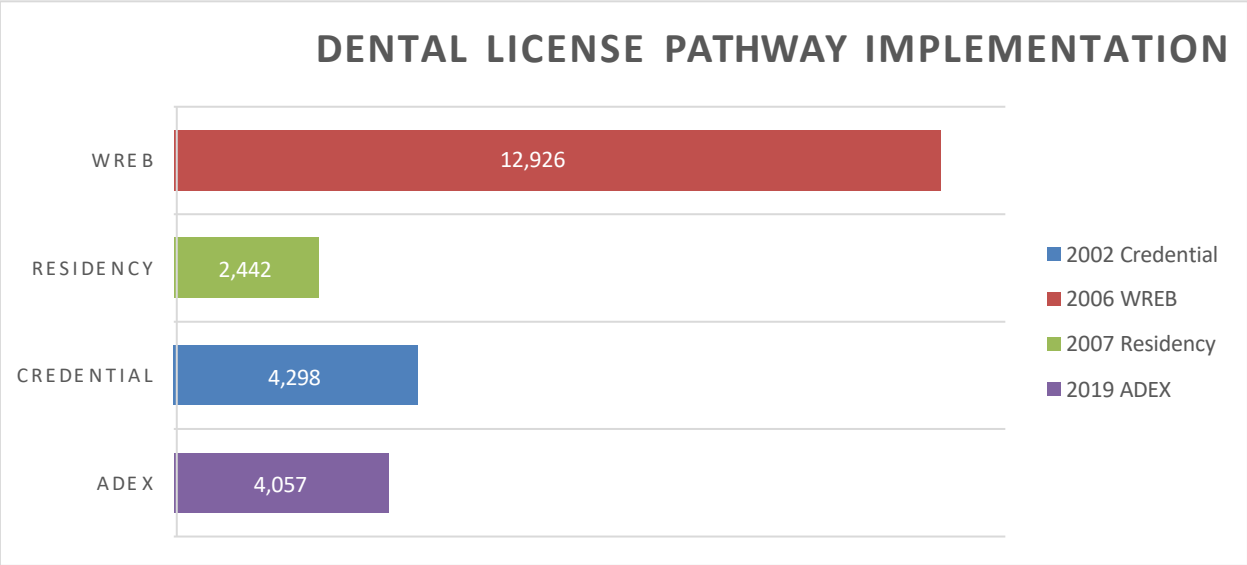
Denied Dental Applications by Month													
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Yearly Totals
WREB	0	0	0	0	0	0	0	0	0	0	0	0	0
Residency	0	0	0	0	0	0	0	0	0	0	0	0	0
Credential	0	0	0	0	0	0	0	0	0	0	0	0	0
ADEX	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**



Application Definitions	
Received	Application submitted in physical form or digitally through Breeze system.
Approved	Application for eligibility of licensure processed with all required documentation.
License Issued	Application processed with required documentation and paid prorated fee for initial license.
Denied	The Board denies an application on the grounds that the applicant has been convicted of a crime or has been subject to formal discipline; in accordance with the Business and Professions Code, Division 1.5, Chapter 2, Denial of Licenses.

Dental License Pathway Implementation Statistics

The following table provides statistics on dentist licenses issued by pathway to licensure from date the pathway was implemented as of March 31, 2026.



Total licenses issued 23,723.
Since the Portfolio pathway was repealed this data will no longer be captured in this report. Portfolio information can be found in previous Board meeting materials.

Dental Law and Ethics Written Examination Statistics

The following table provides statistics on dental Law and Ethics written examination statistics by fiscal year 2022–23, 2023-24, 2024-25, and 2025-26 as of March 31, 2026.

License Type		Dentist License			
Exam Title		**Dental Law and Ethics Examination**			
Licensure Pathway		**WREB**	**LBR**	**ADEX**	***Pathway not chosen**
2022/23	# of 1st Time Candidates	444	52	761	199
	Pass %	74.55%	88.46%	83.57%	69.35%
2023/24	# of 1st Time Candidates	90	18	587	563
	Pass %	91.11%	94.44%	90.12%	82.42%
2024/25	# of 1st Time Candidates	42	11	861	180
	Pass %	92.86%	100.00%	94.77%	86.67%
2025/26	# of 1st Time Candidates	12	4	300	0
	Pass %	100.00%	100.00%	91.67%	0%
Date of Last Occupational Analysis: 2024					
Name of Developer: Office of Professional Examination Services					
Target Occupational Analysis Date: 2029					

Pathway not chosen denotes applicants who have tested, but not yet chosen a pathway to licensure

Dental License and Permits Statistics

The following table provides statistics on dental license and permit status statistics by fiscal year 2022–23, 2023-24, 2024-25, and 2025-26 as of March 31, 2026.

License Type	License Status	FY 22/23	FY 23/24	FY 24/25	FY 25/26
Dental License	Active	34,710	35,078	35,584	35,614
	Inactive	1,691	1,661	1,582	1,558
	Reduced Renewal Fee*	1,168	1,132	943	921
	Disabled	87	94	91	79
	Delinquent	6,180	6,069	6,199	6,270
	Cancelled	20,703	21,735	22,826	23,572
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Additional Office Permit	Active	2,375	2,522	2,676	2,958
	Delinquent	1,390	1,285	1,291	1,252
	Cancelled	7,726	7,979	8,239	8,495
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Continuing Education Registered Provider Permit	Active	746	724	764	746
	Delinquent	660	625	530	531
	Cancelled	2,663	2,782	2,923	2,989
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Elective Facial Cosmetic Surgery Permit	Active	27	27	29	27
	Delinquent	6	6	7	8
	Cancelled	4	5	6	6
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Extramural Facility Registration	Active	60	67	89	112
	Delinquent	N/A	N/A	N/A	N/A
	Cancelled	N/A	N/A	N/A	N/A
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Fictitious Name Permit	Active	6,485	6,877	7,317	7,828
	Delinquent	2,855	2,731	2,737	2,725
	Cancelled	8,350	8,875	9,334	9,700
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
General Anesthesia Permit	Active	949	941	958	955
	Delinquent	41	49	40	37
	Cancelled	1,095	1,131	1,179	1,210
	PE Under 7	-	-	286	130
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Mobile Dental Clinic Permit	Active	45	50	63	77
	Delinquent	39	40	40	45
	Cancelled	88	96	100	104
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Medical General Anesthesia Permit	Active	153	150	154	161
	Delinquent	32	39	37	38
	Cancelled	242	267	291	301

	PE Under 7	-	-	278	106
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Moderate Sedation Permit	Active	192	445	617	656
	Delinquent	1	4	5	15
	Cancelled	3	10	42	56
	PE Under 13	-	-	56	55
	PE Under 7	-	-	55	54
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Oral Conscious Sedation Adults Certificate	Active	1,971	1,460	1,206	1,183
	Delinquent	386	412	439	467
	Cancelled	1,960	2,562	2,891	2,930
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Oral and Maxillofacial Surgery Permit	Active	96	96	96	97
	Delinquent	9	10	12	13
	Cancelled	27	27	27	28
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Pediatric Minimal Sedation Permit	Active	102	309	397	413
	Delinquent	1	3	21	39
	Cancelled	0	0	1	2
License Type	**License Status**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**
Special Permit	Active	34	38	39	42
	Delinquent	6	8	8	13
	Cancelled	203	207	215	216

Status Definitions	
Active	Current and can practice without restrictions *(BPC §1625)*
Inactive	Current but cannot practice, continuing education not required (*CCR §1017.2)*
Reduced Renewal Fee	Current, has practiced over 20 years, eligible for Social Security and can practicewith restrictions *(BPC §1716.1a)*
Disabled	Current with disability but cannot practice *(BPC §1716.1b)*
Delinquent	License or Permit renewal is not completed by expiration date *(BPC §163.5)*
Cancelled	A license that is not renewed within five years after its expiration date shall be cancelled *(BPC §1718.3)*

The following table provides statistics on population, current and active dental licenses by County, and population (Pop.) per dental license by County for fiscal years 2023-24, 2024-25, and 2025-26 as of March 31, 2026. These statistics represent the licensee's address of record and not necessarily the licensee's workplace address.

County	DDS per County in 2023/24	Pop. in 2023/24	Pop. per DDS in 2023/24	DDS per County in 2024/25	Pop. in 2024/25	Pop. per DDS in 2024/25	DDS per County in 2025/26	Pop. In 2025/26	Pop. per DDS in 2025/26
Alameda	1,472	1,651,979	1,112	1,486	1,641,869	1,111	1,469	1,662,482	1,131
Alpine	0	1,200	0	0	1,179	0	0	1,177	0
Amador	23	40,297	1,918	21	39,611	1,918	22	39,563	1,798
Butte	118	201,608	1,625	123	205,928	1,639	110	207,525	1,886
Calaveras	21	45,049	2,145	23	44,842	1,958	16	44,722	2,795
Colusa	4	21,807	3,634	4	21,743	5,451	3	22,026	7,342
Contra Costa	1,092	1,156,555	1,048	1,092	1,146,626	1,059	1,107	1,158,225	1,046
Del Norte	11	27,218	2,474	12	26,345	2,268	11	26,544	2,413
El Dorado	148	190,465	1,253	151	188,583	1,261	144	190,770	1,324
Fresno	625	1,011,273	1,631	625	1,017,431	1,618	646	1,037,053	1,605
Glenn	7	28,750	4,107	7	28,736	4,107	7	29,369	4,195
Humboldt	66	135,168	2,145	66	133,100	2,048	64	133,817	2,090
Imperial	40	179,329	4,598	40	182,881	4,483	35	186,499	5,328
Inyo	7	18,978	3,795	6	18,856	3,163	7	18,800	2,685
Kern	350	909,813	2,668	343	910,300	2,652	357	923,961	2,588
Kings	58	152,023	2,492	59	152,627	2,576	58	154,015	2,655
Lake	37	67,407	1,728	36	67,001	1,872	24	67,254	2,802
Lassen	18	30,274	1,376	21	28,197	1,441	20	28,716	1,435
Los Angeles	8,464	9,861,224	1,171	8,448	9,824,091	1,167	8,446	9,876,811	1,169
Madera	47	157,396	3,577	46	159,328	3,421	53	162,599	3,067
Marin	279	257,135	886	279	252,844	921	257	254,550	990
Mariposa	6	17,045	2,435	7	16,966	2,435	7	16,917	2,416
Mendocino	45	89,999	1,836	47	89,476	1,914	45	89,827	1,996

County	DDS per County in 2023/24	Pop. in 2023/24	Pop. per DDS in 2023/24	DDS per County in 2024/25	Pop. in 2024/25	Pop. per DDS in 2024/25	DDS per County in 2025/26	Pop. In 2025/26	Pop. per DDS in 2025/26
Merced	98	284,338	3,090	98	287,303	2,901	90	293,080	3,256
Modoc	5	8,690	1,738	4	8,484	2,172	5	8,491	1,698
Mono	5	13,379	2,675	5	12,861	2,675	3	12,684	4,228
Monterey	244	433,716	1,777	242	437,614	1,792	247	438,831	1,776
Napa	106	136,179	1,284	105	135,029	1,296	103	136,124	1,321
Nevada	69	101,242	1,467	70	100,177	1,446	64	100,354	1,568
Orange	4,183	3,162,245	755	4,165	3,150,835	759	4,230	3,175,427	750
Placer	482	409,025	848	471	412,844	868	496	421,446	849
Plumas	13	18,942	1,457	13	18,841	1,457	10	18,885	1,888
Riverside	1,163	2,435,525	2,094	1,163	2,442,378	2,094	1,205	2,495,640	2,071
Sacramento	1,207	1,576,618	1,306	1,210	1,578,938	1,302	1,237	1,604,745	1,297
San Benito	26	65,479	2,518	25	65,853	2,619	26	66,822	2,570
San Bernardino	1,403	2,187,665	1,559	1,410	2,181,433	1,551	1,443	2,207,424	1,529
San Diego	2,853	3,287,306	1,152	2,852	3,291,101	1,152	2,880	3,330,139	1,156
San Francisco	1,127	842,754	747	1,138	843,071	740	1,125	842,027	748
San Joaquin	393	784,298	1,995	388	791,408	2,021	399	805,856	2,019
San Luis Obispo	217	280,721	1,293	210	278,469	1,336	212	279,337	1,317
San Mateo	829	744,662	898	830	741,565	897	834	748,337	897
Santa Barbara	312	445,164	1,426	311	443,623	1,431	310	447,132	1,442
Santa Clara	2,283	1,894,783	829	2,296	1,903,198	825	2,296	1,922,259	837
Santa Cruz	171	255,564	1,494	170	262,572	1,503	170	263,710	1,551
Shasta	109	180,531	1,656	106	179,195	1,703	97	180,201	1,857
Sierra	0	3,229	0	0	3,171	0	0	3,170	0
Siskiyou	23	43,830	1,905	22	43,409	1,992	21	43,311	2,062
Solano	277	447,241	1,614	274	446,426	1,632	274	449,839	1,641
Sonoma	374	482,404	1,289	380	478,152	1,269	379	482,848	1,274
Stanislaus	277	549,466	1,983	281	548,744	1,955	273	555,765	2,035
Sutter	49	99,145	2,023	49	100,110	2,023	55	100,257	1,822
Tehama	28	65,052	2,323	28	64,308	2,323	27	64,827	2,401

Trinity	2	16,023	8,011	2	15,915	8,011	1	15,884	7,941
Tulare	218	475,014	2,178	219	478,918	2,169	228	487,209	2,136
Tuolumne	45	55,291	1,228	45	54,407	1,228	38	54,357	1,430
Ventura	634	833,652	1,314	633	823,863	1,316	635	829,005	1,305
Yolo	125	221,165	1,769	125	221,666	1,769	115	225,433	1,960
Yuba	10	82,275	8,227	10	83,721	8,227	10	85,023	8,502
Out of State/Country**	2,284	N/A	N/A	3,072	N/A	N/A	2,362	N/A	N/A
Total	34,582	39,174,605	N/A	37,846	39,128,162	N/A	32,446	39,529,101	N/A

*Population data obtained from Department of Finance, Demographic Research Unit as of 7/01/2025.
**Prior numbers updated and placed in correct columns.

*The counties with the highest Population per DDS are:	Yuba County (1:8,502)	*The counties with the lowest Population per DDS are:	San Francisco County (1:748)
	Trinity County (1:7,941)		Orange County (1:750)
	Colusa County (1:7,342)		Santa Clara (1:837)
	Imperial County (1:5,328)		Placer (1:849)
	Glenn County (1:4,195)		San Mateo (1:897)

* Alpine County (0:1,177) & Sierra County (0:3,170)
No reported address of record in county

Action Requested

No action is requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	April 9, 2026
TO	Members of the Dental Board of California
FROM	Jessica Olney, Anesthesia and Customer Service and Support Units Manager Dental Board of California
SUBJECT	**Agenda Item 11.a.:** General Anesthesia and Sedation Permits: Inspections and Evaluations Statistics

Background

General Anesthesia (GA), Medical General Anesthesia (MGA), and Moderate Sedation (MS) permitholders are subject to an onsite inspection and evaluation prior to the issuance or renewal of a permit at the discretion of the Dental Board of California (Board). The Board must conduct an inspection and evaluation for GA and MGA permitholders at least once every five years, and for MS permitholders at least once every six years to keep a permit active and in good standing. This memo provides a statistical overview of onsite inspections and evaluations administered by the Board for GA, MGA, and MS permits.

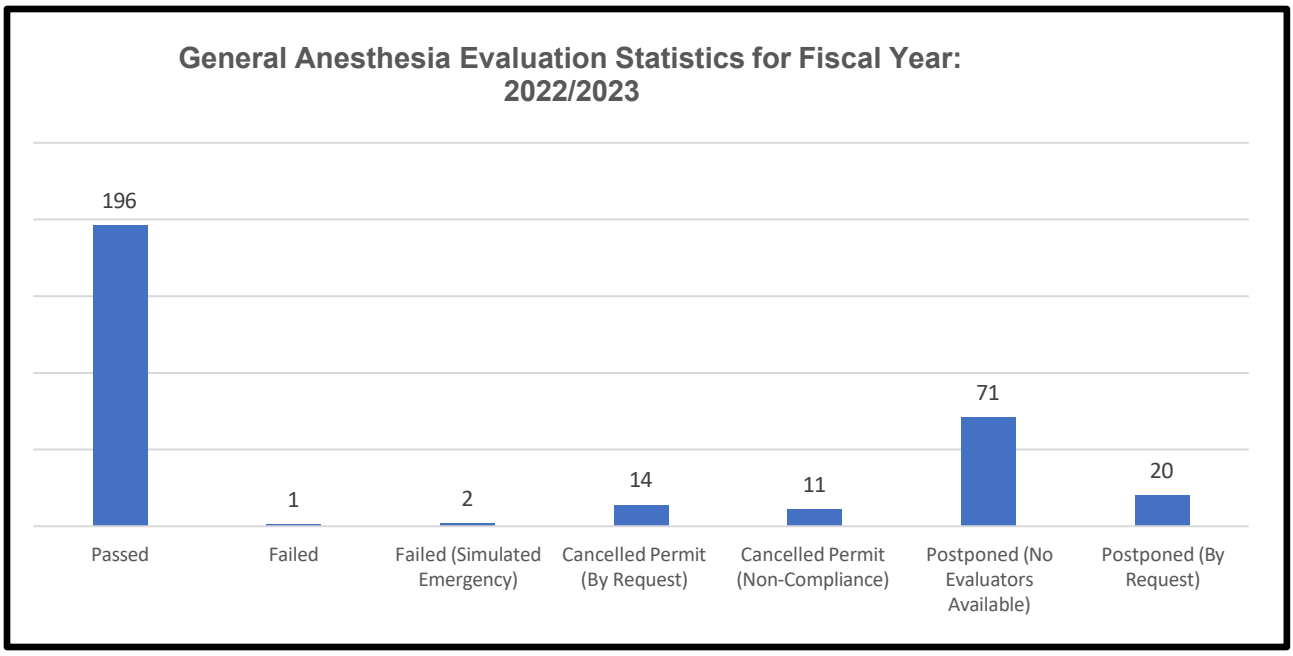
General Anesthesia Evaluation Statistics for Fiscal Year 2025–26

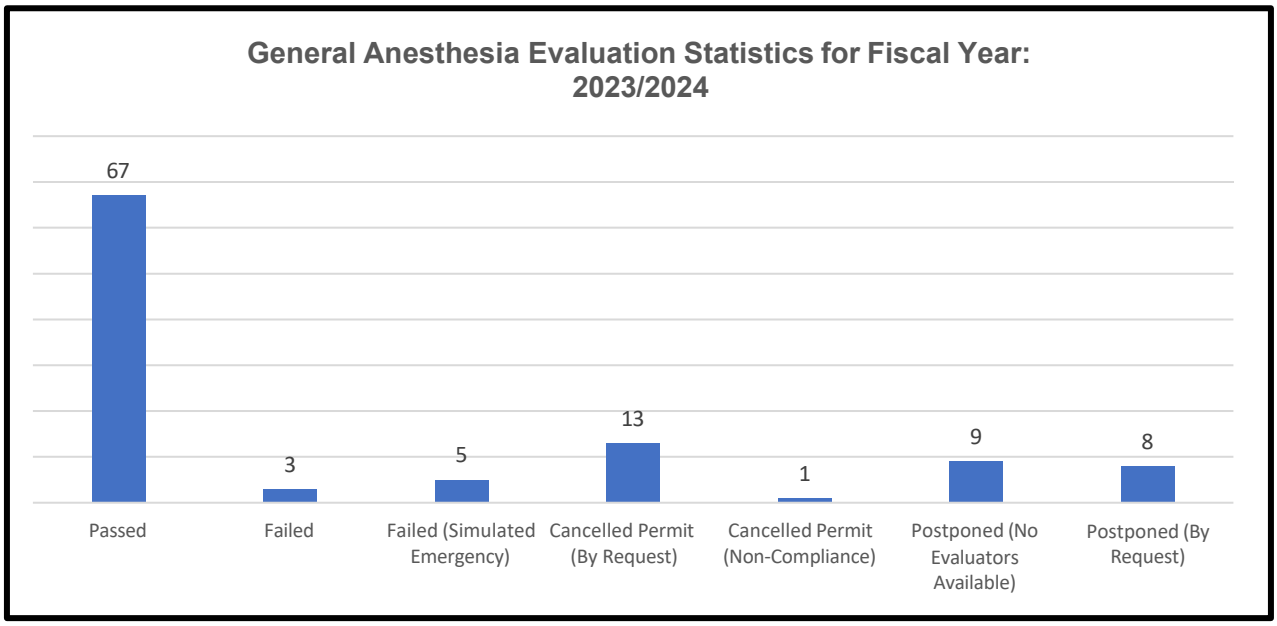
	Passed Evaluation	Failed Evaluation	Failed Simulated Emergency	Cancelled Permit by Request	Cancelled Permit for Non-compliance	Postponed (No Evaluators Available)	Postponed (By Request)
Jul 2025	11	0	0	3	2	0	5
Aug 2025	19	0	0	0	2	0	3
Sep 2025	19	0	0	1	2	0	2
Oct 2025	20	0	0	3	2	0	0
Nov 2025	15	0	0	0	1	0	7
Dec 2025	14	0	0	1	4	1	1
Jan 2026	21	0	0	2	2	3	2
Feb 2026	17	0	0	2	3	1	1
Mar 2026	14	0	0	0	4	0	1

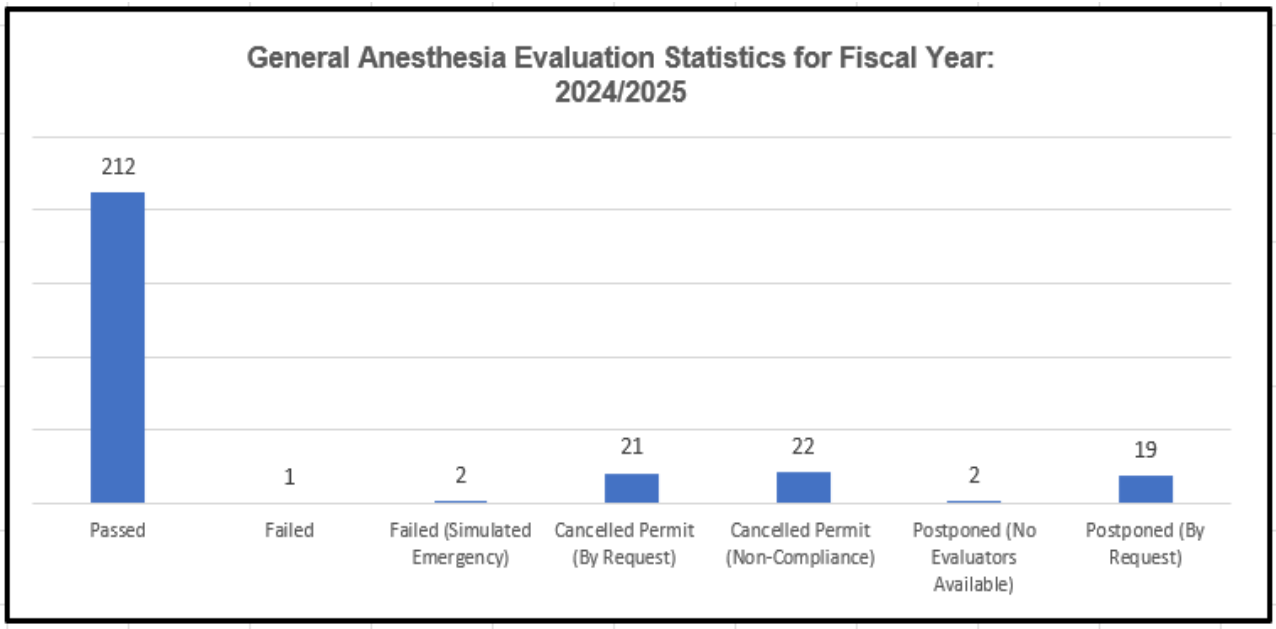
Apr 2026							
May 2026							
Jun 2026							
Total	**150**	**0**	**0**	**12**	**22**	**5**	**22**

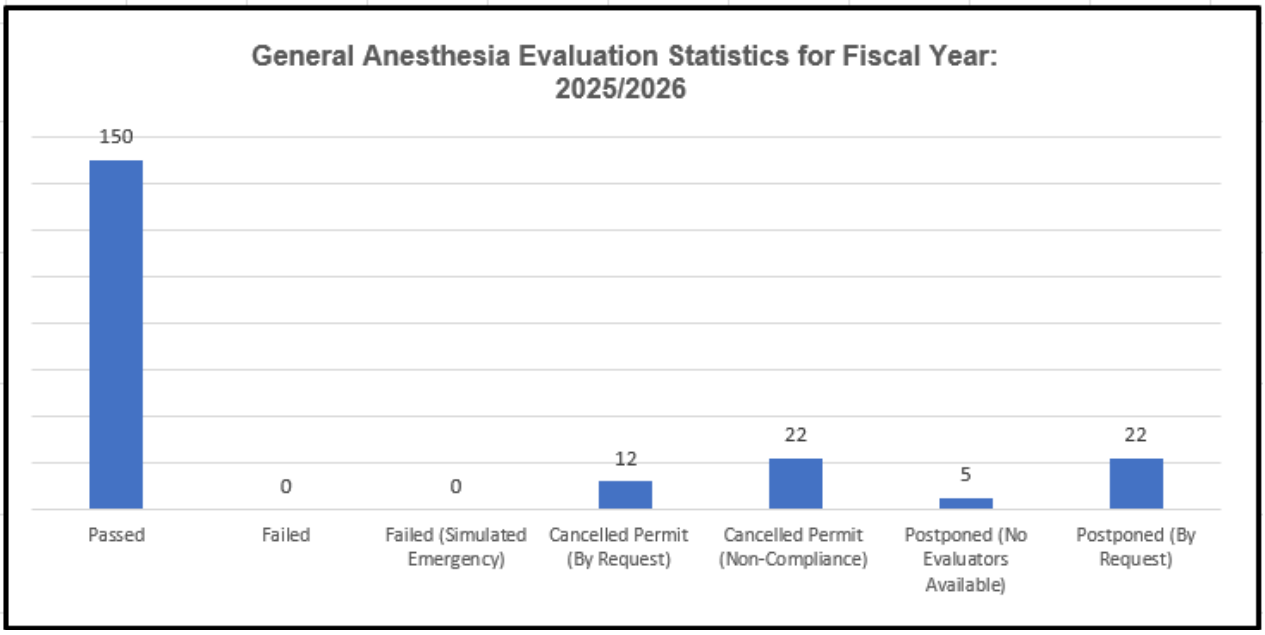
General Anesthesia Evaluation Statistics for Fiscal Years, 2022–23, 2023–24, 2024–25, and 2025/26.

	22–23	**23–24**	**24–25**	**25-26**
Passed Evaluation – Permitholder met all required components of the onsite evaluation.	196	202	212	150
Failed Evaluation – Permitholder failed due to multiple deficient components that were required for the onsite evaluation.	1	0	1	0
Failed Simulated Emergency – Permitholder failed one or more simulated emergency scenarios required for the onsite evaluation.	2	3	2	0
Cancelled Permit by Request – Permitholder no longer wanted permit.	14	13	21	12
Cancelled Permit for Noncompliance – Permitholder did not complete required onsite evaluation.	11	20	22	22
Postponed (No Evaluators Available) – Permitholder evaluation was postponed due to no available evaluators.	71	16	2	5
Postponed (By Request) – Permitholder requested postponement due to scheduling conflict, emergencies, or COVID-related issues.	20	18	19	22


General Anesthesia Evaluation Statistics for Fiscal Year: 2022/2023
196
1
2
14
11
71
20
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


General Anesthesia Evaluation Statistics for Fiscal Year: 2023/2024
67
3
5
13
1
9
8
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


General Anesthesia Evaluation Statistics for Fiscal Year: 2024/2025
212
1
2
21
22
2
19
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

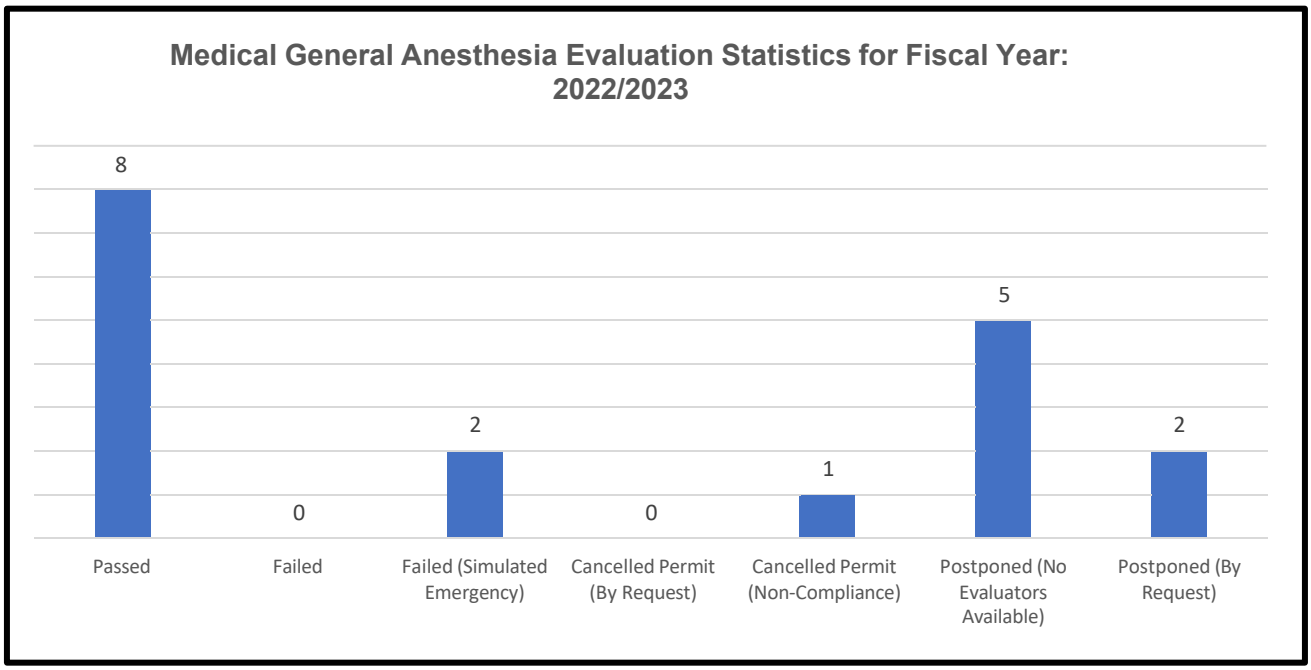

General Anesthesia Evaluation Statistics for Fiscal Year: 2025/2026
150
0
0
12
22
5
22
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

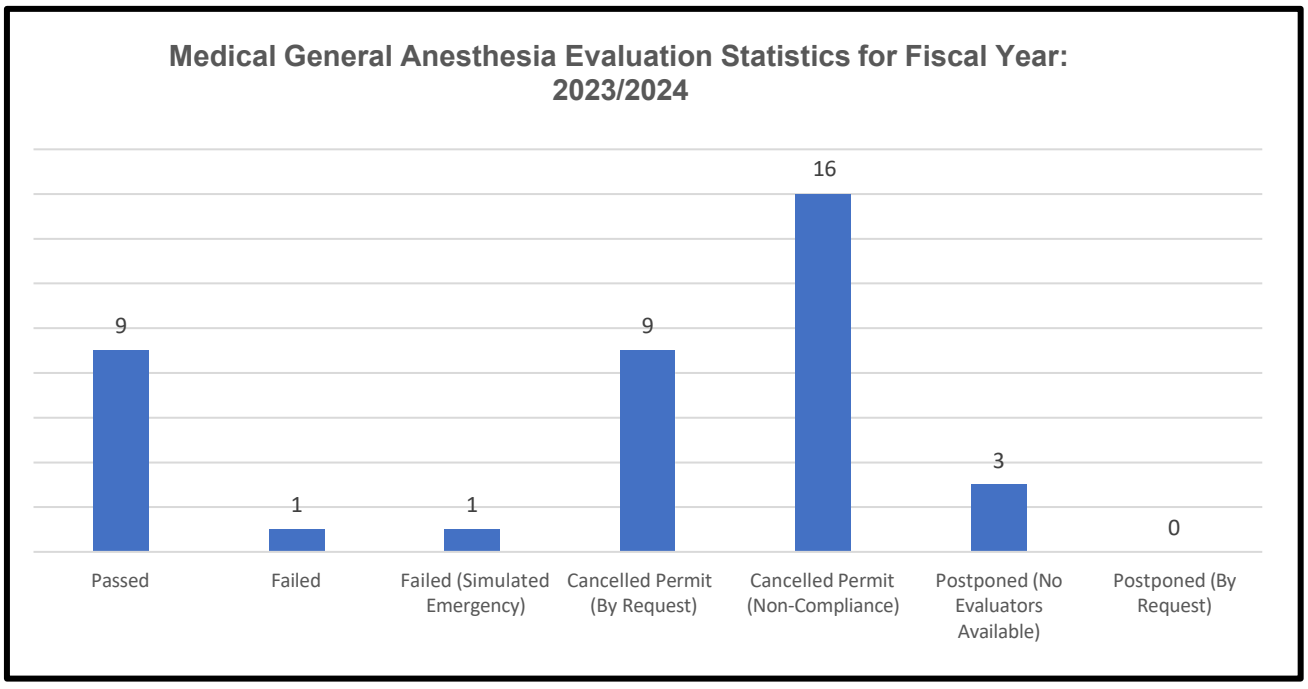
Medical General Anesthesia Evaluation Statistics for Fiscal Year 2025–26

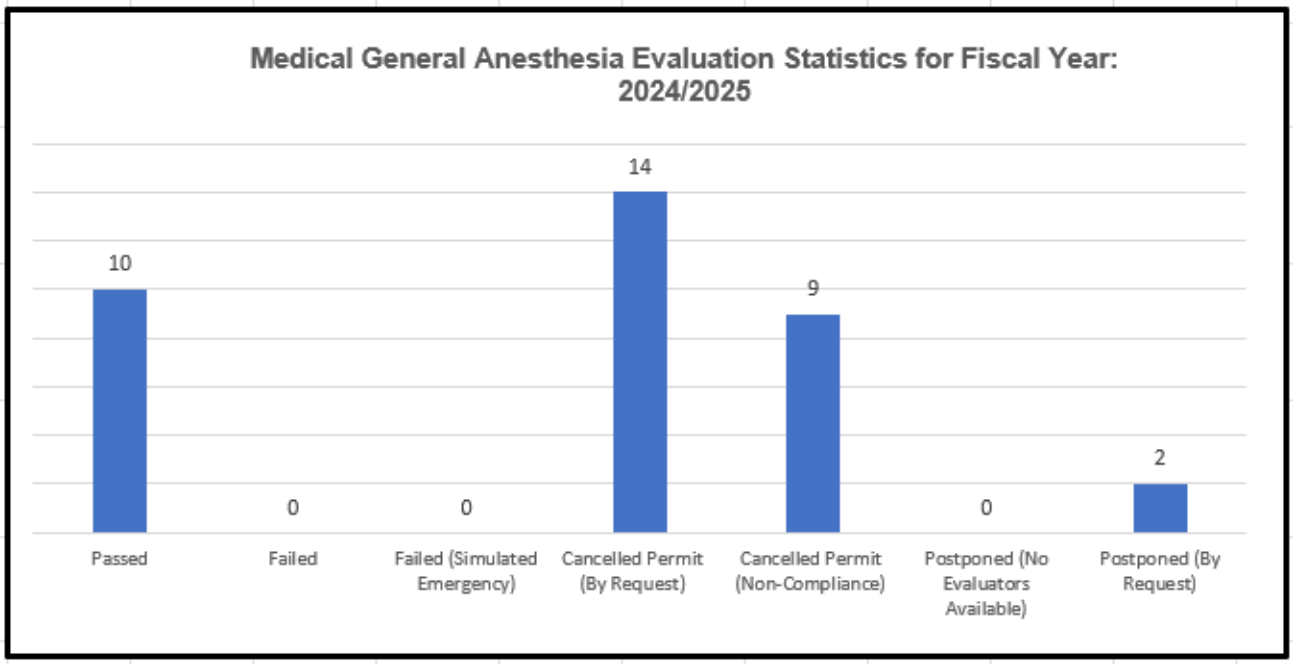
	Passed Evaluation	Failed Evaluation	Failed Simulated Emergency	Cancelled Permit by Request	Cancelled Permit for Non-Compliance	Postponed (No Evaluators Available)	Postponed (By Request)
Jul 2025	1	0	0	0	1	1	0
Aug 2025	2	0	0	0	0	0	0
Sep 2025	2	0	0	0	1	0	0
Oct 2025	1	0	0	0	1	0	1
Nov 2025	3	0	0	1	0	0	0
Dec 2025	2	0	0	1	0	0	0
Jan 2026	2	0	0	1	0	0	0
Feb 2026	2	0	0	0	1	1	0
Mar 2026	1	0	0	1	1	0	0
Apr 2026							
May 2026							
Jun 2026							
Total	**16**	**0**	**0**	**4**	**5**	**2**	**1**

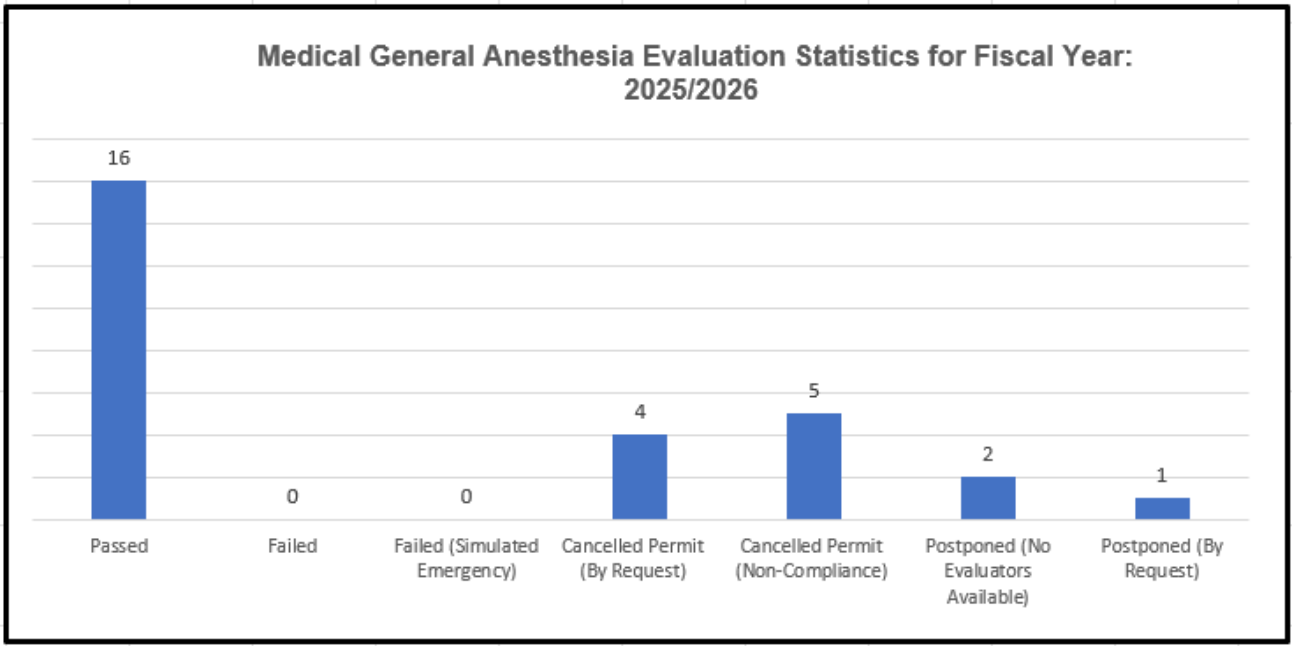
Medical General Anesthesia Evaluation Statistics for Fiscal Years 2022–23, 2023–24, 2024–25, and 2025-26

	22–23	23–24	24–25	25-26
Passed Evaluation – Permitholder met all required components of the onsite evaluation.	5	9	10	16
Failed Evaluation – Permitholder failed due to multiple deficient components that were required for the onsite evaluation.	1	1	0	0
Failed Simulated Emergency – Permitholder failed one or more simulated emergency scenarios required for the onsite evaluation.	0	1	0	0
Cancelled Permit by Request – Permitholder no longer wanted permit.	11	9	14	4
Cancelled Permit for Non-Compliance – Permitholder did not complete required onsite evaluation.	9	16	9	5
Postponed (No Evaluators Available) – Permitholder evaluation was postponed due to no available evaluators.	3	3	0	2
Postponed (By Request) – Permitholder requested postponement due to scheduling conflict, emergencies, or COVID-related issues.	1	0	2	1


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2022/2023
8
0
2
0
1
5
2
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2023/2024
9
1
1
9
16
3
0
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2024/2025
10
0
0
14
9
0
2
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

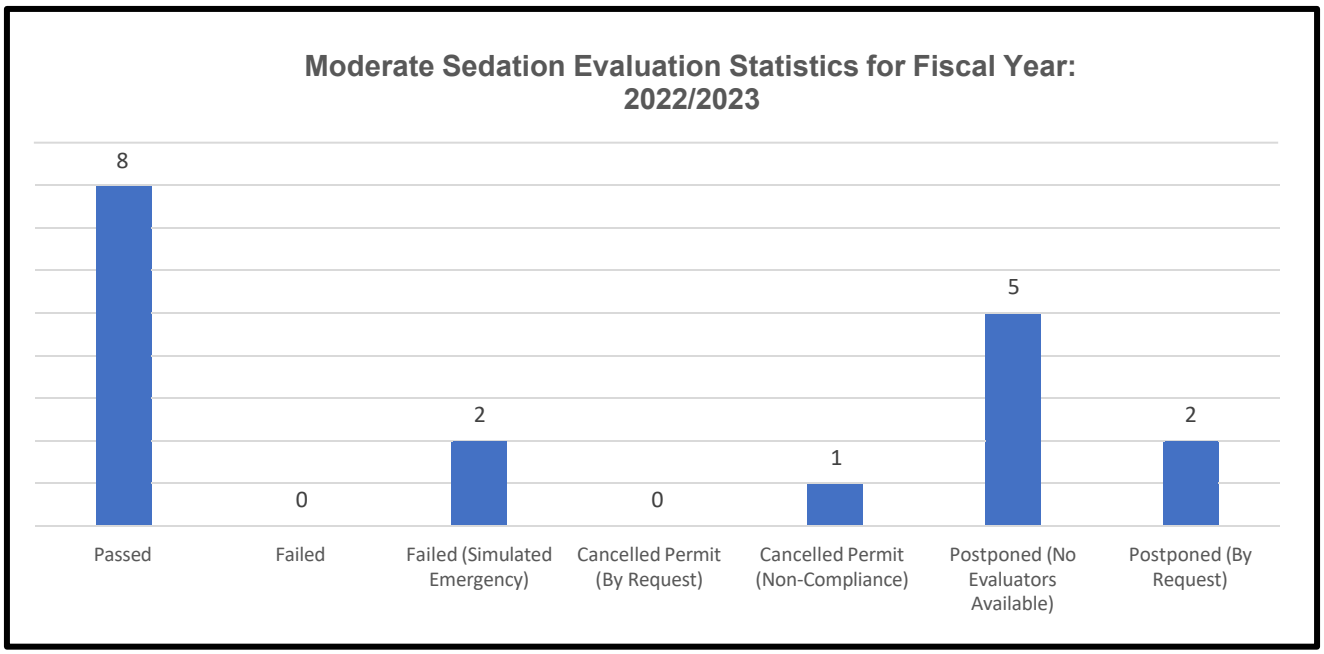

Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2025/2026
16
0
0
4
5
2
1
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

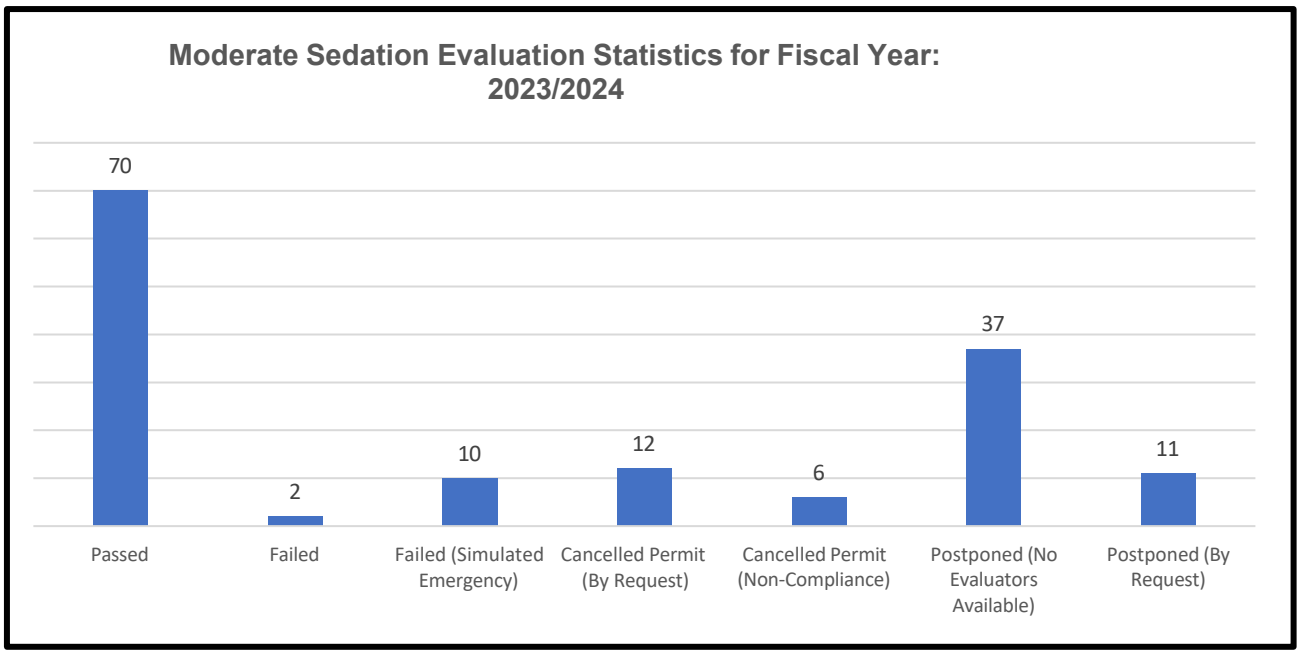
Moderate Sedation Evaluation Statistics for Fiscal Year 2025–26

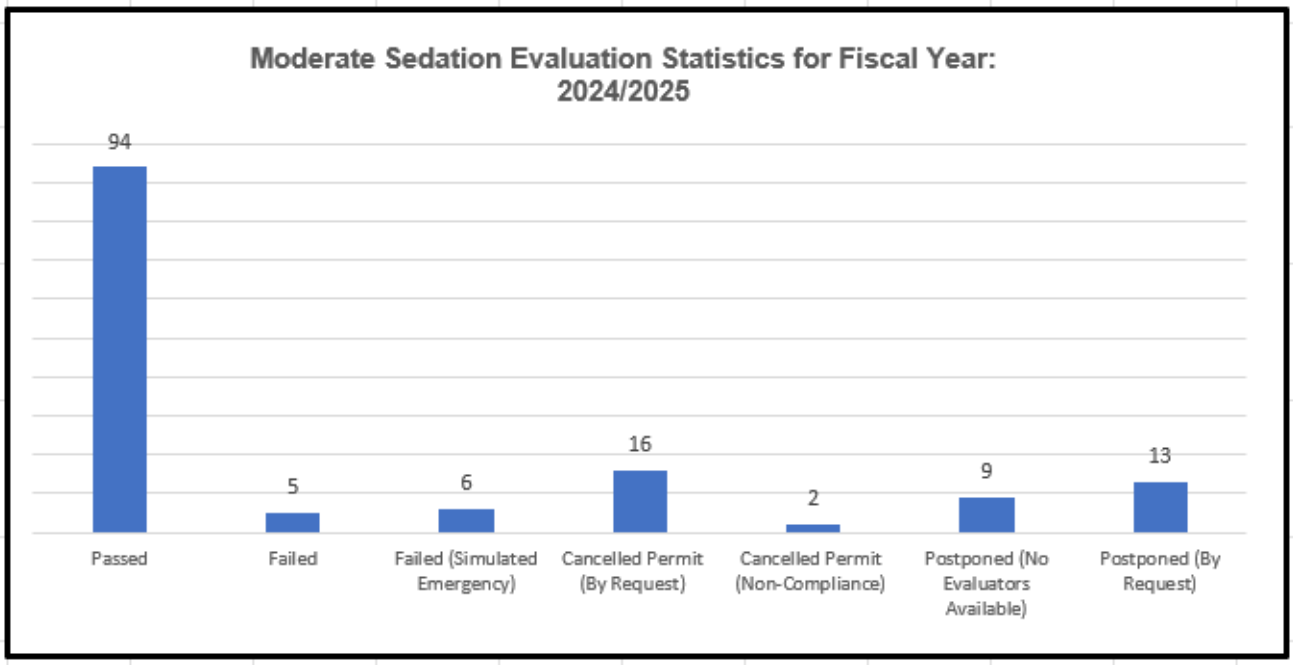
	Passed Evaluation	Failed Evaluation	Failed Simulated Emergency	Cancelled Permit by Request	Cancelled Permit for Non-compliance	Postponed (No Evaluators Available)	Postponed (By Request)
Jul 2025	10	0	0	3	0	0	0
Aug 2025	7	0	0	1	0	0	1
Sep 2025	6	1	2	2	1	0	1
Oct 2025	8	0	0	1	0	2	1
Nov 2025	12	1	1	0	0	0	1
Dec 2025	8	1	0	2	0	1	1
Jan 2026	8	0	0	0	1	0	3
Feb 2026	9	1	0	0	2	0	3
Mar 2026	10	0	0	2	2	0	2
Apr 2026							
May 2026							
Jun 2026							
Total	**78**	**4**	**3**	**11**	**6**	**3**	**13**

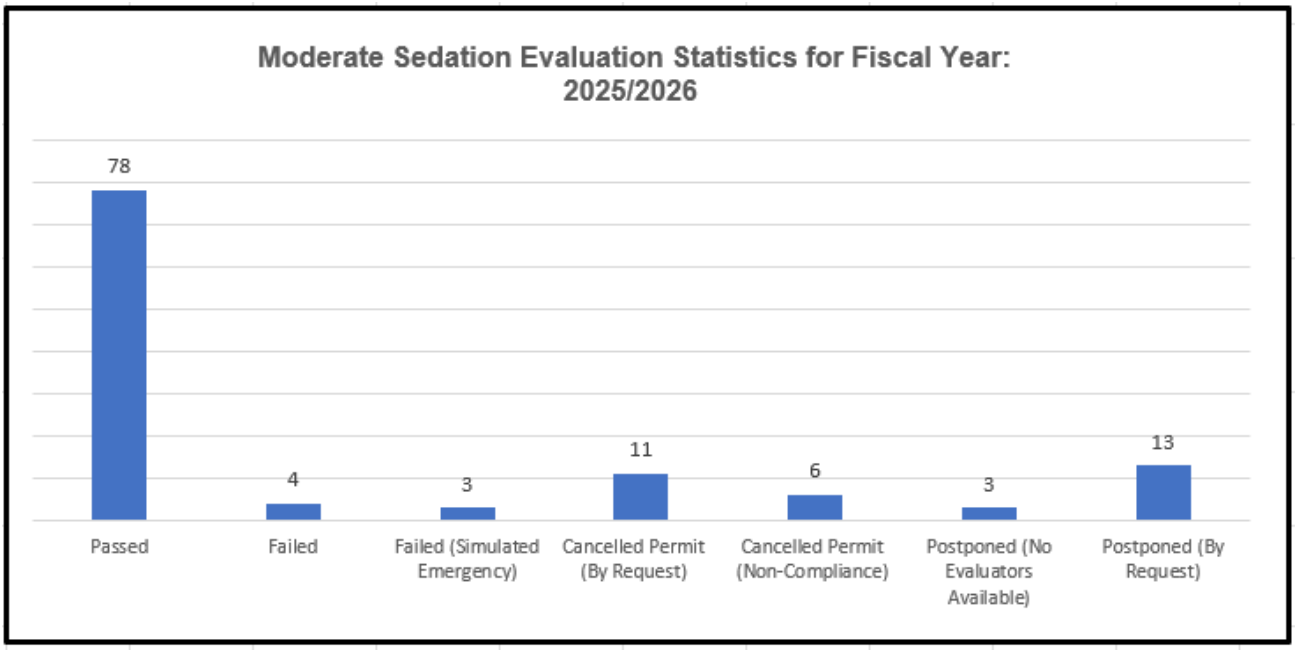
Moderate Sedation Evaluation Statistics for Fiscal Year 2022–23, 2023–24, 2024–25, and 2025/26.

	22–23	23–24	24–25	25-26
Passed Evaluation – Permitholder met all required components of the onsite evaluation.	8	70	94	78
Failed Evaluation – Permitholder failed due to multiple deficient components that were required for the onsite evaluation.	0	2	5	4
Failed Simulated Emergency – Permitholder failed one or more simulated emergency scenarios required for the onsite evaluation.	2	10	6	3
Cancelled Permit by Request – Permitholder no longer wanted permit.	0	12	16	11
Cancelled Permit for Non-Compliance – Permitholder did not complete required onsite evaluation.	1	6	2	6
Postponed (No Evaluators Available) – Permitholder evaluation was postponed due to no available evaluators.	5	37	9	3
Postponed (By Request) – Permitholder requested postponement due to scheduling conflict, emergencies, or COVID-related issues.	2	11	13	13


Moderate Sedation Evaluation Statistics for Fiscal Year: 2022/2023
8
0
2
0
1
5
2
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Moderate Sedation Evaluation Statistics for Fiscal Year: 2023/2024
70
2
10
12
6
37
11
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Moderate Sedation Evaluation Statistics for Fiscal Year: 2024/2025
94
5
6
16
2
9
13
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Moderate Sedation Evaluation Statistics for Fiscal Year: 2025/2026
78
4
3
11
6
3
13
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

Current Evaluators per Region

Region	GA	MGA	MS
Northern California	144	24	59
Southern California	172	17	62

Action Requested

No action is requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	April 14, 2026
TO	Members of the Dental Board of California
FROM	Paige Ragali, Chief of Administration and Compliance Dental Board of California
SUBJECT	**Agenda Item 12.a.:** Enforcement – Review of Statistics and Trends

The Dental Board's Enforcement Division is made up of four different units with a main office in Sacramento (Northern office) and a field office located in Orange (Southern office), which all work together to help fulfill the Board's mission and vision of consumer protection. The Complaint and Compliance Unit is the first step in the complaint process, and they handle the intake of all complaints received. The Investigation and Inspection Units, comprised of both sworn investigators, special investigators and inspectors review the complaints that warrant further investigation or inspection and complete an investigation to determine if violations of the Dental Practice Act occurred and if further action is warranted, such as discipline. The Discipline Coordination Unit works with the Office of the Attorney General and refers cases, assists with settlements, and coordinates discipline against licensees. The final step in the Enforcement Division is compliance. This includes probation monitoring, compliance monitoring (Public Reprovals), and citation monitoring. Desk analysts handle the majority of the cases for monitoring and help ensure the licensees successfully comply with their requirements.

Currently, the Enforcement Division is recruiting for one Supervising Sworn Investigator position and one Inspector II position in the Orange office.

The following are the Enforcement Division statistics for both Northern and Southern offices:

Number of Complaint Cases Received between January 1, 2026 to March 31, 2026

Between January 1, 2026, and March 31, 2026, CCU received **1,675** complaints.

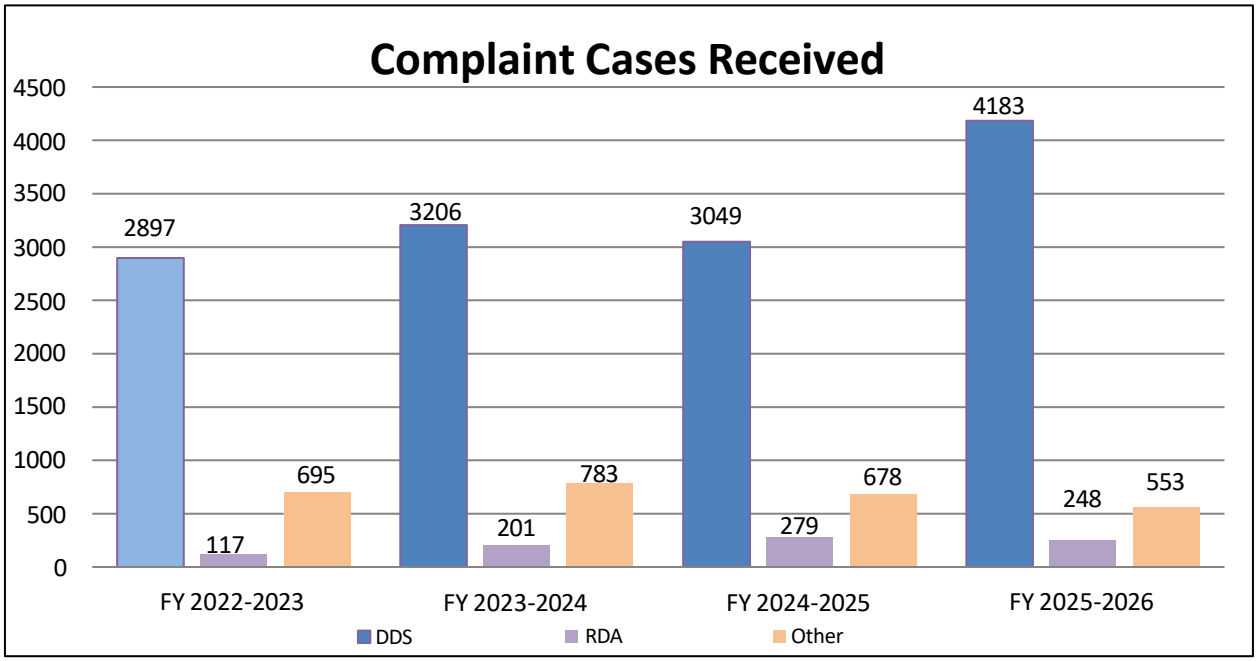
Between January 1, 2026, and March 31, 2026, there were **1,356** complaints closed without referral for investigation.

As of March 31, 2026, there are **428** open SAR cases.

Number of Complaint Cases Received

The graph below shows the number of complaint cases received by fiscal year for the current year fiscal year 2025-2026 and the past three fiscal years.

Complaints Received				
Fiscal Year & Quarter	**Dentists**	**RDA**	**Other**	**Total**
FY 2022-2023	2,897	117	695	3,709
FY 2023-2024	3,206	201	783	4,190
FY 2024-2025	3,049	279	678	4,006
FY 2025-2026 (July-March)	4,183	248	553	4,984
Total	**13,335**	**845**	**2,709**	**16,889**



Number of Investigative Cases Open

As of March 31, 2026, there **1,110** investigative cases open in the Board's Enforcement Units. A breakdown of the cases is as follows:

Investigative Cases Open	
Enforcement Units	**March 31, 2026**
Sacramento Non-Sworn	118
Orange Non-Sworn	136
Sacramento Sworn	78
Orange Sworn	164
Pending Assignment	614
Total	**1,110**

Case Aging for Enforcement Cases

The chart below shows the case aging for all enforcement cases from inception through closure or referral to the Office of the Attorney General between January 1, 2026, and March 31, 2026. A breakdown of the case aging is as follows:

Investigative Case Aging		
Investigation Age	**As of March 31, 2026**	**Percent (%)**
0 – 3 Months	18	10%
3 – 6 Months	29	17%
6 – 9 Months	17	10%
9 – 12 Months	17	10%
1 – 2 Years	33	19%
2 – 3 Years	58	34%
3+ Years	0	0%
Total	**172**	**100%**

***Case aging includes the time the case was received through investigation and until a closure or referral for discipline code was entered.**

Administrative and Disciplinary Action

Cases Assigned to the Office of the Attorney General

Between January 1, 2026, and March 31, 2026, there were **56** cases transmitted to the AG. Of those 56 cases, 40 were referred for dentists and 16 were referred for dental auxiliaries.

As of March 31, 2026, there are **212** cases pending at the AG.

Accusations/Petitions to Revoke/Statement of Issues/Amended Pleadings

Between January 1, 2026, and March 31, 2026, there were **43** pleadings filed with the AG.

Discipline Imposed and Cases Closed

Between January 1, 2026, and March 31, 2026, there were **24** cases closed in the Discipline Coordination Unit. The breakdown of the closures is as follows:

Discipline Coordination Unit Closed Cases			
Closure Type	**January**	**February**	**March**
Revocation	3	5	2
Surrender	2	2	7
Probation	3	12	1
Public Reproval	0	1	0
Other (withdrawal, etc.)	0	2	2
Total	**8**	**22**	**12**

**The consolidated cases closed are not represented in the chart above.*

Citations

Between January 1, 2026, and March 31, 2026, there were **76** citations issued. Citations are issued for investigative cases not rising to the level constituting formal disciplinary action, such as unprofessional conduct, failure to report convictions, compliance issues with inspections, and failure or non-compliance with continuing education audits.

Probation and Compliance Monitoring

Number of Probation Cases Open

As of March 31, 2026, there are **119** probationer cases being monitored. Of those, **114** active probationers and **5** are tolling. A breakdown of the probation cases is as follows:

Field Office	Active Probationers	Tolling Probationers
Sacramento IAU	40	0
Sacramento Field Office	0	4
Orange IAU	73	1
Orange Field Office	1	0
Total	**114**	**5**

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MEMORANDUM

DATE	April 6, 2026
TO	Members of the Dental Board of California
FROM	Paige Ragali, Chief of Administration and Compliance Division Dental Board of California
SUBJECT	**Agenda Item 13.a.:** Diversion Program Report and Statistics

Background

The Diversion Evaluation Committee (DEC) program statistics for the quarter ending on March 31, 2026, are provided below. These statistics reflect the participant activity in the Diversion (Recovery) Program and are presented for informational purposes only.

The next quarterly meeting is anticipated to be scheduled for July 2026.

As of January 1, 2025, Premier Health Group has assumed the administration of the Diversion (Recovery) Program.

Diversion	FY 2025/2026				FY 24/25	FY 23/24	FY 22/23
	Quarter 3			YTD			
	January	February	March	Totals			
New Participants (Close of Qtr)	0	0	0	0	4	2	3
Total Participants (Close of Qtr/FY)	5	5	5	5	5	4	7
Total Completed Cases	0	0	0	0	0	2	5
Positive Drug Tests for Current Participants	0	0	0	0			

Action Requested

None.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 30, 2026
TO	Members of the Dental Board of California
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 14.a.:** Status Update on Pending Regulations

Background

This memo addresses rulemaking packages that have moved forward in the rulemaking process since the last Dental of California Board (Board) meeting. Rulemaking packages that require Board action will be presented as separate agenda items or will be presented at a future Board meeting.

Rulemaking to Amend California Code of Regulations (CCR), Title 16, Section 1005 Regarding Minimum Standards for Infection Control

Summary of Proposed Changes:
A summary of the proposed changes can be found within the May 14-15, 2025 Board meeting materials.

Update:
The proposed text was approved by the Board at its May 14-15, 2025, meeting. Board staff submitted the proposed text to the Dental Hygiene Board of California (DHBC) for review and consideration.

At its meeting on July 19, 2025, the DHBC approved the Board's approved text, and thereby reaching consensus. Board staff have taken the necessary steps to begin the rulemaking process, which includes drafting the necessary regulatory documents (i.e., Notice and Initial Statement of Reasons, etc.) and are working with the Board's Regulations Counsel and Department of Consumer Affairs Budget Office to finalize the documents for departmental review.

Action Requested

This item is informational only. No action is requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 14.b.:** Discussion and Possible Action to Reconsider Previously Approved Text, and to Consider Initiation of a Rulemaking to Amend CCR, Title 16, Sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and Repeal Sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01 Regarding Applications for Dentist Licensure and Fees

Background

This rulemaking was approved by the Board at its February 6-7, 2025, Board meeting. Board staff presented a rulemaking proposal to update the Board's application regulations for licensure by examination and other applications for dentist licensure to reflect changes in law and regulations as well as changes to the Licensing Unit's processes and procedures. A summary of the previously proposed changes can be found within the February 6-7, 2025 Board meeting materials.

Board staff drafted an initial rulemaking package, which includes the proposed text, Notice and Initial Statement of Reasons (ISOR) explaining the regulation's purpose and impact. After internal review by the Department of Consumer Affairs' Regulations Unit, Regulations Counsel, Board Counsel and staff identified further revisions to the proposed text. The changes to the proposed text, approved by the Dental Board at its August 14, 2025 Board meeting, can be found within the August 14, 2025 Board meeting materials.

Business and Professions Code section 135.4 requires this Board, and other boards in this Department, to expedite the application and initial licensure process for an applicant who supplies satisfactory evidence to the Board that they are a refugee, asylee, or are a special immigrant visa holder, as specified. This regulations package contains proposed regulatory language necessary to implement that requirement. All regulations packages are required to be approved both by the Director and the Secretary for the Business, Consumer Services, and Housing Agency ("Agency") prior to filing with the Office of

Administrative Law. Although, the regulations package was approved by the Director on December 1, 2025, it was not approved by Agency due to concerns that the Board's proposed language did not more clearly specify that the disclosure of the applicant's status as a refugee, asylee or special immigrant visa holder was optional and only required if they were seeking an expedite of their application.

Discussion and Recommendations

To address Agency's concerns, the proposed regulatory language at 16 CCR section 1028(b), paragraphs (9) and (10) would be revised, in part, as follows (with new changes shown in underline and strikethrough):

(9) Whether ~~any of the following statements apply to~~ the applicant is seeking expedited processing of their application based on immigration status pursuant to Section 135.4 of the Code. If the answer is "yes", in order to receive expedited review of an application, the applicant shall indicate whether any of the following statements apply to the applicant:
(A) You were admitted to the United States as a refugee pursuant to Section 1157 of Title 8 of the United States Code, or
(B) You were granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to Section 1158 of Title 8 of the United States Code, or,
(C) You have a Special Immigrant Visa and were granted a status pursuant to Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8 [relating to Iraqi and Afghan translators/interpreters or those who worked for or on behalf of the United States government].
(10) Additionally, ~~I~~if the applicant answers "yes" to the question in paragraph (9), the applicant shall provide evidence supporting their status, which shall include any of the following:
(A) Form I-94, arrival/departure record, with an admission class code such as "RE" (refugee) or "AY" (asylee) or other information designating the person a refugee or asylee,
(B) Special Immigrant Visa that includes the "SI" or "SQ",
(C) Permanent Resident Card (Form I-551), commonly known as a "green card," with a category designation indicating that the person was admitted as a refugee or asylee, or,
(D) An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Board that the applicant qualifies for expedited licensure per Section 135.4 of the Code;

Since these changes may be considered substantive, staff and Regulations Counsel request that the Dental Board reauthorize the rulemaking to make these changes to the current proposal.

Action Requested

Board staff requests that the members review the proposed regulatory text and attachments included with this memo and consider whether they would support the regulatory changes as written or if there are suggested changes to the proposed text. After review, the staff requests that the Board consider one of the following motions:

Option 1 (The Board has no suggested changes for the proposed regulatory text.)

Move to rescind the Board's prior August 14, 2025, motion approving prior text for this item, and instead approve the proposed regulatory text in **Attachment 1** including the repeal of the forms incorporated by reference in **Attachments 2 through 6**. I further direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, for amendments to sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and for the repeal of sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01.

Option 2 (The Board has suggested changes for the proposed regulatory text.)

Move to rescind the Board's prior August 14, 2025, motion approving prior text for this item, and instead approve the proposed regulatory text in **Attachment 1** including the repeal of the forms incorporated by reference in **Attachments 2 through 6**. with the following changes. (Describe the proposed changes to the proposed text). I further direct staff to submit the text as amended to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, for amendments to sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and for the repeal of sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01.

Attachments:

1. Proposed Regulatory Language -- Applications for Dentist Licensure and Fees
2. Repealer “Application for Licensure to Practice Dentistry” (WREB) Form 33A-22W (Revised 11/06)
3. Repealer “Application for Determination of Licensure Eligibility (Portfolio)” Form 33A-22P (New 11/2014)
4. Repealer “Application for Issuance of License Number and Registration of Place of Practice,” (Rev. 02-07)
5. Repealer “Application for Law and Ethics Examination” (Rev. 12/07)
6. Repealer of “Certification of Successful Completion of Remedial Education for Portfolio Competency Re-Examination requirements for re-examination Eligibility” (Form New 08/13)
7. Tables entitled “Dental Board of California Licensure By Examination (CCR 1021(a)) Licensing Workload” (Table 1: Costs - Paper Based and Table 2: Costs - Online)
8. Tables entitled “Dental Board of California Licensure By Examination (CCR 1021(a)(c)) Law & Ethics Examination App Workload” (Table 1: Costs - Paper Base and Table 2: Costs - Online)

TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS
DIVISION 10. DENTAL BOARD OF CALIFORNIA

PROPOSED TEXT

Applications for Dentist Licensure and Fees

Proposed amendments to the regulatory language are shown in single underline for new text and single ~~strikethrough~~ for deleted text.

Amend Sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and Repeal Sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01 of Division 10 of Title 16 of the California Code of Regulations to read as follows:

§ 1021. Examination, Permit and License Fees for Dentists.

The following nonrefundable fees are set for dentist examination and licensure by the Board, and for other licensee, registrant, or applicant types specified below [FN**]:

(a) Initial application for those applicants qualifying pursuant to Section 1632(c)(1) and (c)(2) of the Business and Professions Code (the Code) $~~400~~490

(b) Initial application for those applicants qualifying pursuant to Section 1634.1 of the Code $800

(c) ~~Initial application for those applicants qualifying pursuant to Section 1632(c)(1) of the Code $400~~

(~~d~~c) Initial application fee for those applicants applying pursuant to Section 1635.5 of the Code $525

(~~e~~d) Initial License $650 [FN*]

(~~f~~e) Biennial License Renewal fee $650

(~~g~~f) Biennial License Renewal fee for those qualifying pursuant to Section 1716.1 of the Code shall be one half of the renewal fee prescribed by subsection (~~f~~e).

(~~h~~g) Delinquency fee--License Renewal--The delinquency fee for license renewal shall be the amount prescribed by Section 1724(f) of the Code.

(~~i~~h) Substitute Certificate or Pocket License $111

(~~j~~i) Application for an Additional Office Permit $350

(~~k~~j) Biennial Renewal of Additional Office Permit $250

(~~l~~k) Late Change of Practice Registration $50

(~~m~~l) Fictitious Name Permit
The fee prescribed by Section 1724.5 of the Code

(~~n~~m) Fictitious Name Permit Renewal $325

(~~o~~n) Delinquency fee--Fictitious Name Permit Renewal.
The delinquency fee for Fictitious Name Permits shall be one-half of the Fictitious Name Permit renewal fee

(~~p~~o) Continuing Education Registered Provider fee $410

(~~q~~p) Application for General Anesthesia or Moderate Sedation Permit $524

(~~r~~q) Application for Pediatric Minimal Sedation Permit $459

(~~s~~r) General Anesthesia (for dentist and physician licensees) or Moderate Sedation Permit Renewal fee $325

(~~t~~s) Pediatric Minimal Sedation Permit Renewal fee $182

(~~u~~t) General Anesthesia or Moderate Sedation On-site Inspection and Evaluation fee $2,000

(~~v~~u) Application for a Special Permit $1,000

(~~w~~v) Special Permit Renewal $125

(~~x~~w) Initial Application for an Elective Facial Cosmetic Surgery Permit $850

(~~y~~x) Elective Facial Cosmetic Surgery Permit Renewal $800

(~~z~~y) Application for an Oral and Maxillofacial Surgery Permit $500

(~~aa~~z) Oral and Maxillofacial Surgery Permit Renewal $650

(a~~b~~a) Continuing Education Registered Provider Renewal $325

(a~~c~~b) License Certification $50

(a~~d~~c) Application for Law and Ethics Examination $~~125~~180

(a~~e~~d) Application for ~~Use of Oral Conscious Sedation of~~ Adult Oral Conscious Sedation Certificate~~Patients~~ $~~4~~59

(a~~f~~e) Adult Oral Conscious Sedation Certificate Renewal $168

(a~~g~~f) Application for Pediatric Endorsement for General Anesthesia Permit (for dentist and physician licensees) $532

(a~~h~~g) Application for Pediatric Endorsement for Moderate Sedation Permit $532

[FN*]
Fee pro-rated based on applicant's birth date.
[FN**]
Examination, licensure, and permit fees for dentistry may not all be included in this section, and may appear in the Code.

NOTE: Authority cited: Sections 1614, 1635.5, 1634.2(c), 1724 and 1724.5, Business and Professions Code. Reference: Sections 1632, 1634.1, 1638, 1638.1, 1638.3, 1640, 1640.3, 1646.2, 1646.6, 1647.3, 1647.8, 1647.20, 1647.23, 1647.32, 1647.33, 1715, 1716.1, 1718.3, 1724 and 1724.5, Business and Professions Code.

§ 1028. Application for Licensure.

(a) An applicant for licensure as a dentist qualifying pursuant to Section 1632(c)(1) or (2) of the Code shall submit to the Board a completed application as specified in subsection (b) and meet the other applicable requirements of this section. ~~shall submit an "Application for Licensure to Practice Dentistry" (WREB) Form 33A-22W (Revised 11/06), which is hereby incorporated by reference, or "Application for Determination of Licensure Eligibility (Portfolio)" Form 33A-22P (New 11/2014), which are hereby incorporated by reference,~~

(1) For purposes of this section "submit to the Board" means to transmit an application and, if applicable, the initial application fee required by Section 1021 ("required fee") by mail with postage prepaid addressed to the Board at the Board office at the address listed on the Board's website, by hand delivery to the Board office at the address listed on the Board's website, or electronically through a web link to the Department of Consumer Affairs' online licensing system entitled "BreEZe" ("online services system") located on the Board's website in accordance with subparagraph (B) of paragraph (2).

(2) (A) For applications submitted by mail or hand delivery, the application and required fee, if applicable, shall be placed in a sealed envelope and addressed to the Board at the Board office at the address listed on the Board's website. The required fee shall be paid by cash, check, money order, or cashier's check payable to the Dental Board of California.

(B) For applications submitted electronically through the online services system, the applicant shall complete the application according to the following requirements:

1. The applicant shall first login to or register for a user account by typing in a username and password on the initial registration or public sign-in page to access the online services system.

2. After a user account has been created and the online services system accessed online, the applicant shall submit all of the information required by subsection (b) through the online services system.

3. Electronic signature. When a signature is required by the particular instructions of any filing to be made through the online services system, including any attestation under penalty of perjury, the applicant shall affix their electronic signature to the filing by typing their name in the appropriate field and submitting the filing via the Board's online services system. Submission of a filing in this manner shall constitute evidence of legal signature by any individual whose name is typed on the filing.

4. Except as otherwise specified in paragraphs (3), (4), (16) of subsection (b), any documents required to be submitted as part of the application set forth in subsection (b) shall be submitted through the online services system as a .pdf of the document submitted as an attachment to the application.

5. The required fee shall be paid by credit card (Visa, Mastercard, or Discover) through the online services system and paid in full to the Dental Board of California. The applicant shall be required to pay any associated processing or convenience fees to the third-party vendor processing the payment on behalf of the Board, and such fees will be itemized and disclosed to the applicant prior to initiating payment through the online services system.

(b) A completed ~~A~~applications ~~be accompanied by~~ include the following information and fees:

(1) The non-refundable initial application ~~and examination(s) fees~~ as set by Section 1021 unless the applicant meets the requirements for waiver of the fee specified in paragraph (8);

(2) Satisfactory evidence that the applicant has met all applicable requirements in Sections 1628 and 1632 of the Code;

(3) The applicant shall furnish two classifiable sets of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the Board to conduct a criminal history record check in accordance with subsection (e). The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check as set forth in subsection (e);

(4) Where applicable, a record of any previous dental practice and certification ~~of~~ from the applicant's licensing entity or jurisdiction containing the applicant's license number, date of issue, and license status in each state or jurisdiction in which licensure as a dentist has been attained. Certifications sent by mail ~~must~~shall be sent to the attention of the Board's Licensing and Examination Unit at the Board's office, or electronically scanned and emailed to the Board directly by the licensing entity or jurisdiction to DentalBoard@dca.ca.gov;

(5) The applicant's identifying and contact information, including:

(A) Applicant's full legal name ((Last Name) (First Name) (Middle Name) and/or (Suffix)),

(B) Other name(s) applicant has used or has been known by,

(C) Applicant's physical address,

(D) Applicant's ~~social security number, address of residency,~~ mailing address if different from the applicant's physical address ~~of residency~~. The mailing address may be a post office box number or other alternative address,

(E) Applicant's email address, if any,

(F) Applicant's ~~date of birth,~~ telephone number(s),

(G) Applicant's Social Security Number or Individual Taxpayer Identification Number; and,

(H) Applicant's birthdate (month, day, and year) ~~and gender of applicant~~;

(6) Whether the applicant is serving in, or has previously served in, the United States military;

(7) Whether the applicant is seeking expedited processing of their application based on service as an active duty member of the Armed Forces of the United States and being honorably discharged, pursuant to subdivision (a) of Section 115.4 of the Code. If the

answer is “yes”, the applicant shall provide the following documentation along with the application to receive expedited review: a Certificate of Release or Discharge from Active Duty (DD-214) or other documentary evidence showing the date and type of discharge;

(8) Whether the applicant holds a current license or comparable authority to practice dentistry in another state, district, or territory of the United States, and whether their spouse or domestic partner is an active duty member of the Armed Forces of the United States and was assigned to a duty station in California under official active duty military orders. If the answer is “yes”, the applicant shall provide the following documentation with the application to receive expedited review and an initial application fee waiver per Section 115.5 of the Code:

(A) Certificate of marriage or certified declaration/registration of domestic partnership filed with the California Secretary of State or other documentary evidence of legal union with an active duty member of the Armed Forces of the United States,

(B) A copy of the applicant’s current license to practice dentistry in another state, district, or territory of the United States, and,

(C) A copy of the military orders establishing their spouse or partner’s duty station in California;

(9) Whether the applicant is seeking expedited processing of their application based on immigration status pursuant to Section 135.4 of the Code. If the answer is “yes”, in order to receive expedited review of an application, the applicant shall indicate whether any of the following statements apply to the applicant:

(A) You were admitted to the United States as a refugee pursuant to Section 1157 of Title 8 of the United States Code, or

(B) You were granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to Section 1158 of Title 8 of the United States Code, or,

(C) You have a Special Immigrant Visa and were granted a status pursuant to Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8 [relating to Iraqi and Afghan translators/interpreters or those who worked for or on behalf of the United States government].

(10) Additionally, if the applicant answers “yes” to the question in paragraph (9), the applicant shall provide evidence supporting their status, which shall include any of the following:

(A) Form I-94, arrival/departure record, with an admission class code such as “RE” (refugee) or “AY” (asylee) or other information designating the person a refugee or asylee,

(B) Special Immigrant Visa that includes the “SI” or “SQ”,

(C) Permanent Resident Card (Form I-551), commonly known as a “green card,” with a category designation indicating that the person was admitted as a refugee or asylee, or,

(D) An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Board that the applicant qualifies for expedited licensure per Section 135.4 of the Code;

(11) Whether the applicant is an active duty member of a regular component of the United States Armed Forces and enrolled in the United States Department of Defense’s SkillBridge program as authorized under Section 1143(e) of Title 10 of the United States Code and is requesting expedited processing of their application pursuant to subdivision (b) of Section 115.4 of the Code. If the answer is “yes”, the applicant shall provide with their application a copy of an official approval document or letter from their respective United States Armed Forces Service branch (Army, Navy, Air Force, Marine Corps, Space Force, or Coast Guard), signed by the applicant’s first field grade commanding officer that specifies the applicant’s name, the approved SkillBridge opportunity, and the specified duration of participation (i.e., start and end dates);

(12) Information as to whether the applicant is currently registered with the federal Drug Enforcement Administration (DEA) to prescribe or dispense controlled substances. If the applicant answers “yes,” the applicant shall provide their DEA registration number;

(~~6~~13) Information as to whether the applicant has ever taken the California Law and Ethics written examination;

(~~7~~14) Any request for accommodation pursuant to the Americans with Disabilities Act;

~~(8) A 2-inch by 2-inch passport style photograph of the applicant, submitted with the “Application for Licensure to Practice Dentistry (WREB)” Form 33A-22W (Revised 11/06), or “Application for Determination of Licensure Eligibility (Portfolio)” Form 33A-22P (New 11/2014);~~

(~~9~~15) Information regarding the applicant's education including dental education and postgraduate study, if applicable. This information shall include the name(s) and location(s) of institution(s) attended, periods of attendance (showing dates listed by month and year), the type of degree or diploma granted, and the date such degree or diploma was granted;

(~~10~~16)(A) A document containing an acceptable ~~C~~certification meeting the requirements of this paragraph from the dean of the qualifying dental school attended by the applicant to certify the date the applicant graduated. An acceptable certification shall include:

1. The name of the dental school,

2. The date the applicant first enrolled in the school's educational program,

3. The applicant's years of attendance,

4. The date the applicant completed the clinical and didactic requirements of the educational program and graduated,

5. The type of degree granted to the applicant by the dental school,

6. A statement, signed and dated by the dean of the dental school, stating that they hereby certify that the information provided in this certification is true and correct; and,

7. The seal of the dental school.

(B) An acceptable certification must be either sent to the Board by the applicant or dental school by mail to the attention of the Board's Licensing and Examination Unit at the Board's office, or electronically scanned and emailed to the Board directly by the dental school to DentalBoard@dca.ca.gov. Certifications sent by mail to the Board must contain an original signature and original seal of the dental school on the document itself; copies will not be accepted;

(11) ~~Information regarding whether the applicant has any pending or had in the past any charges filed against a dental license or other healing arts license;~~

(17) A written statement, signed and dated by the applicant, that states the applicant authorizes the release to the Board of any information about the applicant from the National Practitioner Data Bank and verification of registration status with the DEA;

(1~~2~~8) Excluding actions based upon the applicant's criminal conviction history, ~~I~~information regarding any prior disciplinary action(s) taken against the applicant within the preceding seven years from the date of the application regarding any dental license or other healing arts license held by the applicant including actions by the United States Military, United States Public Health Service, DEA, or other federal or state government entity ("licensing jurisdiction"). "Disciplinary action" includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction or action taken against a dental license. If an applicant answers "yes", ~~he or she~~ the applicant shall provide ~~the date of~~ a written

statement that includes the name of the licensing jurisdiction, the effective date of disciplinary action, the state, district, or territory where the discipline occurred, the date(s) when the conduct occurred, the charges ~~convicted of~~proven, the disposition of the action, and any other information requested by the ~~b~~Board;

(1~~3~~9) Excluding investigations related to the applicant's criminal conviction history, ~~I~~information as to whether the applicant is currently the subject of any pending investigation by any governmental entity. If the applicant answers "yes," the applicant ~~he or she~~ shall provide any additional information requested by the ~~b~~Board if known to the applicant, including the date the pending investigation was initiated, the name of the licensing entity or jurisdiction, and a description of the allegations that are still pending at the time of application;

(~~14~~20) Excluding denials based upon the applicant's criminal conviction history, ~~I~~information regarding any instances in which the applicant was denied a dental license or DEA registration, denied permission to practice dentistry, or denied permission to take a dental board examination. If the applicant answers "yes", ~~he or she~~ the applicant shall provide the state or country where the denial took place, the date of the denial, the reason for denial, and any other information requested by the ~~b~~Board;

(~~15~~21) Excluding surrenders based upon the applicant's criminal conviction history, ~~I~~information as to whether the applicant has ever surrendered a license to practice dentistry in another state or country. If the applicant answers "yes," additional information shall be provided including state or country of surrender, date of surrender, reason for surrender, and any other information requested by the ~~b~~Board;

~~(16) Information as to whether the applicant is in default on a United States Department of Health and Human Services education loan pursuant to Section 685 of the Code;~~

(22) A written statement, signed and dated by the applicant, that they have read the following notice:

> "Effective January 1, 2008, certain nondentists may, upon your death or incapacity, contract with another licensed dentist or dentists to continue your dental practice for a period not exceeding 12 months if certain conditions are met. Sections 1625.3 and 1625.4 of the Business and Professions Code permit the legal guardian or conservator or authorized representative of an incapacitated dentist, the executor or administrator of the estate of a deceased dentist, or the named trustee or successor trustee of a trust or subtrust who meets certain requirements, to contract with a licensed dentist or dentists to continue the incapacitated or deceased dentist's dental practice for a period not to exceed 12 months from the date of death or incapacity if the practice meets specified criteria and if certain other conditions are met, including providing a specific notification to the Dental Board of California. You and your estate planner should become familiar with these requirements and the

notification process. Please contact the Dental Board of California for additional information."

(23) A written statement, signed and date by the applicant, that they have read the following notice, which is hereby provided for applicants. The Board shall provide all applicants with a copy of this notice on or with any optional paper application provided by the Board for use in submitting the information required by this section, or through the online services system prior to requiring any submission of the signed statement as part of the application.

INFORMATION COLLECTION AND ACCESS

All items in this application are mandatory.

Failure to provide any of the requested information to the Dental Board of California (Board) will delay the processing of your application and will result in the application being rejected as incomplete.

The information provided will be used to determine your eligibility for licensure per California Business and Professions Code (BPC) sections 1628, 1628.5, 1629, and 1632, and California Code of Regulations, title 16, section 1028, which authorizes the collection of this information.

The information on your application may be transferred to other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code section 1798.24. Disclosure of either your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) is mandatory, and collection is authorized by BPC section 30 and 42 U.S.C.A. § 405(c)(2)(C). Your SSN or ITIN will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Family Code section 17520, or for verification of licensure or examination status by a licensing or examination board, and where licensing is reciprocal with the requesting state.

You have the right to review your application and your files except information that is exempt from disclosure as provided in the California Public Records Act (Gov. Code, §§ 7920.000 and following) or as otherwise provided by California Civil Code section 1798.40 of the Information Practices Act of 1977 (Civ. Code, §§ 1798 and following).

Except for your SSN or ITIN, information provided on this application may be disclosed to a member of the public, upon request, under the California Public Records Act. Information may also be disclosed pursuant to court order, subpoena, or search warrant. The address of record you list on this application is a public

record and will be disclosed on the Board's website and otherwise be made available to the public if and when you become licensed. Individuals using a P.O. Box as their address of record are required to provide a physical (street) address to the Board that will not be disclosed to the public pursuant to a public records request or posted on the Board's website.

The Board's Executive Officer is responsible for maintaining the information collected on this application form and may be contacted at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, telephone number (916) 263-2300 regarding questions about this notice or access to records.

The Board is required to notify you that under BPC sections 31 and 494.5, the State California Department of Tax and Fee Administration (CDTFA) and the Franchise Tax Board (FTB) may share taxpayer information with this Board. You are required to pay your state tax obligation. This application may be denied, or your license may be suspended if you have a state tax obligation, the state tax obligation is not paid, and your name appears on the CDTFA or FTB certified list of 500 largest tax delinquencies.

(~~17~~24) A certification, under the penalty of perjury under the laws of the State of California, signed and dated by the applicant that the information provided by the applicant on or with the application is true and correct.

(c) In addition to complying with the applicable provisions contained in subsection~~s (a) through~~ (b) above, an applicant ~~submitting an "Application for Licensure to Practice Dentistry" (WREB) Form 33A-22W (Revised 11/06),~~ for licensure as a dentist who seeks to qualify upon passage of Western Regional Examining Board ("WREB") examination shall also furnish evidence of having successfully passed ~~on or after January 1, 2005,~~ the WREB examination within five years prior to the date of their application. Applicants shall authorize the CDCA-WREB-CITA (hereinafter referred to as the "test administrator") to provide the Board the applicant's cumulative score report showing the applicant's name, test date, the examination taken, and that the applicant passed all portions of the examination as evidence of having successfully passed the WREB examination within five years prior to the date of their application. The applicant shall sign any release, waiver, or consent forms required by the test administrator to authorize the release and submission of their cumulative score report to the Board electronically. Receipt by the Board of the cumulative score report meeting the requirements of this section shall be deemed in compliance with the examination requirements of paragraph (1) of subdivision (c) of Section 1632 of the Code.

(d) In addition to complying with the applicable provisions contained in subsection (b) above, an applicant for licensure who seeks to qualify upon passage of the American Board of Dental Examiners, Inc.'s "ADEX" examination shall also authorize the test

administrator to provide the Board the applicant's cumulative score report showing the applicant's name, test date, the examination taken, and that the applicant passed all portions of the examination as evidence of having successfully passed the ADEX examination within five years prior to the date of their application. The applicant shall sign any release, waiver, or consent forms required by the test administrator to authorize the release and submission of their cumulative score report to the Board electronically. Receipt by the Board of the cumulative score report meeting the requirements of this section shall be deemed in compliance with the examination requirements of paragraph (2) of subdivision (c) of Section 1632 of the Code.

(e) Fingerprinting Requirements. All applicants shall have met the fingerprinting requirements of this subsection prior to issuance of a license to practice dentistry.

(1) Subject to paragraph (3), all applicants shall submit fingerprints through the California Department of Justice's electronic fingerprint submission Live Scan Service ("Live Scan") by completing the California Department of Justice Form "Request for Live Scan Service," and submitting fingerprinting, through Live Scan as described in this subsection.

(2) Each applicant shall take the completed Request for Live Scan Service form to a Live Scan location to have their fingerprints taken by the operator. The applicant shall pay all fingerprint processing fees payable to the Live Scan operator, including the Live Scan operator's "rolling fee," if any, and fees charged by the California Department of Justice and the Federal Bureau of Investigation. For current information about fingerprint background checks and Live Scan locations, please visit the Office of the Attorney General website at: https://oag.ca.gov/fingerprints.

(3) Applicants residing outside of California who cannot be fingerprinted electronically through Live Scan in California must have their fingerprints taken at a law enforcement agency in their state of residence, using fingerprint cards. Applicants shall complete and mail two fingerprint cards, together with the California Department of Justice and the Federal Bureau of Investigation fingerprinting fees (either personal check drawn on a U.S. bank, money order, or certified check), payable to the "Dental Board of California," to:

Dental Board of California
Attention: Licensing and Examination Unit
2005 Evergreen St., Suite 1550
Sacramento, CA 95815

(4) Resubmission process. Applicants will be notified in writing by the Board if the first fingerprint card or Live Scan fingerprints are rejected. If rejected, applicants submitting

under paragraph (3) will have their second fingerprint card resubmitted to the Department of Justice on their behalf by the Board. Applicants submitting fingerprints through Live Scan as set forth in paragraph (1) must follow the instructions on the Board's rejection letter, and resubmit fingerprints as described under the process in paragraphs (1) and (2).

(d) ~~In addition to complying with the applicable provisions contained in subsections (a) through (b) above, an applicant submitting an "Application for Determination of Licensure Eligibility (Portfolio)" Form 33A-22P (New 11/2014) shall also furnish certification from the dean of the qualifying dental school attended by the applicant to certify the applicant has graduated with no pending ethical issues;~~

(e) ~~An "Application for Determination of Licensure Eligibility (Portfolio)" Form 33A-22P (New 11/2014) may be submitted prior to graduation, if the application is accompanied by a certification from the school that the applicant is expected to graduate. The Board shall not issue a license, until receipt of a certification from the dean of the school attended by the applicant, certifying the date the applicant graduated with no pending ethical issues on school letterhead.~~

~~(1) The earliest date upon which a candidate may submit their portfolio for review by the board shall be within 90 days of graduation. The latest date upon which a candidate may submit their portfolio for review by the board shall be no more than 90 days after graduation.~~

~~(2) The candidate shall arrange with the dean of his or her dental school for the school to submit the completed portfolio materials to the Board.~~

~~(3) The Board shall review the submitted portfolio materials to determine if it is complete and the candidate has met the requirements for Licensure by Portfolio Examination.~~

(f) After receipt of the application required by this section, an applicant shall receive written confirmation of the receipt of their application and their assigned application file number ("file number") from the Board to be used in all communications with the Board. The Board shall mail a written deficiency letter or an approval letter notifying the applicant of the requirements of Section 1028.4, as applicable, to the applicant that includes confirmation of receipt and lists their file number.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 30, 31, 114.5, 115.4, 115.5, 135.4, 144, 480, 494.5, 1625.5, 1628, 1628.5, 1629 ~~and~~ 1632 and 1650.1, Business and Professions Code; Sections 1633.2, 1633.7 and 1798.17, Civil Code; Sections 16.5, 6157, 6159 and 6162, Government Code.

§ 1028.4. Application for Issuance of License Number and Registration of Place of Practice Pursuant to Section 1650.

(a) ~~Upon being found eligible for licensure~~ Within 30 days of the date of receiving written approval and notice of their eligibility for licensure as a dentist from the Board per Section 1028, the applicant shall ~~file~~ submit to the Board a completed application as specified in subsection (b) and meet the other applicable requirements of this section to obtain a license number and be deemed compliant with Section 1650 of the Code.

(1) For the purposes of this section "submit to the Board" means to transmit an application and, if applicable, the initial license fee required by Section 1021 ("required fee") by mail with postage prepaid addressed to the Board at the Board office at the address listed on the Board's website, by hand delivery to the Board office, or electronically through a web link to the Department of Consumer Affairs' online licensing system entitled "BreEZe" ("online services system") located on the Board's website in accordance with subparagraph (B) of paragraph (2).

(2) (A) For applications submitted by mail or hand delivery, the application and required fee, if applicable, shall be placed in a sealed envelope and addressed to the Board at the Board office at the address listed on the Board's website. The required fee shall be paid by cash, check, money order, or cashier's check payable to the Dental Board of California.

(B) For applications submitted electronically through the online services system, the applicant shall complete the application according to the following requirements:

1. The applicant shall first login to or register for a user account by typing in a username and password on the initial registration or public sign-in page to access the online services system.

2. After a user account has been created and the online services system accessed online, the applicant shall submit all of the information required by subsection (b) through the online services system.

3. Electronic signature. When a signature is required by the particular instructions of any filing to be made through the online services system, including any attestation under penalty of perjury, the applicant shall affix their electronic signature to the filing by typing their name in the appropriate field and submitting the filing via the Board's online services system. Submission of a filing in this manner shall constitute evidence of legal signature by any individual whose name is typed on the filing.

4. Any documents required to be submitted as part of the application set forth in subsection (b) shall be submitted through the online services system as a .pdf of the document submitted as an attachment to the application.

5. The required fee shall be paid by credit card (Visa, Mastercard, or Discover) through the online services system and paid in full to the Dental Board of California. The applicant shall be required to pay any associated processing or convenience fees to the third-party vendor processing the payment on behalf of the Board and such fees will be itemized and disclosed to the applicant prior to initiating payment through the online services system.

~~an "Application for Issuance of License Number and Registration of Place of Practice," (Rev. 02-07) that is incorporated herein by reference, and shall be accompanied by the licensure fee as set by Section 1021.~~

(b) A completed application for issuance of license number and registration of place of practice shall include the following:

(1) The initial license fee set forth in Section 1021 unless the applicant meets the requirements for waiver of the initial license fee as set forth in Section 115.5 of the Code and further specified in paragraph (5).

(2) The applicant's identifying and contact information, including:

(A) Applicant's full legal name ((Last Name) (First Name) (Middle Name) and/or (Suffix)).

(B) Applicant's address of record.

(C) Applicant's address of place of practice ("practice address"), if different from address of record. Applicants who do not have a practice address in California may leave this section blank.

(D) Applicant's telephone number.

(E) Applicant's email address.

(F) Applicant's file number, which is issued by the Board upon receipt of the application as described in subsection (f) of Section 1028.

(3) Whether the applicant is seeking expedited processing of their application based on service as an active duty member of the Armed Forces of the United States and being honorably discharged, pursuant to subdivision (a) of Section 115.4 of the Code. If the answer is "yes", the applicant shall provide the following documentation along with the

application to receive expedited review: a Certificate of Release or Discharge from Active Duty (DD-214) or other documentary evidence showing the date and type of discharge.

(4) Whether the applicant is an active duty member of a regular component of the United States Armed Forces and enrolled in the United States Department of Defense's SkillBridge program as authorized under Section 1143(e) of Title 10 of the United States Code and is requesting expedited processing of their application pursuant to subdivision (b) of Section 115.4 of the Code. If the answer is "yes", the applicant shall provide with their application a copy of an official approval document or letter from their respective United States Armed Forces Service branch (Army, Navy, Air Force, Marine Corps, Space Force, or Coast Guard), signed by the applicant's first field grade commanding officer that specifies the applicant's name, the approved SkillBridge opportunity, and the specified duration of participation (i.e., start and end dates).

(5) Whether the applicant holds a current license or comparable authority to practice dentistry in another state, district, or territory of the United States, and whether their spouse or domestic partner is an active duty member of the Armed Forces of the United States and was assigned to a duty station in California under official active duty military orders. If the answer is "yes", the applicant shall provide the following documentation with the application to receive expedited review and waiver of the initial license fee per Section 115.5 of the Code:

(A) Certificate of marriage or certified declaration/registration of domestic partnership filed with the California Secretary of State or other documentary evidence of legal union with an active duty member of the Armed Forces of the United States,

(B) A copy of the applicant's current license to practice dentistry in another state, district, or territory of the United States, and,

(C) A copy of the military orders establishing their spouse or partner's duty station in California.

(6) Whether any of the following statements apply to the applicant:

(A) You were admitted to the United States as a refugee pursuant to Section 1157 of Title 8 of the United States Code, or

(B) You were granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to Section 1158 of Title 8 of the United States Code, or,

(C) You have a Special Immigrant Visa and were granted a status pursuant to Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8 [relating to Iraqi and Afghan translators/interpreters or those who worked for or on behalf of the United States government].

(7) If the applicant answers "yes" to the question in paragraph (6), the applicant shall provide evidence supporting their status, which shall include any of the following:

(A) Form I-94, arrival/departure record, with an admission class code such as "RE" (refugee) or "AY" (asylee) or other information designating the person a refugee or asylee,

(B) Special Immigrant Visa that includes the "SI" or "SQ",

(C) Permanent Resident Card (Form I-551), commonly known as a "green card," with a category designation indicating that the person was admitted as a refugee or asylee, or,

(D) An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Board that the applicant qualifies for expedited licensure per Section 135.4 of the Code.

(8) A written statement, signed and date by the applicant, that they have read the following notice, which is hereby provided for applicants. The Board shall provide all applicants with a copy of this notice on or with any optional paper application provided by the Board for use in submitting the information required by this section, or through the online services system prior to requiring any submission of the signed statement as part of the application.

INFORMATION COLLECTION AND ACCESS

All items in this application are mandatory.

Failure to provide any of the requested information to the Dental Board of California (Board) will delay the processing of your application and will result in the application being rejected as incomplete.

The information provided will be used to determine compliance with California Business and Professions Code (BPC) section 1650 and California Code of Regulations, title 16, section 1028.4, which authorizes the collection of this information.

The information on your application may be transferred to other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code section 1798.24.

You have the right to review your application and your files except information that is exempt from disclosure as provided in the California Public Records Act (Gov. Code, §§ 7920.000 and following) or as otherwise provided by Civil Code section 1798.40 of the Information Practices Act of 1977 (Civ. Code, §§ 1798 and following).

Information provided on this application may be disclosed to a member of the public, upon request, under the California Public Records Act. Information may also be disclosed pursuant to court order, subpoena, or search warrant. The address of record you list on this application is a public record and will be disclosed on the Board's website and otherwise be made available to the public if and when you become licensed.

The Board's Executive Officer is responsible for maintaining the information collected on this application form and may be contacted at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, telephone number (916) 263-2300 regarding questions about this notice or access to records.

(9) A certification, under the penalty of perjury under the laws of the State of California, signed and dated by the applicant, that the information provided by the applicant on or with the application is true and correct.

(c) If an applicant files an application per subsection (b) and leaves the practice address "blank," the licensee must immediately report their name, license number, and their practice address to the Board in writing, if and when the licensee has a practice address in California, by either of the following methods: (1) by mail to the attention of the Board's Licensing and Examination Unit at the Board office at the address listed on the Board's website, or (2) by email to DentalBoard@dca.ca.gov.

NOTE: Authority cited: Sections 1614 and 1634.2(c), Business and Professions Code. Reference: Sections 115.4, 115.5, 135.4 and 1650, Business and Professions Code; Sections 1633.2, 1633.7 and 1798.17, Civil Code; Sections 16.5, 6157 and 6162, Government Code.

§ 1028.5. Application for California Law and Ethics Examination Pursuant to Section 1632(b).

(a) Application for the California law and ethics examination required by Section 1632 of the Code and Section 1031 shall be made ~~on an "Application for Law and Ethics Examination" (Rev. 12/07) that is incorporated herein by reference~~by submitting to the Board a completed application as specified in subsection (b) and meeting the other applicable requirements of this section.

(1) For the purposes of this section "submitting to the Board" means to transmit an application and the application for law and ethics examination fee required by Section 1021 ("required fee") by mail with postage prepaid addressed to the Board at the Board office at the address listed on the Board's website, by hand delivery to the Board office, or electronically through a web link to the Department of Consumer Affairs' online licensing system entitled "BreEZe" ("online services system") located on the Board's website in accordance with subparagraph (B) of paragraph (2).

(2) (A) For applications submitted by mail or hand delivery, the application and required fee shall be placed in a sealed envelope and addressed to the Board at the Board office at the address listed on the Board's website. The required fee shall be paid by cash, check, money order, or cashier's check payable to the Dental Board of California.

(B) For applications submitted electronically through the online services system, the applicant shall submit the application according to the following requirements:

1. The applicant shall first login to or register for a user account by typing in a username and password on the initial registration or public sign-in page to access the online services system.

2. After a user account has been created and the online services system accessed online, the applicant shall submit all of the information required by subsection (b) through the online services system.

3. Electronic signature. When a signature is required by the particular instructions of any filing to be made through the online services system, including any attestation under penalty of perjury, the applicant shall affix their electronic signature to the filing by typing their name in the appropriate field and submitting the filing via the Board's online services system. Submission of a filing in this manner shall constitute evidence of legal signature by any individual whose name is typed on the filing.

4. Except as otherwise specified in paragraph (8) of subsection (b), any documents required to be submitted as part of the application set forth in subsection (b) shall be submitted through the online services system as a .pdf of the document submitted as an attachment to the application.

5. The required fee shall be paid by credit card (Visa, Mastercard, or Discover) through the online services system and paid in full to the Dental Board of California. The applicant shall be required to pay any associated processing or convenience fees to the third-party vendor processing the payment on behalf of the Board and such fees will be itemized and disclosed to the applicant prior to initiating payment through the online services system.

(b) A completed application for the California law and ethics examination shall include the following:

(1) The application for law and ethics examination fee set forth in Section 1021.

(2) The applicant's identifying and contact information, including:

(A) Applicant's full legal name ((Last Name) (First Name) (Middle Name) and/or (Suffix)).

(B) Applicant's mailing address.

(C) Applicant's telephone number.

(D) Applicant's email address.

(E) Applicant's Social Security Number or Individual Taxpayer Identification Number.

(F) Applicant's birthdate (month, day, and year).

(3) Whether the applicant is requesting a reasonable accommodation pursuant to subdivision (b) of Section 12944 of the Government Code. If the applicant affirmatively states they are requesting an accommodation, the applicant shall provide medical documentation consisting of a written document with the name, license number, telephone number, date, and signature of a physician confirming the existence of the applicant's disability or medical condition (as defined in Section 12926 of the Government Code) and the need for the reasonable accommodation.

(4) Whether the applicant is seeking expedited processing of their application based on service as an active duty member of the Armed Forces of the United States and being honorably discharged, pursuant to subdivision (a) of Section 115.4 of the Code. If the answer is "yes", the applicant shall provide the following documentation along with the application to receive expedited review: a Certificate of Release or Discharge from Active Duty (DD-214) or other documentary evidence showing the date and type of discharge.

(5) Whether the applicant is an active duty member of a regular component of the United States Armed Forces and enrolled in the United States Department of Defense's SkillBridge program as authorized under Section 1143(e) of Title 10 of the United States Code and is requesting expedited processing of their application pursuant to subdivision (b) of Section 115.4 of the Code. If the answer is "yes", the applicant shall provide with their application a copy of an official approval document or letter from their respective United States Armed Forces Service branch (Army, Navy, Air Force, Marine Corps, Space Force, or Coast Guard), signed by the applicant's first field grade commanding officer that specifies the applicant's name, the approved SkillBridge opportunity, and the specified duration of participation (i.e., start and end dates).

(6) Whether the applicant holds a current license or comparable authority to practice dentistry in another state, district, or territory of the United States, and whether their spouse or domestic partner is an active duty member of the Armed Forces of the United States and was assigned to a duty station in California under official active duty military orders. If the answer is "yes", the applicant shall provide the following documentation with the application to receive expedited review per Section 115.5 of the Code:

(A) Certificate of marriage or certified declaration/registration of domestic partnership filed with the California Secretary of State or other documentary evidence of legal union with an active duty member of the Armed Forces of the United States,

(B) A copy of the applicant's current license to practice dentistry in another state, district, or territory of the United States, and,

(C) A copy of the military orders establishing their spouse or partner's duty station in California.

(7) Whether any of the following statements apply to the applicant:

(A) You were admitted to the United States as a refugee pursuant to Section 1157 of Title 8 of the United States Code, or

(B) You were granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to Section 1158 of Title 8 of the United States Code, or,

(C) You have a Special Immigrant Visa and were granted a status pursuant to Section 1244 of Public Law 110-181, Public Law 109-163, or Section 602(b) of Title VI of Division F of Public Law 111-8 [relating to Iraqi and Afghan translators/interpreters or those who worked for or on behalf of the United States government].

(8) If the applicant answers “yes” to the question in paragraph (7), the applicant shall provide evidence supporting their status, which shall include any of the following:

(A) Form I-94, arrival/departure record, with an admission class code such as “RE” (refugee) or “AY” (asylee) or other information designating the person a refugee or asylee,

(B) Special Immigrant Visa that includes the “SI” or “SQ”,

(C) Permanent Resident Card (Form I-551), commonly known as a “green card,” with a category designation indicating that the person was admitted as a refugee or asylee, or,

(D) An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Board that the applicant qualifies for expedited licensure per Section 135.4 of the Code.

(9) (A) A document containing an acceptable certification meeting the requirements of this paragraph from the dean of the qualifying dental school attended by the applicant to certify the date the applicant graduated or is expected to graduate. An acceptable certification shall include:

1. The name of the dental school,

2. The date the applicant first enrolled in the school’s educational program,

3. The applicant’s years of attendance,

4. The date the applicant completed the clinical and didactic requirements of the educational program,

5. The type of degree granted to the applicant by the dental school or the date the applicant is expected to graduate and receive their degree,

6. A statement, signed and dated by the dean of the dental school, stating that they hereby certify that the information provided in this certification is true and correct; and,

7. The seal of the dental school.

(B) An acceptable certification must be either sent to the Board by the applicant or dental school by mail to the attention of the Board’s Licensing and Examination Unit at the Board’s office, or electronically scanned and emailed to the Board directly by

the dental school to DentalBoard@dca.ca.gov. Certifications sent by mail to the Board must contain an original signature and original seal of the dental school on the document itself; copies will not be accepted.

(10) A written statement, signed and dated by the applicant, that they have read the following notice, which is hereby provided for applicants. The Board shall provide all applicants with a copy of this notice on or with any optional paper application provided by the Board for use in submitting the information required by this section, or through the online services system prior to requiring any submission of the signed statement as part of the application.

INFORMATION COLLECTION AND ACCESS

All items in this application are mandatory.

Failure to provide any of the requested information to the Dental Board of California (Board) will delay the processing of your application and will result in the application being rejected as incomplete.

The information provided will be used to determine your eligibility for examination and licensure per California Business and Professions Code (BPC) sections 1628, 1629 and 1632 and California Code of Regulations, title 16, section 1028.5, which authorizes the collection of this information.

The information on your application may be transferred to other governmental or law enforcement agencies to perform their statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code section 1798.24. Disclosure of either your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) is mandatory, and collection is authorized by BPC section 30 and 42 U.S.C.A. § 405(c)(2)(C). Your SSN or ITIN will be used exclusively for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Family Code section 17520, or for verification of licensure or examination status by a licensing or examination board, and where licensing is reciprocal with the requesting state.

You have the right to review your application and your files except information that is exempt from disclosure as provided in the California Public Records Act (Gov. Code, §§ 7920.000 and following) or as otherwise provided by Civil Code section 1798.40 of the Information Practices Act of 1977 (Civ. Code, §§ 1798 and following).

Except for your SSN or ITIN, information provided on this application may be disclosed to a member of the public, upon request, under the California Public Records Act. Information may also be disclosed pursuant to court order, subpoena,

or search warrant. The address of record you list on this application is a public record and will be disclosed on the Board's website and otherwise be made available to the public if and when you become licensed.

The Board's Executive Officer is responsible for maintaining the information collected on this application form and may be contacted at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, telephone number (916) 263-2300 regarding questions about this notice or access to records.

(11) A certification, under the penalty of perjury under the laws of the State of California, signed and dated by the applicant, that the information provided by the applicant on or with the application is true and correct.

NOTE: Authority cited: Sections 1614 and 1634.2(c), Business and Professions Code. Reference: Sections 30, 31, 115.4, 115.5, 135.4 and 1632, Business and Professions Code; Sections 1633.2, 1633.7 and 1798.17, Civil Code; Sections 16.5, 6157 and 6162, Government Code.

§ 1030. Theory Examination.

An applicant shall successfully complete the National Board Dental Examinations of the Joint Commission on National Dental Examinations and shall submit confirmation thereof to the Board within one year from the date of submission of the application in Section 1028 in compliance with this section. ~~prior to submission of the "Application for Issuance of License Number and Registration of Place of Practice," (Rev. 11-07)~~ Applicants shall submit proof of successful completion to the Board using one of the following methods:

(a) The applicant's submission of an original score card by mail with postage prepaid or by hand delivery to the Board office at the address listed on the Board's website, and that is issued by the Joint Commission on National Dental Examinations ("Joint Commission") containing all of the following:

(1) Name of the applicant;

(2) Test date;

(3) Name of the examination taken;

(4) Status showing a "pass" for all required sections (either Part I and Part II, or the Integrated National Board Dental Examination); and

(5) Printed on the Joint Commission's proprietary watermark and colored paper.

(b) The applicant shall access online the Joint Commission's website at www.jcnde.ada.org, and follow all instructions required by the Joint Commission to authorize the electronic release and email of the applicant's National Board Dental Examination (NBDE) score directly to the Board to the following email address: DentalBoard@dca.ca.gov. The email from the Joint Commission shall contain all of the following to confirm the applicant's score: first and last name of the applicant; name of the examination taken; the applicant's birth date; the applicant's exam date; the applicant's score result; and, whether the applicant passed or failed the examination.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1634.1, Business and Professions Code.

~~§ 1032. Portfolio Examination: Eligibility.~~

~~The portfolio examination shall be conducted while the candidate is enrolled in a Board-approved dental school located in California. A student may elect to begin the portfolio examination process during the clinical training phase of their dental education.~~

~~NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.~~

~~§ 1032.1. Portfolio Examination: Definitions.~~

~~As used in this Article, the following definitions shall apply:~~

~~(a) "Candidate" means a dental student who is taking the examination for the purpose of applying to the Board for licensure.~~

~~(b) "Case" means a dental procedure which satisfies the required clinical experiences.~~

~~(c) "Clinical experiences" means procedures, performed with or without faculty intervention, that the candidate must complete to the satisfaction of his or her clinical faculty prior to submission of his or her portfolio examination application. Clinical experiences have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge, and skill level to reliably demonstrate competency.~~

~~(d) "Competency examination" means a candidate's final assessment in a portfolio examination competency, performed without faculty intervention and graded by competency examiners registered with the Board.~~

(e) “Critical error” means a gross error that is irreversible or may impact the patient’s safety and wellbeing.

(f) “Patient management” means the interaction between patient and candidate from initiation to completion of treatment, including any post-treatment complications that may occur.

(g) “Portfolio” means the cumulative documentation of clinical experiences and competency examinations submitted to the Board.

(h) “Portfolio competency examiner” means the dental school faculty examiner. The portfolio competency examiner shall be a faculty member chosen by the school, registered with the Board, and shall be trained and calibrated to conduct and grade the portfolio competency examinations.

(i) “School” means a Board-approved dental school located in California.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632, Business and Professions Code.

§ 1032.2. Portfolio Examination: Requirements for Demonstration of Clinical Experience.

(a) Each candidate shall complete at least the minimum number of clinical experiences in each of the competencies prior to submission of their portfolio to the Board. All clinical experiences shall be performed on patients under the supervision of school faculty and shall be included in the portfolio submitted to the Board. Clinical experience shall be performed at the dental school clinic, an extramural dental facility or a mobile dental clinic approved by the Board. The portfolio shall contain documentation that the candidate has completed the minimum number of clinical experiences as follows:

(1) Oral diagnosis and treatment planning (ODTP) clinical experiences shall include a minimum of twenty (20) patient cases. Clinical experiences for ODTP include: comprehensive oral evaluations, limited (problem-focused) oral evaluations, and periodic oral evaluation.

(2) Direct restorative clinical experiences shall include a minimum of sixty (60) restorations. The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including: amalgams, composites, crown build-ups, direct pulp caps, and temporizations.

(3) Indirect restorative clinical experiences shall include a minimum of fourteen (14) restorations. The restorations completed in the clinical experiences may be a combination of the following procedures: inlays, onlays, crowns, abutments, pontics, veneers, cast posts, overdenture copings, or dental implant restorations.

(4) Removable prosthodontic clinical experiences shall include a minimum of five (5) prostheses. One of the five prostheses may be used as a portfolio competency examination provided that it is completed in an independent manner with no faculty intervention. A prosthesis shall include any of the following: full denture, partial denture (cast framework), partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth), immediate treatment denture, or overdenture retained by a natural tooth or dental implants.

(5) Endodontic clinical experiences on patients shall include five (5) canals or any combination of canals in three separate teeth.

(6) Periodontal clinical experiences shall include a minimum of twenty-five (25) cases. A periodontal experience shall include the following: An adult prophylaxis, treatment of periodontal disease such as scaling and root planing, any periodontal surgical procedure, and assisting on a periodontal surgical procedure when performed by a faculty or an advanced education candidate in periodontics. The combined clinical periodontal experience shall include a minimum of five (5) quadrants of scaling and root planning procedures.

(b) Completion of all required clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be included in the candidate's portfolio.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1032.3. Portfolio Examination: Oral Diagnosis and Treatment Planning (ODTP).

(a) The portfolio examination shall contain the following documentation of the minimum ODTP clinical experiences and documentation of ODTP portfolio competency examination:

(1) Evidence of successful completion of the ODTP clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New

~~08/13), which is hereby incorporated by reference, and shall be maintained in the candidate's portfolio.~~

~~(2) Documentation providing proof of satisfactory completion of a final assessment in the ODTP competency examination. For purpose of this section, satisfactory proof means the ODTP competency examination has been approved by the designated dental school faculty.~~

~~(b) Competency Examination Requirements: The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The ODTP competency examination shall include:~~

~~(1) Fifteen (15) scoring factors:~~

~~(A) Medical Issues That Impact Dental Care;~~

~~(B) Treatment Modifications Based on Medical Conditions;~~

~~(C) Patient Concerns/Chief Complaint;~~

~~(D) Dental History;~~

~~(E) Significant Radiographic Findings;~~

~~(F) Clinical Findings;~~

~~(G) Risk Level Assessment;~~

~~(H) Need for Additional Diagnostic Tests/Referrals;~~

~~(I) Findings From Mounted Diagnostic Casts;~~

~~(J) Comprehensive Problem List;~~

~~(K) Diagnosis and Interaction of Problems;~~

~~(L) Overall Treatment Approach;~~

~~(M) Phasing and Sequencing of Treatment;~~

~~(N) Comprehensiveness of Treatment Plan; and~~

~~(O) Treatment Record.~~

~~(2) Initiation and completion of one (1) multidisciplinary portfolio competency examination.~~

~~(3) The treatment plan shall involve at least three (3) of the following six disciplines: periodontics, endodontics, operative (direct and indirect restoration), fixed and removable prosthodontics, orthodontics, and oral surgery.~~

~~(4) Patient's Medical History: The medical history shall include: an evaluation of past illnesses and conditions, hospitalizations and operations, allergies, family history, social history, current illnesses and medications, and their effect on dental condition.~~

~~(5) Patient's Dental History: The dental history shall include: age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts.~~

~~(6) Documentation of a comprehensive examination of patient's current oral health condition and vital signs. The documentation shall include:~~

~~(A) Interpretation of radiographic series;~~

~~(B) Performance of caries risk assessment;~~

~~(C) Determination of periodontal condition;~~

~~(D) Performance of a head and neck examination, including oral cancer screening;~~

~~(E) Screening for temporomandibular disorders;~~

~~(F) Assessment of vital signs;~~

~~(G) Performance of a clinical examination of dentition; and~~

~~(H) Performance of an occlusal examination.~~

~~(7) Documentation the candidate evaluated data to identify problems. The documentation shall include:~~

~~(A) Chief complaint;~~

~~(B) Medical problem;~~

~~(C) Stomatognathic problems; and~~

~~(D) Psychosocial problems.~~

~~(8) Documentation the candidate worked-up the problems and developed a tentative treatment plan. The documentation shall include:~~

~~(A) Problem definition, e.g., severity/chronicity and classification;~~

~~(B) Determination if additional diagnostic tests are needed;~~

~~(C) Development of a differential diagnosis;~~

~~(D) Recognition of need for referral(s);~~

~~(E) Pathophysiology of the problem;~~

~~(F) Short term needs;~~

~~(G) Long term needs;~~

~~(H) Determination interaction of problems;~~

~~(I) Development of treatment options;~~

~~(J) Determination of prognosis; and~~

~~(K) Patient information regarding informed consent.~~

~~(9) Documentation the candidate developed a final treatment plan. The documentation shall include:~~

~~(A) Rationale for treatment;~~

~~(B) Problems to be addressed, or any condition that puts the patient at risk in the long term; and~~

~~(C) Determination of sequencing with the following framework:~~

~~(i) Systemic: medical issues of concern, medications and their effects, effect of diseases on oral condition, precautions, treatment modifications;~~

~~(ii) Urgent: Acute pain/infection management, urgent esthetic issues, further exploration/additional information, oral medicine consultation, pathology;~~

(iii) Preparatory: Preventive interventions, orthodontic, periodontal (Phase I, II), endodontic treatment, caries control, other temporization;

(iv) Restorative: operative, fixed, removable prostheses, occlusal splints, implants;

(v) Elective: esthetic (veneers, etc.) any procedure that is not clinically necessary, replacement of sound restoration for esthetic purposes, bleaching; and

(vi) Maintenance: periodontic recall, radiographic interval, periodic oral examination, caries risk management.

(c) Acceptable Patient Criteria for ODTP Competency Examination. The patient used for the competency examination shall meet the following criteria:

(1) Maximum of ASA II, as defined by the American Society of Anesthesiologists (ASA) Physical Status Classification System;

(2) Missing or will be missing two or more teeth, not including third molars; and

(3) At least moderate periodontitis with probing depths of 5 mm or more.

(d) Competency Examination Scoring: The scoring system used for the ODTP competency examination is defined as follows:

(1) A score of 0 is unacceptable; candidate exhibits a critical error.

(2) A score of 1 is unacceptable; major deviations that are correctable

(3) A score of 2 is acceptable; minimum competence

(4) A score of 3 is adequate; less than optimal

(5) A score of 4 is optimal

A score rating of "2" shall be deemed the minimum competence level performance.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1632.1, Business and Professions Code.

§ 1032.4. Portfolio Examination: Direct Restoration.

~~(a) The portfolio examination shall contain the following documentation of the minimum direct restoration clinical experiences and documentation of the direct restoration portfolio competency examination:~~

~~(1) Evidence of successful completion of the direct restoration clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the candidate's portfolio.~~

~~(2) Documentation providing proof of satisfactory completion of a final assessment in the direct restoration competency examination. For purpose of this section, satisfactory proof means the direct restoration competency examination has been approved by the designated dental school faculty.~~

~~(b) Competency Examination Requirements: The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The direct restoration portfolio shall include documentation of the candidate's clinical competency to perform a direct restoration on teeth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials. The case selection shall be based on minimum direct restoration criteria for any permanent anterior or posterior teeth. Each procedure may be considered a clinical experience. The direct restoration competency examination shall include:~~

~~(1) Seven (7) scoring factors:~~

~~(A) Case Presentation;~~

~~(B) Outline and Extensions;~~

~~(C) Internal Form;~~

~~(D) Operative Environment;~~

~~(E) Anatomical Form;~~

~~(F) Margins; and~~

~~(G) Finish and Function.~~

~~(2) Two (2) restorations: One (1) Class II amalgam or composite, maximum one slot preparation; and one (1) Class III/IV composite.~~

(3) Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.

(4) A case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.

(5) Patient Management. The candidate shall be familiar with the patient's medical and dental history.

(6) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(c) Acceptable Criteria for Direct Restoration Examination: The tooth used for each of the competency examinations shall meet the following criteria:

(1) A Class II direct restoration shall be performed on any permanent posterior tooth.

(A) The treatment shall be performed in the sequence described in the treatment plan.

(B) More than one test procedure shall be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments.

(C) Caries as shown on either of the two required radiographic images of an unrestored proximal surface shall extend to or beyond the dento-enamel junction.

(D) The tooth to be treated shall be in occlusion.

(E) The restoration shall have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration shall be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.

(F) The tooth shall be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.

(G) Any tooth with bonded veneer is not acceptable.

(2) A Class III/IV direct restoration shall be performed on any permanent anterior tooth.

(A) The treatment shall be performed in the sequence described in the treatment plan.

(B) Caries as shown on the required radiographic image of an unrestored proximal surface shall extend to or beyond the dento-enamel junction.

(C) Carious lesions shall involve the interproximal contact area.

(D) The restoration shall have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration shall be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.

(E) The tooth shall be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.

(F) The lesion shall not be acceptable if it is in contact with circumferential decalcification.

(G) Procedural approach shall be appropriate for the lesion on the tooth.

(H) Any tooth with bonded veneer is not acceptable.

(d) Competency Examination Scoring. The scoring system used for the direct restoration competency examination is defined as follows:

(1) A score of 0 is unacceptable; candidate exhibits a critical error.

(2) A score of 1 is unacceptable; multiple major deviations that are correctable.

(3) A score of 2 is unacceptable; one major deviation that is correctable.

(4) A score of 3 is acceptable; minimum competence.

(5) A score of 4 is adequate; less than optimal.

(6) A score of 5 is optimal.

A score rating of "3" shall be deemed the minimum competence level performance.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 16327 and 1632.1, Business and Professions Code.

§ 1032.5. Portfolio Examination: Indirect Restoration.

~~(a) The portfolio examination shall contain the following documentation of the minimum indirect restoration clinical experiences and documentation of the indirect restoration portfolio competency examination:~~

~~(1) Evidence of successful completion of the indirect restoration clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the candidate's portfolio.~~

~~(2) Documentation providing proof of satisfactory completion of a final assessment in the indirect restoration competency examination. For purpose of this section, satisfactory proof means the indirect restoration competency examination has been approved by the designated dental school faculty.~~

~~(b) Competency Examination Requirements: The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The indirect restoration competency examination shall include documentation of the candidate's competency to complete a ceramic onlay or more extensive, a partial gold restoration onlay or more extensive, a metal-ceramic restoration, or full gold restoration. The indirect restoration competency examination shall include:~~

~~(1) Seven (7) scoring factors:~~

~~(A) Case Presentation;~~

~~(B) Preparation;~~

~~(C) Impression;~~

~~(D) Provisional;~~

~~(E) Candidate Evaluation of Laboratory Work;~~

~~(F) Pre-Cementation~~

~~(G) Cementation and Finish.~~

~~(2) One (1) indirect restoration which may be any of the following procedures.~~

~~(A) Ceramic restoration shall be onlay or more extensive;~~

~~(B) Partial gold restoration shall be onlay or more extensive;~~

~~(C) Metal ceramic restoration; or~~

~~(D) Full gold restoration.~~

(3) A case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.

(4) Patient Management. The candidate shall be familiar with the patient's medical and dental history.

(5) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(c) Acceptable Criteria for Indirect Restoration Examination: The tooth used for the competency examination shall meet the following criteria:

(1) Treatment shall be performed in the sequence described in the treatment plan.

(2) The tooth shall be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment.

(3) The tooth selected for restoration, shall have opposing occlusion that is stable.

(4) The tooth shall be in occlusal contact with a natural tooth or a permanent restoration. Occlusion with a full or partial denture is not acceptable.

(5) The restoration shall include at least one cusp.

(6) The restoration shall have an adjacent tooth to be able to restore a proximal contact; proximal surface of the tooth adjacent to the planned restoration shall be either an enamel surface or a permanent restoration; temporary restorations or removable partial dentures are not acceptable adjacent surfaces.

(7) The tooth selected shall require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns.

(8) The candidate shall not perform any portion of the crown preparation in advance.

(9) The direct restorative materials which are placed to contribute to the retention and resistance form of the final restoration may be completed in advance, if needed.

(10) The restoration shall be completed on the same tooth and same patient by the same candidate.

(11) A validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of the existing crown.

(12) Teeth with cast post shall not be allowed.

(13) A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.

(d) Competency Examination Scoring. The scoring system used for the indirect restoration competency examination is defined as follows:

(1) A score of 0 is unacceptable; candidate exhibits a critical error

(2) A score of 1 is unacceptable; multiple major deviations that are correctable

(3) A score of 2 is unacceptable; one major deviation that is correctable

(4) A score of 3 is acceptable; minimum competence

(5) A score of 4 is adequate; less than optimal

(6) A score of 5 is optimal

A score rating of "3" shall be deemed the minimum competence level of performance.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1032.6. Portfolio Examination: Removable Prosthodontics.

(a) The portfolio examination shall contain the following documentation of the minimum removable prosthodontic clinical experiences and documentation of the removable prosthodontic portfolio competency examination:

(1) Evidence of successful completion of the removable prosthodontic clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the candidate's portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the removable prosthodontic competency examination. For purpose of this section, satisfactory proof means the removable prosthodontic competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements. The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The removable prosthodontic competency examination shall include:

(1) One (1) of the following prosthetic treatments from start to finish on the same patient:

(A) Denture or overdenture for a single edentulous arch; or

~~(B) Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch.~~

~~(2) Scoring factors on prosthetic treatments for denture or overdenture for a single edentulous arch or scoring factors on prosthetic treatments for cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially endentulous arch, as follows:~~

~~(A) Nine (9) scoring factors on prosthetic treatments for denture or overdenture for a single edentulous arch, as follows:~~

~~(i) Patient Evaluation and Diagnosis~~

~~(ii) Treatment Plan and Sequencing~~

~~(iii) Preliminary Impressions~~

~~(iv) Border Molding and Final Impressions~~

~~(v) Jaw Relation Records~~

~~(vi) Trial Dentures~~

~~(vii) Insertion of Removable Prosthesis~~

~~(viii) Post-Insertion~~

~~(ix) Laboratory Services for Prosthesis~~

~~(B) Twelve (12) scoring factors on prosthetic treatments for cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially endentulous arch, as follows:~~

~~(i) Patient Evaluation and Diagnosis~~

~~(ii) Treatment Plan and Sequencing~~

~~(iii) Preliminary Impressions~~

~~(iv) RPD Design~~

~~(v) Tooth Modification~~

~~(vi) Border Molding and Final Impressions~~

~~(vii) Framework Try-in~~

~~(viii) Jaw Relation Records~~

~~(ix) Trial Dentures~~

~~(x) Insertion of Removable Prosthesis~~

~~(xi) Post-Insertion~~

~~(xii) Laboratory Services for Prosthesis~~

~~(3) Documentation the candidate developed a diagnosis, determined treatment options and prognosis for the patient to receive a removable prosthesis. The documentation shall include:~~

~~(A) Evidence the candidate obtained a patient history, (e.g. medical, dental and psychosocial).~~

~~(B) Evaluation of the patient's chief complaint.~~

~~(C) Radiographs and photographs of the patient.~~

~~(D) Evidence the candidate performed a clinical examination, (e.g. hard/soft tissue charting, endodontic evaluation, occlusal examination, skeletal/jaw relationship, VDO, DR, MIP).~~

~~(E) Evaluation of existing prosthesis and the patient's concerns.~~

~~(F) Evidence the candidate obtained and mounted a diagnostic cast.~~

~~(G) Evidence the candidate determined the complexity of the case based on ACP classifications.~~

~~(H) Evidence the patient was presented with treatment plan options and assessment of the prognosis, (e.g. complete dentures, partial denture, overdenture, implant options, FPD).~~

~~(I) Evidence the candidate analyzed the patient risks/benefits for the various treatment options.~~

~~(J) Evidence the candidate exercised critical thinking and made evidence based treatment decisions.~~

~~(4) Documentation of the candidate's competency to successfully restore edentulous spaces with removable prosthesis. The documentation shall include:~~

~~(A) Evidence the candidate developed a diagnosis and treatment plan for the removable prosthesis.~~

~~(B) Evidence the candidate obtained diagnostic casts.~~

~~(C) Evidence the candidate performed diagnostic wax-up/survey framework designs.~~

~~(D) Evidence the candidate performed an assessment to determine the need for pre-prosthetic surgery and made the necessary referral.~~

~~(E) Evidence the candidate performed tooth modifications and/or survey crowns, when indicated.~~

~~(F) Evidence the candidate obtained master impressions and casts.~~

~~(G) Evidence the candidate obtained occlusal records.~~

~~(H) Evidence the candidate performed a try-in and evaluated the trial dentures.~~

~~(I) Evidence the candidate inserted the prosthesis and provided the patient with post-insertion care.~~

~~(J) Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).~~

~~(5) Documentation of the candidate's competency to manage tooth loss transitions with immediate or transitional prostheses. The documentation shall include:~~

~~(A) Evidence the candidate developed a diagnosis and treatment plan that identified teeth that could be salvaged and or teeth that needed extraction.~~

~~(B) Evidence the candidate educated the patient regarding the healing process, denture experience, and future treatment need.~~

~~(C) Evidence the candidate developed prosthetic phases which included surgical plans.~~

~~(D) Evidence the candidate obtained casts (preliminary and final impressions).~~

~~(E) Evidence the candidate obtained the occlusal records.~~

~~(F) Evidence the candidate did try-ins and evaluated trial dentures.~~

~~(G) Evidence the candidate competently managed and coordinated the surgical phase.~~

~~(H) Evidence the candidate provided the patient post insertion care including adjustment, relines and patient counseling within the established standards of care.~~

~~(I) Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).~~

~~(6) Documentation of the candidate's competency to manage prosthetic problems. The documentation shall include:~~

~~(A) Evidence the candidate competently managed real or perceived patient problems.~~

~~(B) Evidence the candidate evaluated existing prosthesis.~~

~~(C) Evidence the candidate performed uncomplicated repairs, relines, re-base, re-set or re-do, if needed.~~

~~(D) Evidence the candidate made a determination if specialty referral was necessary.~~

~~(E) Evidence the candidate obtained impressions/records/information for laboratory use.~~

~~(F) Evidence the candidate competently communicated needed prosthetic procedure to laboratory technician.~~

~~(G) Evidence the candidate inserted the prosthesis and provided the patient follow-up care.~~

~~(H) Evidence the candidate performed in-office maintenance, (e.g. prosthesis cleaning, clasp tightening and occlusal adjustments).~~

~~(7) Documentation the candidate directed and evaluated the laboratory services for the prosthesis. The documentation shall include:~~

(A) Complete laboratory prescriptions sent to the dental technician.

(B) Copies of all communications with the laboratory technicians.

(C) Evaluations of the laboratory work product, (e.g. frameworks, processed dentures).

(8) Prosthetic treatment for the examination shall include an immediate or interim denture.

(9) Patients shall not be shared or split between examination candidates.

(10) Patient Management. The candidate shall be familiar with the patient's medical and dental history.

(11) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(12) Case complexity shall not exceed the American College of Prosthodontics Class II for partially edentulous patients.

(c) Acceptable Criteria for Removable Prosthodontics Examination. Prosthetic procedures shall be performed on patients with supported soft tissue, implants, or natural tooth retained overdentures.

(d) Competency Examination Scoring. The scoring system used for the removable prosthodontics competency examination is defined as follows:

(1) A score of 1 is unacceptable with gross errors

(2) A score of 2 is unacceptable with major errors

(3) A score of 3 is minimum competence with moderate errors that do not compromise outcome

(4) A score of 4 is acceptable with minor errors that do not compromise outcome

(5) A score of 5 is optimal with no errors evident

A score rating of "3" shall be deemed the minimum competence level of performance.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1032.7. Portfolio Examination: Endodontics.

(a) The portfolio examination shall contain the following documentation of the minimum endodontic clinical experiences and documentation of the endodontic portfolio competency examination:

(1) Evidence of successful completion of the endodontic clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the candidate's portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the endodontic competency examination. For purpose of this section, satisfactory proof means the endodontic competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements. The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The endodontic examination shall include:

(1) Ten (10) scoring factors:

(A) Pretreatment Clinical Testing and Radiographic Imaging;

(B) Endodontic Diagnosis;

(C) Endodontic Treatment Plan;

(D) Anesthesia and Pain Control;

(E) Caries Removal, Removal of Failing Restorations, Evaluation of Restorability, Site Isolation;

(F) Access Opening;

(G) Canal Preparation Technique;

(H) Master Cone Fit;

(I) Obturation Technique;

(J) Completion of Case.

(2) One (1) clinical case.

(3) Documentation the candidate applied case selection criteria for endodontic case. The portfolio shall contain evidence the case selected met the American Association of

~~Endodontics case criteria for minimum difficulty such that treated teeth have uncomplicated morphologies, have signs and symptoms of swelling and acute inflammation and have not had previously completed or initiated endodontic therapy. The documentation shall include:~~

~~(A) The determination of the diagnostic need for endodontic therapy;~~

~~(B) Charting and diagnostic testing;~~

~~(C) A record of radiographs performed on the patient and an interpretation of the~~

~~(D) Evidence of a pulpal diagnosis within approved parameters, including consideration and determination following the pulpal diagnosis that it was within the approved parameters. The approved parameters for pulpal diagnosis shall be normal pulp, reversible pulpits, irreversible pulpits, and necrotic pulp.~~

~~(E) Evidence of a periapical diagnosis within approved parameters, including consideration and determination following the periapical diagnosis that it was within the approved parameters. The approved parameters for periapical diagnosis shall be normal periapex, asymptomatic apical periodontitis, symptomatic apical periodontitis, acute apical abscess, and chronic apical abscess.~~

~~(F) Evidence of development of an endodontic treatment plan that included trauma treatment, management of emergencies, and referrals when appropriate. An appropriate treatment plan may include an emergency treatment due to a traumatic dental injury or for relief of pain or acute infection. The endodontic treatment may be done at a subsequent appointment.~~

~~(4) Documentation the candidate performed pretreatment preparation for endodontic treatment. The documentation shall include:~~

~~(A) Evidence the patient's pain was competently managed.~~

~~(B) Evidence the caries and failed restorations were removed.~~

~~(C) Evidence of determination of tooth restorability.~~

~~(D) Evidence of appropriate isolation with a dental dam.~~

~~(5) Documentation the candidate competently performed access opening. The documentation shall include:~~

~~(A) Evidence of creation of the indicated outline form.~~

~~(B) Evidence of creation of straight line access.~~

~~(C) Evidence of maintenance of structural integrity.~~

(D) Evidence of completion of un-roofing of pulp chamber.

(E) Evidence of identification of all canal systems.

(6) Documentation the candidate performed proper cleaning and shaping techniques. The documentation shall include:

(A) Evidence of maintenance of canal integrity.

(B) Evidence of preservation of canal shape and flow.

(C) Evidence of applied protocols for establishing working length.

(D) Evidence of demonstration of apical control.

(E) Evidence of applied disinfection protocols.

(7) Documentation of performance of proper obturation protocols, including selection and fitting of master cone, determination of canal condition before obturation, and verification of sealer consistency and adequacy of coating.

(8) Documentation of demonstrated proper length control of obturation, including achievement of dense obturation of filling material and obturation achieved to a clinically appropriate height for the planned definitive coronal restoration.

(9) Documentation of a competently completed endodontic case, including evidence of an achieved coronal seal to prevent recontamination and creation of diagnostic, radiographic, and narrative documentation.

(10) Documentation of provided recommendations for post-endodontic treatment, including evidence of recommendations for final restoration alternatives and recommendations for outcome assessment and follow-up.

(11) Patient Management. The candidate shall be familiar with the patient's medical and dental history.

(12) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(c) Acceptable Criteria for Endodontics Competency Examination. The procedure shall be performed on any tooth to completion by the same candidate on the same patient. A "completed case" means a tooth with an acceptable and durable coronal seal.

(d) Competency Examination Scoring. The scoring system used for the endodontics competency examination is defined as follows:

(1) A score of 0 is unacceptable; candidate exhibits a critical error.

(2) A score of 1 is unacceptable; major deviations that are correctable.

(3) A score of 2 is acceptable; minimum competence.

(4) A score of 3 is adequate; less than optimal.

(5) A score of 4 is optimal.

A score rating of "2" shall be deemed the minimum competence level performance.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1632.1, Business and Professions Code.

§ 1032.8. Portfolio Examination: Periodontics.

(a) The portfolio examination shall contain the following documentation of the minimum periodontic clinical experiences and documentation of the periodontic portfolio competency examination:

(1) Evidence of successful completion of the periodontic clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the candidate's portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the periodontic competency examination. For purpose of this section, satisfactory proof means the periodontic competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements. The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The periodontic competency examination shall include:

(1) One (1) case to be scored in three parts, as follows:

(A) Part A: Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, and treatment plan;

(B) Part B: Calculus detection and effectiveness of calculus removal; and

(C) Part C: Periodontal re-evaluation.

~~(2) Nine (9) scoring factors:~~

~~(A) Review Medical and Dental History (Part A);~~

~~(B) Radiographic Findings(Part A);~~

~~(C) Comprehensive Periodontal Data Collection (Part A);~~

~~(D) Evaluate Periodontal Etiology/Risk Factors (Part A);~~

~~(E) Comprehensive Periodontal Diagnosis (Part A);~~

~~(F) Treatment Plan (Part A);~~

~~(G) Calculus Detection (Part B);~~

~~(H) Effectiveness of Calculus Removal (Part B); and~~

~~(I) Periodontal Re-evaluation (Part C).~~

~~(3) All three parts of the examination shall be performed on the same patient. In the event the patient does not return for periodontal re-evaluation (Part C), the student shall use a second patient for the completion of the periodontal re-evaluation (Part C) portion of the periodontic competency examination.~~

~~(4) Documentation the candidate performed a comprehensive periodontal examination. The documentation shall include:~~

~~(A) Evidence that the patient's medical and dental history was reviewed.~~

~~(B) Evidence that the patient's radiographs were evaluated.~~

~~(C) Evidence of performance of an extra-oral and intra-oral examination on the patient.~~

~~(D) Evidence of performance of comprehensive periodontal data collection. Evidence shall include evaluation of patient's plaque index, probing depths, bleeding on probing, suppurations, cementoenamel junction to the gingival margin (CEJ-GM), clinical attachment, furcations, and tooth mobility.~~

~~(E) Evidence of performance of an occlusal assessment.~~

~~(5) Documentation the candidate diagnosed and developed a periodontal treatment plan. The documentation shall include:~~

~~(A) Evidence of determination of periodontal diagnosis.~~

~~(B) Evidence of formulation of an initial periodontal treatment plan that demonstrates~~

~~(i) Determination of periodontal diagnosis.~~

~~(ii) Formulation of an initial periodontal treatment plan that demonstrates the following:~~

~~(a) Determination to treat or refer patient to periodontist or periodontal surgery;~~

~~(b) Discussion with patient regarding etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient-specific oral hygiene instructions;~~

~~(c) Determination on non-surgical periodontal therapy;~~

~~(d) Determination of re-evaluation need; and~~

~~(e) Determination of recall interval.~~

~~(6) Documentation of performance of non-surgical periodontal therapy. The documentation shall include:~~

~~(A) Detected supragingival and subgingival calculus;~~

~~(B) Performance of periodontal instrumentation, including:~~

~~(i) Removed calculus;~~

~~(ii) Removed plaque; and~~

~~(iii) Removed stains;~~

~~(C) Demonstration that excessive soft tissue trauma was not inflicted; and~~

~~(D) Demonstration that anesthesia was provided to the patient.~~

~~(7) Documentation of performance of periodontal re-evaluation. The documentation shall include:~~

~~(A) Evidence of evaluation of effectiveness of oral hygiene;~~

~~(B) Evidence of assessment of periodontal outcomes, including:~~

~~(i) Review of the patient's medical and dental history;~~

~~(ii) Review of the patient's radiographs;~~

~~(iii) Performance of comprehensive periodontal data collections (e.g. evaluation of plaque index, probing depths, bleeding on probing, suppurations, cementoenamel junction to the gingival margin (CEJ-GM), clinical attachment level, furcations, and tooth mobility.~~

~~(C) Evidence of discussion with patient regarding current periodontal status as compared to the pre-treatment status, patient-specific oral hygiene instructions, and modifications of specific risk factors;~~

~~(D) Evidence of determination of further periodontal needs including the need for referral to a periodontist and periodontal surgery; and~~

~~(E) Evidence of establishment of a recall interval for periodontal treatment.~~

~~(c) Acceptable Patient Criteria for Periodontics Competency Examination:~~

~~(1) The examination, diagnosis, and treatment planning shall include:~~

~~(A) A patient with a minimum of twenty (20) natural teeth, with at least four (4) molars;~~

~~(B) At least one probing depth of five (5) mm or greater shall be present on at least four (4) of the teeth, excluding third molars, with at least two of these teeth with clinical attachment loss of 2 mm or greater;~~

~~(C) A full mouth assessment or examination~~

~~(D) The patient shall not have had previous periodontal treatment at the dental school where the examination is being conducted. Additionally, the patient shall not have had previous non-surgical or surgical periodontal treatment within the past six (6) months.~~

~~(2) Calculus detection and periodontal instrumentation (scaling and root planing) shall include:~~

(A) A patient with a minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which shall be a molar. Third molars may be used if they are fully erupted.

(B) At least one probing depth of five (5) mm or greater shall be present on at least two (2) of the teeth that require scaling and root planing.

(C) A minimum of six (6) surfaces of clinically demonstrable subgingival calculus shall be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus shall be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual. If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.

(3) Re-evaluation shall include:

(A) A thorough knowledge of the patient's case;

(B) At least two (2) quadrants of scaling and root planing on the patient being reevaluated.

(C) At least two documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing shall be completed within an interval of 6 weeks or less.

(D) A patient with a minimum twenty (20) natural teeth with at least four (4) molars.

(E) Baseline probing depth of at least five (5) mm on at least four (4) of the teeth, excluding third molars.

(d) Competency Examination Scoring. The scoring system used for the periodontics competency examination is defined as follows:

(1) A score of 0 is unacceptable; candidate exhibits a critical error

(2) A score of 1 is unacceptable; major deviations that are correctable

(3) A score of 2 is acceptable; minimum competence

(4) A score of 3 is adequate; less than optimal

(5) A score of 4 is optimal

A score rating of “2” shall be deemed the minimum competence level performance.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1632.1, Business and Professions Code.

§ 1032.9. Portfolio Examination: Competency Examiner Qualifications.

(a) Portfolio competency examiners shall meet the following criteria:

(1) An examiner shall be full-time or part-time faculty member of a Board-approved California dental school.

(2) An examiner shall have a minimum of one (1) year of previous experience in administering clinical examinations.

(3) An examiner shall undergo calibration training in the Board’s standardized evaluation system through didactic and experiential methods as established in section 1032.10. Portfolio competency examiners are required to attend Board-developed standardized calibration training sessions offered at their schools prior to administering a competency examination and annually thereafter.

(b) At the beginning of each school year, each school shall submit to the Board the names, credentials and qualifications of the dental school faculty to be approved or disapproved by the Board as portfolio competency examiners. Documentation of qualifications shall include a letter from the dean of the California dental school stating that the dental school faculty satisfies the criteria and standards established by the dental school to conduct portfolio competency examinations in an objective manner, and has met the requirements of subdivision (a)(1) through (a)(3) of this section.

(c) In addition to the names, credentials and qualifications, the dean of the California dental school shall submit documentation that the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board’s requirements established in section 1032.10.

(d) Any changes to the list of portfolio competency examiners shall be reported to the Board within thirty (30) days, including any action taken by the school to replace an examiner.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1632.1, Business and Professions Code.

§ 1032.10. Portfolio Examination: Competency Examiner Training Requirements.

(a) Prospective portfolio competency examiners are required to attend Board-developed standardized calibration training sessions offered at their schools prior to administering a competency examination. Each of the schools will designate faculty who have been approved by the Board to serve as competency examiners and is responsible for administering the Board developed calibration course for said examiners. Examiners may grade any competency examination in which they have completed the required calibration. Each training session shall be presented by designated Portfolio competency examiners at their respective schools and require the prospective examiners to participate in both didactic and hands-on activities.

(b) Didactic Training Component. During didactic training, designated Portfolio competency examiners shall present an overview of the examination and its evaluation (grading) system through lecture, review of examiner training materials, including slide presentations, sample documentation, and sample cases.

(c) Hands-On Component. Training shall include multiple examples of performance that clearly relate to the specific judgments that examiners are expected to provide during the portfolio competency examinations. Hands-on training sessions include an overview of the rating process, clear examples of rating errors, examples of how to mark the grading forms, a series of several sample cases for examiners to hone their skills, and opportunities for training staff to provide feedback to individual examiners.

(d) Calibration of Examiners. The calibration of portfolio competency examiners shall be conducted to maintain common standards as an ongoing process. Portfolio competency examiners shall be provided feedback about their performance and how their scoring varies from their fellow examiners. Portfolio competency examiners whose error rate exceeds psychometrically accepted standards for reliability shall be re-calibrated. A school shall notify the Board if, at any time, it is determined that a competency examiner is unable to meet the Board's calibration standards. If any portfolio competency examiner is unable to be re-calibrated, the Board shall disapprove the portfolio competency examiner from further participation in the portfolio examination process.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1632.1, Business and Professions Code.

§ 1033.1. General Procedures and Policies for Portfolio Examination.

The following rules, which are in addition to any other examination rules set forth elsewhere in this chapter, are adopted for the uniform conduct of the portfolio examination.

(a) The candidate shall be able to read and interpret instructions and examination material as part of the examination.

(b) A patient shall be in a health condition acceptable for dental treatment. If conditions indicate a need to consult the patient's physician or for the patient to be premedicated (e.g. high blood pressure, heart murmur, rheumatic fever, heart condition, prosthesis), the candidate must obtain the necessary written medical clearance and/or, evidence of premedication before the patient will be accepted. If the patient's well-being is put into jeopardy at any time during the portfolio competency examination, the examination shall be terminated. The candidate shall fail the examination, regardless of performance on any other part of the examination.

(c) The use of local anesthetics shall be administered according to the school's protocol and standards of care. The type and amount of anesthetics shall be consistent with the patient's medical history and current condition.

(d) A candidate may be dismissed from the entire examination, and a statement of issues may be filed against the candidate, for acts which interfere with the board's objective of evaluating professional competence. Such acts include, but are not limited to the following:

(1) Allowing another person to take the portfolio examination in the place of, and under the identity of, the candidate.

(2) Presenting purported carious lesions which are artificially created, whether or not the candidate created the defect.

(3) Presenting radiographs which have been altered, or contrived to represent other than the patient's true condition, whether or not the misleading radiograph was created by the candidate.

(4) Bringing any notes, textbooks, unauthorized models, periodontal charting information or other informative data into the clinic during any portfolio competency examination.

(5) Assisting another candidate during the portfolio examination process.

(6) Failing to comply with the board's infection control regulations. Candidates shall be responsible for maintaining all of the standards of infection control while treating patients. This shall include the appropriate sterilization and disinfection of the cubicle, instruments and handpieces, as well as, the use of barrier techniques (including glasses, mask, gloves, proper attire, etc.) as required by the California Division of Occupational Safety and Health (Cal/OSHA) and California Code of Regulations, Title 16, Section 1005.

(7) Treating a patient, or causing a patient to receive treatment outside the designated examination settings and timeframes.

(e) Candidates shall wear personal protective equipment (PPE) during the portfolio competency examinations. PPE shall include masks, gloves, and eye protection during each portfolio competency examination.

(f) Radiographs for each of the portfolio competency examinations shall be of diagnostic quality. Digital or conventional radiographs may be used.

(g) Dental dams shall be used during endodontic treatment and the preparation of amalgam and composite restorations. Finished restorations shall be graded without the dental dam in place.

(h) Candidates shall provide clinical services upon patients of record of the dental school who fulfill the acceptable criteria for each of the six (6) portfolio competency examinations.

(i) Candidates shall be allowed three (3) hours and thirty (30) minutes for each patient treatment session.

(j) Each portfolio competency examination shall be performed by the candidate without faculty intervention. Completion of a successful portfolio competency examination may be counted as a clinical experience for the purpose of meeting the requirements of section 1032.2.

(k) Candidates who fail a portfolio competency examination three (3) times shall not be permitted to retake the portfolio competency examination until remediation has been completed as specified in section 1036.

(l) Readiness for a candidate to take a portfolio competency examination shall be determined by the dental school's clinical faculty.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and 1632.1, Business and Professions Code.

§ 1034. Portfolio Competency Examination Grading.

This section shall apply, in addition to any other examination rules set forth in this Chapter, for the purpose of uniform conduct of the portfolio examination grading.

(a) Each portfolio competency examination shall be graded by two (2) independent portfolio competency examiners and shall use the Board's standardized scoring system as specified in subdivision (f) of this section. There shall be no communication between grading examiners.

~~(b)~~

~~(c) A candidate shall be deemed to have passed the portfolio competency examination if his or her overall scaled score is at least 75 in each of the portfolio competency examinations.~~

~~(d) The Board shall notify candidates who have passed or failed the portfolio examination.~~

~~(e) Each portfolio competency examination shall be signed by the school portfolio competency examiners who performed the grading.~~

~~(f) Competency Examination Scoring: The portfolio competency examiners shall use the following scoring system for each of the competency examinations:~~

~~(1) The scoring system used for the ODTP competency examination as specified in Section 1032.3(d).~~

~~(2) The scoring system used for the direct restoration competency as specified in Section 1032.4(d).~~

~~(3) The scoring system used for the indirect restoration competency examination as specified in Section 1032.5(d).~~

~~(4) The scoring system used for the removable prosthodontics competency examination as specified in Section 1032.6(d).~~

~~(5) The scoring system used for the endodontics competency examination as specified in Section 1032.7(d).~~

~~(6) The scoring system used for the periodontics competency examination as specified in Section 1032.8(d).~~

~~(g) If a candidate commits a critical error, the candidate shall not proceed with the portfolio competency examination. If the candidate makes a critical error at any point during a portfolio competency examination, a score of "0" shall be assigned and the portfolio competency examination shall be terminated immediately.~~

~~NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, 1632.1 and 1634, Business and Professions Code.~~

§ 1035. Examination Review Procedures; Appeals.

(a) An candidate who has failed an examination administered pursuant to subdivision (b) of Section 1632 of the Code shall be provided with notice, upon written request, of those areas in which he/she is they were deficient.

(b) An unsuccessful candidate who has been informed of the areas of deficiency in his/her their performance and who has determined that one or more of the following errors was made during the course of his/hertheir examination and grading may appeal to the Bboard within sixty (60)fifteen (15) days following receipt of his/hertheir examination results:

(1) Significant procedural error in the examination process.;

(2) Evidence of adverse discrimination.;

(3) Evidence of substantial disadvantage to the candidate.

(c) TheSuch appeal provided in subsection (b) shall be made by means of a written letter specifying the grounds upon which the appeal is based. The Bboard's designee shall respond to the appeal in writing and may request a personal appearance by the candidate. The Bboard shall thereafter take such action as it deems appropriate.

(c) This section shall not apply to the portfolio examination of a candidate's competence to enter the practice of dentistry.

NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.

§ 1036.01. Remedial Education: Portfolio Competency Examinations.

A candidate, who fails to pass a portfolio competency examination after three attempts, shall not be eligible for further re-examination until the candidate has successfully completed the required additional education as specified in Section 1633(b) of the Business and Professions Code.

(a) The course work shall be taken at a dental school approved by the Commission on Dental Accreditation or a comparable organization approved by the Board, and shall be completed within a period of one year from the date of notification of the applicant's third failure.

(1) The course of study must be didactic, laboratory or a combination of the two. Use of patients is optional.

(2) Instruction must be provided by a faculty member of a dental school approved by the Commission on Dental Accreditation or a comparable organization approved by the Board.

~~(3)) Pre-testing and post-testing must be part of the course of study.~~

~~(b) When an applicant applies for reexamination, he or she shall furnish evidence of successful completion of the remedial education requirements for reexamination.~~

~~(1) Evidence of successful completion must be on the "Certification of Successful Completion of Remedial Education for Portfolio Competency Re-Examination requirements for re-examination Eligibility" (Form New 08/13), that is hereby incorporated by reference, that is submitted prior to the examination.~~

~~(2) The form must be signed and sealed by the Dean of the dental school providing the remedial education course.~~

~~NOTE: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632.5, Business and Professions Code.~~

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
P (916) 263-2300 F (916) 263-2140 | www.dbc.ca.gov

APPLICATION FOR LICENSURE TO PRACTICE DENTISTRY (WREB)

FEES

Application Fee: $100.00
Fingerprint Fee: $51.00
(Livescan applicants pay fee at time of service)

ALL FEES ARE NON-REFUNDABLE

For Office Use Only

ATS# _____
REC# _____
Fee Pd _____

Date Cashiered _____

For Office Use Only

Received

QM		Reviewed By:		FP		DC	
Conf Sent		WREB score		NB		LC	
		CBT		SCH			
Def Sent		Notify		CODE		Law	P/F
DOJ		FBI		YG		Ethics	P/F
ATI		ENF					

For Office Use Only

(Please type or print neatly)

1. LEGAL NAME: LAST FIRST MIDDLE | U.S. Social Security Number

2. List other names you have used:

3. Address: Street City State Zip Code

4. Mailing Address: Street City State Zip Code

5. Birthdate MM/DD/YR | Sex: Male ☐ Female ☐ | TELEPHONE NUMBER: Day Evening

6. Do you have a certified disability or condition that requires special accommodations for testing? YES ☐ NO ☐
   If yes, fax the Board for a "REQUEST FOR ACCOMODATION" packet.
7. Have you previously taken the California Law and Ethics Examination? YES ☐ NO ☐
8. Have you ever been issued a dental license in any State or Country? YES ☐ NO ☐
   If yes, a Certification of License must be submitted for each State/country

STATE OR COUNTRY	LICENSE NUMBER	ISSUE DATE

~~Passport style Photograph~~

33A-22W (revised 11/06)

9. DENTAL EDUCATION:

Name and Location of institution(s) attended

Period(s) of attendance (show MM/YYYY)

Degree, Diploma granted DATE GRANTED

☐ D.D.Sc. ☐ D.D.S. ☐ D.M.D. ☐ Other (please specify)

10. POSTGRADUATE STUDY:

Name and Location of Institution(s) attended

Period(s) of attendance (show dates MM/YYYY)

Are you a Diplomate? YES ☐ NO ☐

Name of Specialty Board

11. CERTIFICATION OF DEAN OF DENTAL COLLEGE GRANTING DEGREE:

I HERE BY CERTIFY THAT _____
Full Name of Student

matriculated in the _____
Name of University

Dental College the _____ day of _____ and attended _____ years,

Has completed the clinic and didactic requirements and

☐ HAS GRADUATED, OR ☐ WILL GRADUATE OR ☐ IS EXPECTED TO GRADUATE* with the

Degree of ☐ D.D.Sc., ☐ D.D.S., ☐ D.M.D. on the _____ day of _____ _____

_____
SIGNATURE OF DEAN

***The Dean must certify actual graduation, if certification is signed that applicant will graduate or is expected to graduate. Certification must be completed on official school letterhead including the Dean's signature and seal of the Dental School.**

12. Do you have any pending of have you ever had any disciplinary action taken or changes filed against a dental license of other healing arts license? Include any disciplinary actions taken by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity

Disciplinary action includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction of action taken against a dental license. If yes, provide a detailed explanation and a copy of all documents relating to the disciplinary action.

Yes ☐ No ☐

13. Are there any pending investigations by any State or Federal agencies against you?

If yes, provide a detailed explanation of circumstances surrounding the investigation and a copy of the document(s).

Yes ☐ No ☐

14. Have you ever been denied a dental license or permission to take a dental examination?

If yes, provide a detailed explanation of circumstances surrounding the denial and a copy of the document(s).

Yes ☐ No ☐

15. Have you ever surrendered a license, either voluntarily of otherwise?

If yes, provide a detailed explanation and a copy of all documents relating to the surrender.

Yes ☐ No ☐

16. Are you in default on a United States Department of Health Services education loan pursuant to Section 685 of the Code?

If yes, provide a detailed explanation.

Yes ☐ No ☐

17. With the exception of a conviction for an infraction resulting in a fine of less than $300, have you ever been convicted of any crime, including an infraction, misdemeanor or felony?

"Conviction" includes a plea of no contest and any conviction that been set aside pursuant to Section 1203.4 of the Penal code. Therefore, you must disclose any convictions in which you entered a plea of no contest and any convictions that were subsequently set aside pursuant to Section 1203.4 of the Penal Code.

If yes, provide a detailed explanation and a copy of all documents relating to the conviction(s).

Yes ☐ No ☐

19. Executed in _____ (City), on the _____ Day of _____ ,20 _____

I am the applicant for licensure referred to in this application. I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely.

I certify under penalty of perjury under the laws of the State of California that the information I provided to the Board in this application is true and correct to the best of my knowledge and belief.

_____ Date

_____ Signature of Applicant

Important Information: You must report to the Board the results of any actions which have been filed or were pending against any dental license you hold at the filing of this application. Failure to report this information may result in the denial of your application or subject your license to discipline pursuant to Section 480 (c) of the Business & Professions Code.

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 2005 Evergreen Street, Suite 1550 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. Your name and address listed on this application will be disclosed to the public upon request if and when you become licensed.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
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 DETERMINATION OF LICENSURE ELIGIBILITY (PORTFOLIO)

FEES	FOR OFFICE USE ONLY	DATE RECEIVED
Application Fee: $350.00 Fingerprinting: All applicants are required to submit via Live Scan. Applicants will pay a fee of $49.00 plus any additional costs for the rolling of fingerprints by the Live Scan agency.	ID NUMBER _____ Receipt Number _____ Fee Paid _____ Date Cashiered _____	

(Please print or type)

1. United States Social Security Number		2. Birth Date (MM/DD/YYYY)	
3.Legal Name: Last		First	Middle
4. List any other names used:			
5. Mailing Address(The address you enter is public information and will be placed on the Internet pursuant to B & P Code 27):			
6. Alternate Address(If you do not want your home or work address available to the public, provide an alternate address):			
7. Home/Cellular Telephone (Include area code):		8. Gender: Male ☐ Female ☐	
9. Have you previously taken the California Dentistry Law and Ethics Examination		Yes	No
10. Do you have a certified disability or condition that requires special accommodations for testing? If yes, fax the Board for a "REQUEST FOR ACCOMMODATION" packet.		Yes ☐	No ☐
11. Have you been issued a dental license in any State or Country? If yes, a Certification of License must be submitted for each State/Country		Yes ☐	No ☐
State/Country:	License Number:	Issue Date:	

Passport Style Photograph

Tape photo here

FOR OFFICE USE ONLY

12. DENTAL EDUCATION:

_____

Name and Location of Institution(s) attended

_____ Date Graduated _____

Period(s) of attendance (show MM/YYYY)

Degree, Diploma granted: ☐ D.D.Sc. ☐ D.D.S. ☐ D.M.D. ☐ Other (please specify) _____

14.CERTIFICATION OF DEAN OF DENTAL COLLEGE GRANTING DEGREE:

I HEREBY CERTIFY THAT _____

FULL NAME OF STUDENT

matriculated in the _____

NAME OF UNIVERSITY

Dental College the _____ day of _____ and attended _____ years. Has completed the clinic and didactic requirements and is in good academic standings with no pending ethical issues and ☐ HAS GRADUATED, ☐ WILL GRADUATE* OR ☐ IS EXPECTED TO GRADUATE* with degree of ☐ D.D.Sc., ☐ D.D.S., ☐ D.M.D. on the _____ day of _____, 20_____.

SEAL OF COLLEGE OR UNIVERSITY

_____

SIGNATURE OF DEAN

*The Dean must certify actual graduation, if certification is signed that the student will graduate or is expected to graduate. Certification must be completed on official school letterhead including certification by the Dean that there are no pending ethical issues, the Dean's signature and seal of the Dental School.

15. Do you have any pending or have you ever had any disciplinary action taken or charges filed against a dental license or other healing arts license, pursuant to California Code of Regulations, Title 16, Section 1028(b)(11)? Include any disciplinary actions taken by the U.S. Military, U.S. Public Health Service or other U.S. Federal Government entity, pursuant to California Code of Regulations, Title 16, Section 1028(b)(12). Disciplinary action includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction or action taken against a dental license. If yes, provide a detailed explanation and a copy of all documents relating to the disciplinary action, pursuant to California Code of Regulations, Title 16, Section 1028(b)(12).	Yes ☐ No ☐
16. Are there any pending investigations by any State or Federal agencies against you? If yes, provide a detailed explanation of the circumstances surrounding the investigation and a copy of the document(s), pursuant to California Code of Regulations, Title 16, Section 1028(b)(13).	Yes ☐ No ☐
17. Have you ever been denied a dental license or permission to take a dental examination? If yes, provide a detailed explanation of the circumstances surrounding the denial and a copy of the document(s), pursuant to California Code of Regulations, Title 16, Section 1028(b)(14).	Yes ☐ No ☐
18. Have you ever surrendered a license, either voluntarily or otherwise? If yes, provide a detailed explanation and a copy of all documents relating to the surrender pursuant to California Code of Regulations, Title 16, Section 1028(b)(15).	Yes ☐ No ☐
19. Are you in default on a United States Department of Health Services education loan pursuant to Section 685 of the code? (Cal. Code of Regs., Title 16, Section 1028(b)(17)). If yes, provide an explanation.	Yes ☐ No ☐
20. Have you ever been convicted of any crime including infractions, misdemeanors and felonies, with the exception of an infraction with a fine of less than $1,000 that did not involve alcohol or drugs? Information as to whether the applicant has ever been convicted of any violation of the law in this or any other state, the United States or other county, omitting traffic infractions under $1,000.00 not involving alcohol, dangerous drugs, or controlled substances, pursuant to California Code of Regulations, Title 16, Section 1028(b)(16). "Conviction" means a plea or verdict of guilty or a conviction following a please of nolo contendere or "no contest" and any conviction that has been set aside or deferred pursuant to Sections 1000 or 1203.4 of the Penal Code, including infractions, misdemeanors, and felonies. (Cal. Code of Regs., Title 16, Section 1028(b)(16)). If yes, provide a detailed explanation and a copy of all documents relating to the conviction(s).	Yes ☐ No ☐

21. Executed in _____, on the _____day of _____, 20 _____
City

I am the applicant for licensure referred to in this application. I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely.

I certify under penalty of perjury under the laws of the State of California that the information I provided to the Board in this application is true and correct to the best of my knowledge and belief.

_____ _____
Date Signature of Applicant

Important Information: You must report to the Board the results of any actions which have been filed or were pending against any dental license you hold at the filing of this application. Failure to report this information may result in the denial of your application or subject your license to discipline pursuant to Section 480(c) of the Business & Professions Code.

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by the Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 92815, 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. Your name and address listed on this application will be disclosed to the public upon request if and when you become licensed.

STATE OF CALIFORNIA
oca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS CONSUMER SERVICES AND HOUSING AGENCY • GOVERNOR EDMUND G BROWN JR
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 Issuance of License Number and Registration of Place of Practice*

Business & Professions Code §§ 1650

OFFICE USE ONLY

Date Application Received

OFFICE USE ONLY

ATS#_____

Rec#_____

Fee Paid _____

Date cashiered _____

Date License mailed _____

License# _____

Complete this form to obtain your license. Please print legibly.

Name _____ Last _____ First _____

Address of Record (will be public information)

Street and Number _____

City _____ State _____ Zip Code _____

Address of Practice, if different
Street and Number _____

City _____ State _____ ZIP Code _____

***Note: If you do not yet have a practice address in California, you may leave this section blank. However, if and when you do have a practice address in California, you must report it to the Board immediately.**

Telephone number (__,)_____ Email address (optional) _____

Applicant's File Number issued by Dental Board of California _____

Certification

I certify under penalty of perjury under the laws of the State of California that the information I provided to the Board in this application is true and correct.

_____ Date

_____ Signature of Applicant

The information requested herein is mandatory unless designated as optional and is maintained by Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, Executive Officer, 916-263-2300, in accordance with Business & Professions Code, §1600 et seq.

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. 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 names(s) and address(es) submitted may, under limited circumstances, be made oublic.

Rev(1 1/07)

Dental Board of California

Initial Dental License Fee Calculation

Business & Professions Code §1715.

Your first license fee will be pro-rated. California dental licenses expire every two years on the last day of the month of your birthday.

For example, if your birthday is June 14. 1982 (an even year), your license will expire:

June 30, 2018
June 30, 2020, etc.

However, if your birthday is June 14. 1983 (an odd year), your license will expire:

June 30, 2019
June 30, 2021, etc.

To calculate the fee for your initial (pro-rated) license:

1. Count the number of months between the day you send payment until the date your license will expire. If you send payment on the 15th day of the month or later, do not count that month.

2. Find that number below to know your initial license fee.

# of months	Initial license fee
1*	
2**	
3	$81.25
4	$108.33
5	$135.42
6	$162.50
7	$189.58
8	$216.67
9	$243.75
10	$270.83
11	$297.92
12	$325.00
13	$352.08
14	$379.17
15	$406.25
16	$433.33
17	$460.42
18	$487.50
19	$514.58
20	$541.67
21	$568.75
22	$595.83
23	$622.92
24	$650.00
25*	$677.09
26**	$704.17

If you need assistance calculating your initial license fee, call the Licensing Unit at 916-263-2300.

*If the number of months until your birthday is 1, use the $ amount for 25 months.
**If the number of months until your birthday is 2, use the $ amount for 26 months.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR
DENTAL BOARD OF CALIFORNIA
1432 Howe Avenue, Suite 85, Sacramento, CA 95825
P (916) 263-2300 F (916) 263-2140 | www.dbc.ca.gov

APPLICATION FOR LAW AND ETHICS EXAMINATION

For Office Use Only	*For Office Use Only*
ATS#_____	**Received**

No Fee Required

(Please type or print neatly)

1. LEGAL NAME: _____
LAST FIRST MIDDLE

2. ADDRESS _____
Street City State Zip Code

3. TELEPHONE NUMBER (____)_____ (____)_____
Evening Day

4. Do you have a disability or condition that requires special accommodations? YES NO
If yes, email db_examinations@dca.ca.gov for a "REQUEST FOR ACCOMMODATION" packet.

5. Preferred Examination: Northern California □ Southern California □ Month: _____

_____ _____
Date Signature of Applicant

6. CERTIFICATION OF DEAN OF DENTAL COLLEGE GRANTING DEGREE:
(Must be completed or application will be returned)

I HEREBY CERTIFY THAT_____
Full Name of Student

matriculated in the _____
Name of University

Dental College the _____day of _____and attended _____years,

has completed the clinic and didactic requirements and

HAS GRADUATED, OR WILL GRADUATE OR IS EXPECTED TO GRADUATE
with the degree of:

Circle One D.D.Sc., D.D.S., D.M.D.

on the _____day of _____, 20_____.

(SEAL OF COLLEGE OR UNIVERSITY)

_____
SIGNATURE OF DEAN

12/07

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
Dental Board of California
2005 Evergreen Street, Suite 1550, Sacramento, California 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

CERTIFICATION OF SUCCESSFUL COMPLETION OF REMEDIAL EDUCATION FOR PORTFOLIO COMPETENCY RE-EXAMINATION ELIGIBILITY

Candidate Name: _____

Candidate Number: _____

Competency Examination Subject Remediated (Please mark all that apply)

Competency	Type of Course* (Circle)	Date Completed	Signature of Faculty
Oral Diagnosis and Treatment Planning	D L C		
Periodontics	D L C		
Endodontics	D L C		
Direct Restorations	D L C		
Indirect Restorations	D L C		
Removable Prosthodontics	D L C		

*Type of Course D=Didactic L=Labo atory C=Clinical

Guidelines for Remedial Education

- Course of study must be a minimum of 50 hours for each competency failed three (3) times.
- Course work must be completed prior to re-examination of the competency.
- Course of study must b didactic and/or laboratory. Use of patients is optional.
- Instruction must be provided by a faculty member(s) of an approved dental school.
- Pre-testing and post-testing must be a part of the course of study to ensure the pr gram has been effective in improving knowledge and skills.

Summary of Requirement

An applicant who fails to pass the examination required by Section 1632 of the Business and Professions Code after three (3) attempts shall not be eligible for further reexamination until the applicant has successfully completed a minimum of 50 hours of education for each subject which the applicant failed in the examination. The coursework shall be taken at a dental school approved by either the Commission on Dental Accreditation or a comparable organization approved by the board, and shall be completed within one year from the date of notification of the applicant's third failure.

Form New (08/13)

Dental Board of California
Licensure By Examination (CCR 1021(a))
Licensing Workload (Costs - Paper Based)

Workload Tasks	Per Application	Minutes per Application	MST	SSA	AGPA	SSMI
Receive Application and assign to staff	1	15	0	0	15	0
Process Application/Communicate Deficiencies to Applicant	1	75	0	75	0	0
Respond to Inquiries	1	60	0	60	0	0
Confirm Completeness of Application and Background Checks	1	60	0	60	0	0
Final Review	1	30	0	0	0	30
Cashiering and Data Entry	1	20	20	0	0	0
Issuing License	1	30	0	30	0	0
Minutes per Classification:			20	225	15	30
Hours per Classification:			0.3	3.8	0.3	0.5
Costs per Classification:			$30	$370	$28	$62
Total Costs:			**$490**			

MST: Management Services Technician - $92 per hour (includes benefits, OE&E and DCA distributed administration)
SSA: Staff Services Analyst - $97 per hour (includes benefits, OE&E, and DCA distributed administration)
AGPA: Associate Governmental Program Analyst - $112 per hour (includes benefits, OE&E, and DCA distributed administration)
SSMI: Staff Services Manager I - $122 per hour (includes benefits, OE&E, and DCA distributed administration)

Dental Board of California
Licensure By Examination (CCR 1021(a))
Licensing Workload (Costs - Online)

Workload Tasks	Per Application	Minutes per Application	MST	SSA	AGPA	SSMI
Receive Application and assign to staff	1	15	0	0	15	0
Process Application/Communicate Deficiencies to Applicant	1	75	0	75	0	0
Respond to Inquiries	1	60	0	60	0	0
Confirm Completeness of Application and Background Checks	1	60	0	60	0	0
Final Review	1	30	0	0	0	30
Download and Print Applications and Attachments	1	20	20	0	0	0
Issuing License	1	30	0	30	0	0
Minutes per Classification:			20	225	15	30
Hours per Classification:			0.3	3.8	0.3	0.5
Costs per Classification:			$30	$370	$28	$62
Total Costs:			**$490**			

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Dental Board of California
Licensure By Examination (CCR 1021(a)(c))
Law & Ethics Examination App Workload (Costs - Paper Base)

Workload Tasks	Per Application	Minutes per Application	MST	SSA	AGPA
Assign work to staff	1	15	0	0	15
Receive and Process Application/Communicate Deficiencies to Applicant	1	30	0	30	0
Respond to Inquiries	1	30	0	30	0
Confirm Completeness of Application and Supporting Documentation	1	15	0	15	0
Cashiering and Data Entry	1	20	20	0	0
Minutes per Classification:			20	75	15
Hours per Classification:			0.3	1.3	0.3
Costs per Classification:			$31	$121	$28
Total Costs:				**$180**	

MST: Management Services Technician - $92 per hour (includes benefits, OE&E and DCA distributed administration)
SSA: Staff Services Analyst - $97 per hour (includes benefits, OE&E, and DCA distributed administration)
AGPA: Associate Governmental Program Analyst - $112 per hour (includes benefits, OE&E, and DCA distributed administration)

Dental Board of California
Licensure By Examination (CCR 1021(a)(c))
Law & Ethics Examination App Workload (Costs - Online)

Workload Tasks	Per Application	Minutes per Application	MST	SSA	AGPA
Assign work to staff	1	15	0	0	15
Receive and Process Application/Communicate Deficiencies to Applicant	1	30	0	30	0
Respond to Inquiries	1	30	0	30	0
Confirm Completeness of Application and Supporting Documentation	1	15	0	15	0
Download and Print Applications and Attachments	1	20	20	0	0
Minutes per Classification:			20	75	15
Hours per Classification:			0.3	1.3	0.3
Costs per Classification:			$31	$121	$28
Total Costs:				**$180**	

MST: Management Services Technician - $92 per hour (includes benefits, OE&E and DCA distributed administration)
SSA: Staff Services Analyst - $97 per hour (includes benefits, OE&E, and DCA distributed administration)
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CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	April 29, 2026
TO	Members of the Dental Board of California
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 14.c.:** Discussion and Possible Action to Consider Initiation of a Rulemaking to Amend CCR, Title 16, Section 1066 Regarding Vaccine Administration Updates

Background

During the COVID-19 pandemic, the Director of the Department of Consumer Affairs issued a public health emergency waiver allowing dentists to administer the COVID-19 vaccines. Subsequently, Assembly Bill (AB) 526 (Wood, Chapter 653, Statutes of 2021) amended provisions of the Dental Practice Act to permanently authorize dentists to prescribe and administer influenza and COVID-19 vaccines approved or authorized by the federal Food and Drug Administration (FDA).

To administer those vaccines, the dentist was required to comply with the individual federal Advisory Committee on Immunization Practices (ACIP) influenza and COVID–19 vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) to persons 3 years of age or older. (Business and Professions Code (BPC), § 1625.6.) The Dental Board of California (Board) promulgated California Code of Regulations (CCR), title 16, section 1066 to implement the new vaccine authority.

Update

On August 27, 2025, the FDA revoked the remaining Emergency Use Authorizations for COVID-19 vaccines and shifted to a model where vaccines are available primarily for high-risk individuals and those over 65. In response, effective September 17, 2025, AB 144 (Committee on Budget, Chapter 105, Statutes of 2025) (**Attachment 2)**, among other things, amended BPC section 1625.6 to authorize dentists to prescribe and administer the influenza and COVID-19 vaccines consistent with California Department of Public Health (CDPH) recommendations pursuant to Health and Safety Code (HSC) section 120164.

Notably, the recent amendments removed requirements to comply with federal ACIP recommendations. However, HSC section 120164 does require the list of immunizations, items, and services that were recommended by ACIP, among others, in effect on January 1, 2025, to serve as the CDHP's baseline recommendations (see **Attachment 3**). CDPH has posted its recommendations for implementation of AB 144 on its website (**Attachment 4**).

Accordingly, staff recommends that CCR, title 16, section 1066 be amended to conform with the recent amendments to BPC section 1625.6. Attached hereto are proposed amendments to CCR, title 16, section 1066 to accomplish these updates. (**Attachment 1**.)

Action Requested

The Board is asked to review staff's recommendation and discuss the proposed regulatory text and related attachments and consider making one of the following motions:

Option 1 (if the Board agrees with the staff recommendation and has no changes)

Move to approve the proposed regulatory text in **Attachment 1** and direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, section 1066.

Option 2 (The Board has suggested changes to the proposed regulatory text in **Attachment 1**.)

Move to approve the proposed regulatory text in **Attachment 1** with the following changes (Describe the proposed changes to the proposed text here). Further, direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, section 1066.

Attachments:

1. Proposed Regulatory Text for Vaccine Administration Updates to Amend California Code of Regulations, Title 16, Section 1066 Dentists Initiating and Administering Vaccines
2. Assembly Bill 144 (Committee on Budget, Chapter 105, Statutes of 2025)
3. Health and Safety Code Section 120164
4. CDPH Immunization Recommendations Under Assembly Bill 144 Website Printout

TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS
DIVISION 10. DENTAL BOARD OF CALIFORNIA

PROPOSED REGULATORY LANGUAGE

Vaccine Administration Updates

Proposed amendments to the regulatory language are shown in single underline for new text and single ~~strikethrough~~ for deleted text.

Amend Section 1066 of Division 10 of Title 16 of the California Code of Regulations to read as follows:

§ 1066. Dentists Initiating and Administering Vaccines

(a) A dentist prescribing and administering any vaccine pursuant to section 1625.6 of the Code shall follow the requirements specified in subdivisions (b) through (f) of this section. Failure to comply with this section constitutes unprofessional conduct in accordance with section 1680 of the Code.

(b) Training. A dentist who prescribes and administers any vaccine shall keep documentation of completion of an immunization training program from an approved provider as set forth in subdivision (c). A dentist who prescribes and administers vaccines shall retain certificates of course completion for any approved training program on premises and according to the requirements of section 1017.

(c) Continuing Education. A dentist must complete one hour of continuing education from an approved provider once every two years focused on immunization training that includes, at a minimum, training in vaccine administration, prevention and management of adverse reactions, and maintenance of vaccine records. For the purposes of this section, an “approved provider” means: (1) the federal Centers for Disease Control and Prevention (CDC); or, (2) a continuing education provider registered and approved by the Board pursuant to section 1016.

(d) Notifications: A dentist shall notify each patient's primary care provider of any vaccine administered to the patient, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by the primary care provider. Primary care provider notification must take place within 14 days of the administration of any influenza or COVID-19 vaccine. If a patient does not have a primary care provider, or is unable to provide contact information for his or her primary care provider, the dentist shall advise the patient to consult an appropriate health care provider of the patient's choice. A dentist shall notify each pregnant patient's prenatal care provider, if known, of any influenza or COVID-19 vaccine administered to the patient within 14 days of the administration of any vaccine.

(e) Immunization Registry: A dentist shall report, in accordance with section 1625.6, subdivision (b)(2) of the Code, the information described in section 120440, subdivision

~~(c)~~ , of the Health and Safety Code in the registry designated by the Immunization Branch of the California Department of Public Health known as the “California Immunization Registry” or “CAIR” within 14 days of the administration of any influenza vaccine and within 24 hours of the administration of any COVID-19 vaccine. A dentist shall complete the required registration process for reporting this information in the California Immunization Registry via the online CAIR portal designated on the California Department of Public Health's website at: https://igs.cdph.ca.gov/cair/. A dentist shall inform each patient or the patient's parent or guardian of immunization record sharing preferences, detailed in section 120440, subdivision (e), of the Health and Safety Code.

(f) Documentation: For each vaccine administered by a dentist, a patient vaccine administration record shall be maintained for at least 3 years from the date of administration of the vaccine to the patient in an automated data processing or manual record mode such that the information required under section 300aa-25 of title 42 of the United States Code is readily retrievable during normal operating hours. A dentist shall provide each patient with a patient vaccine administration record ~~or card~~ at the time of vaccination, which fully documents the vaccines administered by the dentist, including names of vaccines administered and the dates of administration. ~~The dentist's provision of the CDC's “COVID-19 Vaccination Record Card” (Form MLS-319813_r [08/17/2020]) to patients receiving the COVID-19 vaccine, or the California Department of Public Health's Immunization Record and History Form (CDPH 8608P (06/17)) to patients receiving the influenza vaccine shall be deemed compliant with the patient vaccine administration record requirement.~~

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

(1) “patient vaccine administration record” shall mean the patient record that fully documents the vaccines administered by the dentist including (A) names of vaccines administered, (B) dates of administration, (C) the dates of the provision of a Vaccine Information Statement ~~(for influenza vaccines) if applicable or a COVID-19 Vaccine Emergency Use Authorization Fact Sheet (EUA Fact Sheet) to the patient (for COVID-19 vaccines) if applicable,~~ and (D) any other information required to be documented pursuant to section 300aa-25 of title 42 of the United States Code.

(2) “Vaccine Information Statement” means a document produced by the CDC that informs vaccine recipients, or their parents or legal representatives, about the benefits and risks of the influenza <u>or COVID-19</u> vaccine they are receiving as required by 300aa-26 of title 42 of the United States Code.

(3) ~~“COVID-19 Vaccine Emergency Use Authorization Fact Sheet” or “EUA Fact Sheet” means a document, produced by the manufacturer of the particular COVID-19 vaccine and authorized by the federal Food and Drug Administration under authority of the Federal Food, Drug, and Cosmetic Act pursuant to section 360bbb-3 of title 21 of the United States Code, that informs vaccine recipients, or their parents or legal representatives, about the benefits and risks of a particular COVID-19 vaccine.~~

Note: Authority cited: Sections 1614 and 1625.6, Business and Professions Code. Reference: Sections 1625.6, 1645.2 and 1680, Business and Professions Code; and Section 120440, Health and Safety Code.

Assembly Bill No. 144

CHAPTER 105

An act to amend Sections 1246, 1300, 1300.1, 1625.6, 2473, 3041, and 3041.5 of, and to add Sections 901 and 4052.05 to, the Business and Professions Code, to amend Section 48980.4 of the Education Code, to amend Section 100520.5 of, and add Section 100503.6 to, the Government Code, to amend Sections 1206, 1261.3, 1342.2, 1342.3, 1347.8, 1367.002, 1367.3, 1367.35, 100425, 100450, 104151, 120372, 120372.05, 120392.2, 120392.3, 120392.6, 120392.9, 120393, 124981, and 124982 of, to amend, repeal, and add Sections 120336, 120390.6, and 120455 of, to add Sections 1797.11 and 120164 to, to add and repeal Chapter 6.1 (commencing with Section 127640) of Part 2 of Division 107 of, and to repeal Section 11756.8 of, the Health and Safety Code, to amend Sections 10110.7, 10110.75, 10112.2, 10123.5, and 10123.55 of the Insurance Code, to amend Section 30461.6 of the Revenue and Taxation Code, to amend Sections 5961.4, 11265.8, 14005.27, 14005.62, 14007.5, 14007.8, 14012.5, 14105.47, 14105.475, 14124.11, 14146, 14146.5, and 14501 of, to add Section 14132.995 to, and to repeal Sections 14007.95 and 14100.95 of, the Welfare and Institutions Code, to amend Section 118 of Chapter 21 of the Statutes of 2025, and to repeal Section 34 of Chapter 80 of the Statutes of 2005, and Section 67 of Chapter 758 of the Statutes of 2008, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor September 17, 2025. Filed with Secretary of State September 17, 2025.]

legislative counsel's digest

AB 144, Committee on Budget. Health.

(1) Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which the practitioner is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

This bill would exempt health care practitioners licensed in another state, territory, or country from certain healing arts licensure, certification, or registration requirements, as described above, while providing professional services at Olympic and Paralympic activities, as defined, if the health care practitioner has been invited by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games to provide those services and the committee provides specified information to the Director of Consumer

Affairs. The bill would specify that the exemption applies while the health care practitioner is providing professional services at the invitation of the committee and only during the time sanctioned by the committee.

This bill would authorize the official team representative who is responsible for any member participating in Olympic and Paralympic activities to give consent to the furnishing of professional services to a team member who, due to age, disability, or injury, is not able to personally consent in the event the consent of a parent, guardian, or legal representative of a team member cannot be obtained. The bill would specify that in the case of emergency, the consent of the parent, guardian, or legal representative of the team member would not be necessary in order to authorize the performance of professional services.

(2) Existing law sets forth various powers and responsibilities for the State Department of Public Health concerning communicable disease prevention and control, in relation to persons, animals, and places, as necessary to protect or preserve the public health.

This bill would require that the list of immunizations, items, and services that were recommended by the United States Preventive Services Task Force (USPSTF), the federal Advisory Committee on Immunization Practices (ACIP), and the federal Health Resources and Services Administration (HRSA) that were in effect on January 1, 2025, serve as a baseline of recommendations and would authorize the State Department of Public Health, notwithstanding the rulemaking provisions of the Administrative Procedure Act, to modify or supplement those baseline recommendations, as specified. The bill would require the department to publish recommendations and any updates, modifications, or supplements.

(3) Existing law authorizes various healing arts licensees, including dentists, doctors of podiatric medicine, optometrists, and pharmacists, to independently prescribe, initiate, or administer specified immunizations approved or authorized by the United States Food and Drug Administration in compliance with specified recommendations, including those by the ACIP.

This bill would instead authorize those licensees to prescribe, initiate, or administer specified immunizations in a manner consistent with a recommendation made by the State Department of Public Health, as specified.

(4) Existing law provides for the licensure, registration, and regulation of clinical laboratories and various clinical laboratory personnel by the State Department of Public Health. Existing law requires the fees or charges accompanying an application for the issuance or renewal of these licenses, among others, to be adjusted annually by the percentage change printed in the Budget Act and determined by dividing the General Fund appropriation to Laboratory Field Services in the current state fiscal year by the General Fund appropriation to Laboratory Field Services in the preceding state fiscal year. Commencing January 1, 1995, upon establishment of the Clinical Laboratory Improvement Fund, existing law requires this annual adjustment to be determined by dividing the current fiscal year appropriation to the

Clinical Laboratory Improvement Fund by the General Fund appropriation to Laboratory Field Services of the department in the preceding fiscal year. Existing law also requires these fees and charges to be adjusted annually by a percentage determined by dividing the total amount of federal funds available for all programs in Laboratory Field Services of the department during the federal fiscal year ending on September 30 of the year immediately preceding the effective date of the change in fees, as specified.

This bill would delete the above provisions pertaining to the annual adjustment of fees or charges and replace them with a requirement that the annual adjustment be done by the department to cover the estimated licensing program costs.

Existing law requires a tissue bank, as defined, to have a current and valid tissue bank license. Under existing law, the application and annual renewal fee for a tissue bank license is $950, adjusted annually by a percentage listed in the Budget Act.

This bill would adjust the fees or charges for a tissue bank license annually pursuant to the provision above requiring the annual adjustment be done by the department to cover the estimated licensing program costs.

This bill would additionally revise the application, registration, and license fees for clinical laboratories and clinical laboratory personnel.

(5) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law establishes the Health Care Affordability Reserve Fund to be used, upon appropriation by the Legislature, for health care affordability programs operated by the Exchange.

If a qualified health plan is required to cover state-mandated gender-affirming care benefits determined to be in addition to essential health benefits, this bill would require the Exchange to provide payments to issuers of qualified health plans to defray the costs of offering those benefits for plan years beginning on or after January 1, 2026, subject to an appropriation by the Legislature. The bill would authorize the Health Care Affordability Reserve Fund to be used, upon appropriation by the Legislature, for these payments.

(6) Existing law establishes the State Department of Public Health and sets forth its powers and duties, including, but not limited to, duties relating to the licensing and regulation of various entities, including clinics. Existing law exempts specified clinics from these licensure requirements, including, among others, certain federal clinics, clinics maintained as outpatient departments of hospitals, and student health centers operated by public institutions of higher education.

This bill would exempt from the above-described licensure requirements a clinic approved by, and that provides health care services at locations designated or sanctioned by, the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games from May 15, 2028, to September 15, 2028, inclusive.

(7) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority, which is responsible for the coordination of various state activities concerning emergency medical services (EMS), including, among others, establishing minimum standards and promulgating regulations for the training and scope of practice for an Emergency Medical Technician I and II (EMT-I and EMT-II) and Emergency Medical Technician-Paramedic (EMT-P). Existing law requires the authority to have a chief medical officer who is required to provide clinical leadership and oversight concerning treatment, education, and other matters involving medical decisionmaking and delivery of patient care.

This bill, notwithstanding any other law, would exempt from the EMS licensure, certification, or accreditation requirements of this state an EMT-I, EMT-II, EMT-P, or similar EMS provider, as defined, licensed or certified in another state or territory of the United States, who provides EMS for which they are licensed, if they are authorized by the chief medical officer of the authority to provide EMS at sites in this state sanctioned by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games and associated with the 2028 Olympic and Paralympic Games. The bill would require the chief medical officer to authorize those EMS personnel based on system needs and informed by committee needs, qualifications of the emergency medical services personnel, and public safety considerations. The bill would prohibit EMS providers authorized by the chief medical officer from being liable for any act or omission taken in good faith while providing authorized services. The bill would require authorization pursuant to these provisions to be valid from May 15, 2028, to September 15, 2028, inclusive, or until authorization is otherwise withdrawn by the chief medical officer.

(8) Existing law requires the State Department of Health Care Services (DHCS) to annually report to certain legislative committees, and publicly post, a summary of outcome and expenditure data with regard to outcome measures for alcohol and drug program services, as specified.

This bill would repeal the above-described reporting and publication provisions.

(9) Existing law requires DHCS to provide certain legislative committees with biannual updates on caseload, estimated expenditures, and related program monitoring data for the Every Woman Counts (EWC) Program, as specified. Existing law requires that expenditures for the EWC Program included in the department's budget for services provided on or after July 1, 2017, be charged against the appropriation for the fiscal year in which the billing is paid.

This bill would delete the above-described requirements relating to the EWC Program.

(10) Existing law establishes the public policy of the state that pupils are advised to adhere to current immunization guidelines, as recommended by, among other entities, the ACIP. Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil unless, before the person's admission to that institution, the person has been fully immunized against various diseases, including any disease deemed appropriate by the State Department of Public Health, taking into consideration recommendations of various entities, including the ACIP. Existing law requires a medical exemption form and the appeal process for revocation of a medical exemption to be consistent with specified guidelines, including those by the ACIP.

This bill would delete certain references to the ACIP and replace other references to the ACIP with the State Department of Public Health. Some of these provisions would be operative beginning July 1, 2026. To the extent that this bill imposes new duties on a local education agency, the bill would impose a state-mandated local program.

(11) Existing law, from October 1 to the following April 1, inclusive, of each year, requires specified health facilities to offer immunizations for influenza and pneumococcal disease to residents or inpatients 65 years of age or older who are receiving services at the facility, based upon the latest recommendations of specified entities, including the ACIP.

This bill would replace those references to ACIP with the State Department of Public Health.

Existing law requires the State Department of Public Health to post on its internet website educational information regarding influenza in accordance with the latest recommendations of the ACIP.

This bill would replace the reference to ACIP with the State Department of Public Health.

(12) Existing law, the Hereditary Disorders Act, requires the State Department of Public Health to license genetic counselors and temporary genetic counselors who meet specified requirements. Existing law prohibits the license fee from exceeding $200 for an original license, license renewal, or temporary license. Existing law requires all moneys collected by the department under the act to be deposited in the Genetic Disease Testing Fund, which is continuously appropriated to the department to carry out the purposes of the act.

This bill would instead set the fee for an original license, license renewal, and temporary license at $300. The bill would authorize the department to adjust those fees to an amount not to exceed $500. The bill would require the department to solicit input from affected stakeholders before raising these fees. By authorizing additional moneys to be deposited into a continuously appropriated fund, the bill would make an appropriation.

(13) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the

act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plan contracts, or specified disability or health insurance policies, to cover an evidence-based item, service, or immunization that has in effect a specified rating in the recommendations of the USPSTF or an immunization that has in effect a recommendation from specified entities, including the ACIP. Existing law also requires specified health care service plans or disability insurers to offer benefits for the comprehensive prevention care of children consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by various entities, including the ACIP.

This bill would require those health care service plan contracts or disability or health insurance policies to cover an evidence-based item, service, or immunization that had in effect on January 1, 2025, a specified rating in the recommendations of USPSTF. The bill would replace references to the ACIP with the State Department of Public Health. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(14) Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, for this purpose. PPACA generally prohibits the use of federal funds for abortion services, but if a qualified health plan provides abortion coverage, PPACA requires the issuer of the plan to collect specified amounts from each enrollee and deposit those funds into a segregated account to be used to pay for abortion services. Under state law, the Exchange makes those payments to qualified health plans on behalf of enrollees. Existing state law requires a health care service plan that provides a qualified health plan through the Exchange to report to the Director of the Department of Managed Health Care the total amount of funds maintained in a segregated account.

This bill would establish the Abortion Access Fund, a continuously appropriated fund, to provide funding for abortion services, including for abortion services funded through grants to provide abortion access. The bill would authorize the Department of Health Care Access and Information to distribute moneys in the fund through grants and contracts. Under the bill, contracts, grants, and related information would be exempt from public disclosure. From the 2025–26 fiscal year to the 2028–29 fiscal year, inclusive, the bill would require the Director of the Department of Managed Health Care to order a health care service plan that provides a qualified health plan through the Exchange to transfer to the Abortion Access Fund up to the total amount previously funded by the Exchange, not to exceed a specified percentage of the ending balance in its segregated account, and would require a plan to complete the transfer. Because a willful violation

of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

(15) Under existing law, the Breast Cancer Fund consists of the Breast Cancer Research Account and the Breast Cancer Control Account. Under existing law, revenues from a specified cigarette tax are deposited into the fund and divided equally between the 2 accounts, to be allocated upon appropriation.

Existing law requires any entity funded by the Breast Cancer Control Program to collect data and maintain records that are determined by the State Department of Public Health to be necessary to facilitate the department's ability to monitor and evaluate the effectiveness of the entities and the program. Existing law requires the department to submit an annual report to the Legislature and any other appropriate entity.

This bill would switch the jurisdiction from the State Department of Public Health to DHCS for purposes of the above-described and other related provisions. The bill would make certain changes to the required contents of the report.

Existing law requires the State Department of Public Health to provide for breast cancer screening services at the level of funding budgeted from state and other resources during the fiscal year in which the Legislature has appropriated funds to the department for this purpose, with administrative or indirect costs not exceeding certain limits.

This bill would delete those provisions.

(16) Existing law establishes the Children and Youth Behavioral Health Initiative, administered by the California Health and Human Services Agency and its departments, as applicable. Under existing law, the purpose of the initiative is to transform the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs.

Existing law requires DHCS, or a contracted vendor, to provide competitive grants to qualified entities to build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services, among other purposes, for children and youth 25 years of age and younger. For these purposes, existing law requires the department to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student who is 25 years of age or younger at a schoolsite. Existing law requires the department to develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors. Existing law authorizes the department to contract with an entity to administer the school-linked statewide behavioral health provider network. Existing law requires that administrator to, among other things, create and administer a process for the submission and reimbursement of eligible claims.

This bill would require the department to convene a working group twice each year of specified stakeholders, including, among others, behavioral health providers and local educational agencies, to discuss the status of, and

receive feedback regarding, the implementation of the fee schedule. The bill would require a contracted administrator to automate the matching of student records with health plan enrollment information and to reimburse claims pursuant to claim payment deadlines, as specified. The bill would require the California Health and Human Service Agency to publish a manual to assist a local educational agency with navigating certain federal laws.

(17) Existing law, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, requires all applicants for or recipients of CalWORKs to ensure and provide documentation that each child in the assistance unit who is not required to be enrolled in school has received all age-appropriate immunizations. Existing law requires all applicants and recipients to be given notice of that obligation and for the notice to include specified recommended childhood immunization schedules, as approved by various entities, including the ACIP.

This bill would remove the reference to the ACIP and replace it with the State Department of Public Health, as specified.

(18) Existing law establishes the Medi-Cal program, which is administered by DHCS and 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. Existing law sets a schedule of benefits that are covered by the Medi-Cal program.

This bill would require that vaccines and immunizations are covered in accordance with a recommendation from ACIP, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and any modification or supplement to a recommendation adopted by the State Department of Public Health. The bill would make the implementation of this provision contingent to the extent that federal financial participation is available and any necessary federal approvals are obtained.

(19) Existing law prohibits the use of an assets or resources test for individuals whose income eligibility for Medi-Cal is determined based on the application of a modified adjusted gross income (MAGI). Existing law prohibits, until January 1, 2026, the use of resources to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, subject to receipt of any necessary federal approvals.

Under existing law, operative on January 1, 2026, for those applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, DHCS is required to seek federal approval to implement a disregard of $130,000 in nonexempt property for a case with one member and $65,000 for each additional household member, up to a maximum of 10 members. Existing law requires that provision to be implemented only after the Director of Health Care Services determines that systems have been programmed for the disregards and they communicate that determination in writing to the Department of Finance.

This bill would additionally specify that the above-described implementation condition occur no sooner than January 1, 2026.

(20) Existing law sets forth provisions for the transition of certain children from the former Healthy Families Program to the Medi-Cal program. Existing law requires DHCS to provide monthly status reports to certain legislative committees on the transition, with a final comprehensive report provided within 90 days after completion of the last phase of transition.

This bill would delete the above-described reporting requirement.

(21) Existing law establishes a program, known as the 250% Working Disabled Program (250% WDP), under which certain working persons with disabilities are eligible for Medi-Cal benefits based on a net countable income of less than 250% of the federal poverty level and other specified criteria. Existing law requires DHCS to report to the Governor and the Legislature any information that DHCS gathers that may explain the low participation rates in 250% WDP and any recommendations on increasing participation, as specified.

This bill would repeal the above-described reporting provision.

(22) The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to individuals who do not have satisfactory immigration status if they are otherwise eligible for those benefits, with the exception of specified dental benefits for individuals who are 19 years of age or older. Existing law makes an individual who is 19 years of age or older, who does not have satisfactory immigration status, and who applies for Medi-Cal on or after January 1, 2026, eligible only for pregnancy-related services and emergency medical treatment. Existing law, beginning no sooner than July 1, 2026, or July 1, 2027, as specified, requires individuals who do not have satisfactory immigration status, who are not pregnant, and who are 19 to 59 years of age, inclusive, to pay a monthly premium of $30, subject to certain exceptions.

This bill would make certain nonminor dependents and foster youths exempt from the service limitations and monthly premium provisions described above. The bill would require the monthly premium payments described above to begin no sooner than July 1, 2027, and make other technical and conforming changes.

(23) Existing law requires DHCS to implement a process that allows applicants and beneficiaries of certain Medi-Cal programs to self-certify the amount and nature of assets and income without the need to submit income or asset documentation. Existing law requires DHCS to implement the process in 2 phases, with the first phase in 2 counties and the 2nd phase statewide, with each county agreeing to meet all federal requirements for income, resource, and other verifications and to perform determinations and verifications in a timely manner. Existing law requires DHCS to promptly provide certain legislative committees with an evaluation of the process and its impact on the Medi-Cal program.

This bill would delete certain provisions relating to the 2 phases, including the evaluation requirement.

(24) Existing law, under Medi-Cal provisions, requires DHCS to enter into demonstration contracts with manufacturers of medical supplies for 4 items of its own selection of medical supplies existing on the pharmacy claims processing system, for the purpose of establishing rebates or other cost-saving mechanisms and demonstrating cost savings in the purchase of these medical supplies.

This bill would repeal those and related provisions. The bill would make conforming changes to other provisions.

(25) Existing law requires DHCS to establish a 2-year pilot program to utilize the federal Public Assistance Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are enrolled in the Medi-Cal program and assist them in obtaining federal veteran health care benefits. Existing law requires DHCS to monitor the pilot program, evaluate the outcomes and savings, and provide the fiscal committees of the Legislature with a report on the findings and recommendations.

This bill would delete the above-described monitoring, evaluation, and reporting requirements.

(26) Existing law, operative until July 1, 2025, requires DHCS to work with stakeholders to conduct a study to identify current requirements for medical interpretation services and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP). Existing law requires the department to establish a pilot project to evaluate certain factors, including whether disparities in care are reduced, with respect to LEP Medi-Cal beneficiaries compared with Medi-Cal beneficiaries who are proficient in English. Existing law requires the department to expend up to $5,000,000 for the pilot project pursuant to an appropriation made in the Budget Act of 2019, and makes those funds available for that purpose until June 30, 2025.

This bill would extend the operation of these provisions until July 1, 2026, and make those funds available for expenditure, encumbrance, and liquidation until June 30, 2026. By extending the period of time in which previously appropriated funds are available for expenditure, encumbrance, and liquidation, the bill would make an appropriation.

(27) Existing law requires the Office of Family Planning within DHCS to submit a biennial report to the Legislature on specified subjects relating to family planning services.

This bill would instead require the office to post annual reports on its internet website.

(28) Existing law requires the former State Department of Health Services, whose functions were transferred to other departments, to provide certain legislative committees with quarterly updates regarding core activities to improve the Medi-Cal managed care program and county expansion, as specified.

This bill would repeal those reporting provisions.

(29) Existing law requires the former State Department of Mental Health, whose functions were transferred to other departments, to provide certain

legislative committees with semiannual updates regarding key results and funding for the capital costs associated with development, acquisition, construction, and rehabilitation of permanent supportive housing for individuals with mental illness, as specified.

This bill would repeal those reporting provisions.

(30) Existing law authorizes the State Public Health Officer, to the extent allowable under federal law, and upon the availability of funds, to expend moneys from the continuously appropriated AIDS Drug Assistance Program (ADAP) Rebate Fund for a program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs. Existing law authorizes the State Department of Public Health to spend up to $75,000,000 from the ADAP Rebate Fund to support current or eligible HIV services and programs, as specified. Existing law prescribes the allocation of those funds, including by authorizing up to $65,000,000 of that $75,000,000 to be spent to supplement or fund services, programs, or initiatives for which federal funding has been reduced or eliminated and making $9,000,000 available to fund state and local disease intervention specialists.

This bill would make up to $18,000,000 of the above-described $65,000,000 available for state operations and would make up to $1,640,000 of the above-described $9,000,000 available for state operations. By adding to the purposes for which the ADAP Rebate Fund may be spent, the bill would make an appropriation.

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

This bill would make legislative findings to that effect.

(32) 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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

(33) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

Appropriation: yes.

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

SECTION 1. Section 901 is added to the Business and Professions Code, to read:

901. (a) For purposes of this section, the following definitions shall apply:

(1) "Committee" means the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

(2) "Health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under this division or under any initiative act referred to in this division and who maintains an active license in good standing to provide the same or substantially similar services in another state, territory, or country.

(3) "Olympic and Paralympic activities" means any competition, non competition, athlete village, training, or support sites in this state sanctioned by the committee.

(b) Notwithstanding any other law, any licensure, certification, or registration requirements of this division shall not apply to a health care practitioner licensed in another state, territory, or country while providing professional services for which a license would otherwise be required in this state if both of the following conditions are met:

(1) The health care practitioner has been invited by the committee to provide professional services at Olympic and Paralympic activities.

(2) The committee provides to the Director of Consumer Affairs, to forward to the applicable licensing entity within the department that corresponds to the licensing entity in the state, territory, or country where the health care practitioner is licensed before the provision of professional services by a health care practitioner, all of the following information:

(A) The name of the health care practitioner.

(B) The state, territory, or country of the health care practitioner's licensure and the licensing entity from which the health care practitioner holds a license.

(C) The dates for which the health care practitioner has been invited to provide professional services.

(D) The scope of practice the committee requires for that practitioner at Olympic and Paralympic activities.

(c) The exemption granted under this section shall be limited to only those professional services required by or on behalf of the committee. Those professional services shall be within the scope of the health care practitioner's existing licensure, certification, or registration and shall only be provided at Olympic and Paralympic activities.

(d) A health care practitioner shall cease to be exempted under this section upon a request made by the department to the committee on behalf of an applicable licensing entity.

(e) The exemption provided in this section shall remain in force while the health care practitioner is providing professional services at the invitation of the committee and only during the time sanctioned by the committee.

(f) (1) Notwithstanding any other law, in the event the consent of the parent, guardian, or legal representative of a team member cannot be obtained, the official team representative who is responsible for any member participating in Olympic and Paralympic activities may give consent to the

furnishing of professional services to a team member who, due to age, disability, or injury, is not able to personally consent.

(2) Consent given pursuant to paragraph (1) shall not be subject to disaffirmance or invalidation due to the individual's age, disability, or injury.

(3) In the case of an emergency, the consent of the parent, guardian, or legal representative of the team member shall not be necessary in order to authorize the performance of professional services.

(g) This section does not apply to persons who engage in acts that are subject to licensure or regulation pursuant to Chapter 9 (commencing with Section 4000) or Chapter 9.5 (commencing with Section 4430).

SEC. 2. Section 1246 of the Business and Professions Code is amended to read:

1246. (a) (1) On and after the effective date of the regulations specified in paragraph (2), any unlicensed person employed by a clinical laboratory performing the duties described in this section shall possess a valid and current certification as a certified phlebotomy technician issued by the department.

(2) The department shall adopt regulations for certification by January 1, 2001, as a certified phlebotomy technician that shall include all of the following:

(A) The applicant shall hold a valid, current certification as a phlebotomist issued by a national accreditation agency approved by the department, and shall submit proof of that certification when applying for certification pursuant to this section.

(B) An applicant with fewer than 1,040 hours of work experience shall complete education, training, and experience requirements as specified by regulations that shall include, but not be limited to, the following:

(i) At least 40 hours of didactic instruction.

(ii) At least 40 hours of practical instruction.

(iii) At least 50 successful venipunctures.

(C) An applicant who has at least 1,040 hours of work experience that includes at least 50 successful venipunctures shall complete at least 20 hours of didactic instruction, as specified in regulations adopted by the department.

(D) Each certified phlebotomy technician shall complete at least three hours per year or six hours every two years of continuing education or training. The department shall consider a variety of programs in determining the programs that meet the continuing education or training requirement.

(E) The applicant has been found to be competent in phlebotomy by a licensed physician and surgeon or person licensed pursuant to this chapter.

(F) The applicant works under the supervision of a licensed physician and surgeon, licensed registered nurse, or person licensed under this chapter, or the designee of a licensed physician and surgeon or the designee of a person licensed under this chapter.

(3) A certified phlebotomy technician may collect blood through a peripheral venous catheter if all of the following are met:

(A) The blood collection procedure is performed in a facility licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code.

(B) The blood collection procedures or protocols are developed and approved by the facility's supervising physician and surgeon or licensed clinical laboratory director and approved by the licensed facility.

(C) The certified phlebotomy technician has received a minimum of three hours of training by the supervising physician and surgeon or their delegate in the proper procedures to be employed when collecting blood through a peripheral venous catheter.

(i) Training in the blood collection procedure through a peripheral venous catheter shall be conducted according to standardized training procedures developed and approved by the facility's supervising physician and surgeon or licensed clinical laboratory director. The facility shall make these standardized procedures available to the department upon request.

(ii) The instructor shall document the certified phlebotomy technician's successful completion of training. The facility shall maintain and make available to the department, upon request, documentation of training completed by a certified phlebotomy technician pursuant to this paragraph.

(D) The certified phlebotomy technician performs the blood collection procedure under the supervision of a physician and surgeon licensed under Chapter 5 (commencing with Section 2000). Notwithstanding subdivision (b), the physician and surgeon may only delegate the supervision duties in this subparagraph to a registered nurse. A physician and surgeon or a registered nurse may restrict or limit a certified phlebotomy technician's ability to collect blood from a patient's peripheral venous catheter.

(E) The certified phlebotomy technician performs the blood collection procedure using a device or devices approved by the licensed facility and the United States Food and Drug Administration.

(F) This paragraph does not authorize the certified phlebotomy technician to manage, stop, or restart a patient's active intravenous infusion or insert or remove a peripheral intravenous catheter.

(4) Paragraph (3) does not authorize a certified phlebotomy technician to withdraw blood through a peripherally inserted central catheter or central venous catheter.

(5) The department shall adopt regulations establishing standards for approving training programs designed to prepare applicants for certification pursuant to this section. The standards shall ensure that these programs meet the state's minimum education and training requirements for comparable programs.

(6) The department shall adopt regulations establishing standards for approving national accreditation agencies to administer certification examinations and tests pursuant to this section.

(7) The department shall charge fees for application for and renewal of the certificate authorized by this section pursuant to subdivision (f) of Section 1300.

(b) (1) (A) A certified phlebotomy technician may perform venipuncture or skin puncture to obtain a specimen for nondiagnostic tests assessing the health of an individual, for insurance purposes, provided that the technician works under the general supervision of a physician and surgeon licensed under Chapter 5 (commencing with Section 2000). The physician and surgeon may delegate the general supervision duties to a registered nurse or a person licensed under this chapter, but shall remain responsible for ensuring that all those duties and responsibilities are properly performed. The physician and surgeon shall make available to the department, upon request, records maintained documenting when a certified phlebotomy technician has performed venipuncture or skin puncture pursuant to this paragraph.

(B) As used in this paragraph, general supervision requires the supervisor of the technician to determine that the technician is competent to perform venipuncture or skin puncture, or to collect blood, before the technician's first blood withdrawal, and on an annual basis thereafter. The supervisor is also required to determine, on a monthly basis, that the technician complies with appropriate venipuncture, skin puncture, and blood collection policies and procedures approved by the medical director and required by state regulations. The supervisor, or another designated licensed physician and surgeon, registered nurse, or person licensed under this chapter, shall be available for consultation with the technician, either in person or through telephonic or electronic means, at the time of blood withdrawal.

(2) (A) Notwithstanding any other law, a person who has been issued a certified phlebotomy technician certificate pursuant to this section may draw blood following policies and procedures approved by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000), appropriate to the location where the blood is being drawn and in accordance with state regulations. The blood collection shall be done at the request and in the presence of a peace officer for forensic purposes in a jail, law enforcement facility, or medical facility, with general supervision.

(B) As used in this paragraph, "general supervision" means that the supervisor of the technician is licensed under this code as a physician and surgeon, physician assistant, clinical laboratory bioanalyst, registered nurse, or clinical laboratory scientist, and reviews the competency of the technician before the technician may perform blood withdrawals without direct supervision, and on an annual basis thereafter. The supervisor is also required to review the work of the technician at least once a month to ensure compliance with venipuncture policies, procedures, and regulations. The supervisor, or another person licensed under this code as a physician and surgeon, physician assistant, clinical laboratory bioanalyst, registered nurse, or clinical laboratory scientist, shall be accessible to the location where the technician is working to provide onsite, telephone, or electronic consultation, within 30 minutes when needed.

(c) The department may adopt regulations providing for the issuance of a certificate to an unlicensed person employed by a clinical laboratory authorizing only the performance of skin punctures for test purposes.

SEC. 3. Section 1300 of the Business and Professions Code is amended to read:

1300. The amount of application, registration, certification, and license fees under this chapter shall be as follows:

(a) The application fee for a histocompatibility laboratory director's, clinical laboratory bioanalyst's, clinical chemist's, clinical microbiologist's, clinical laboratory toxicologist's, clinical genetic molecular biologist's, clinical cytogeneticist's, clinical laboratory geneticist's, or clinical reproductive biologist's license, or license for another specialty or subspecialty specified by regulation adopted by the department, is five hundred seventy dollars ($570).

(b) The annual renewal fee for a license listed in subdivision (a) is five hundred seventy dollars ($570).

(c) The application fee for a clinical laboratory scientist's or limited clinical laboratory scientist's license is three hundred dollars ($300).

(d) The application and annual renewal fee for a cytotechnologist's license is two hundred sixty dollars ($260).

(e) The annual renewal fee for a clinical laboratory scientist's or limited clinical laboratory scientist's license is three hundred dollars ($300).

(f) The application and annual renewal fee for a phlebotomist's certification is one hundred fifty dollars ($150).

(g) A clinical laboratory applying for a license to perform tests or examinations classified as of moderate or of high complexity under CLIA and a clinical laboratory applying for certification under subdivision (c) of Section 1223 shall pay an application fee for that license or certification based on the number of tests it performs or expects to perform in a year, as follows:

(1) Less than 2,001 tests: three hundred thirty-five dollars ($335).

(2) Between 2,001 and 10,000, inclusive, tests: one thousand one hundred dollars ($1,100).

(3) Between 10,001 and 25,000, inclusive, tests: one thousand eight hundred dollars ($1,800).

(4) Between 25,001 and 50,000, inclusive, tests: two thousand two hundred dollars ($2,200).

(5) Between 50,001 and 75,000, inclusive, tests: two thousand seven hundred dollars ($2,700).

(6) Between 75,001 and 100,000, inclusive, tests: three thousand three hundred dollars ($3,300).

(7) Between 100,001 and 500,000, inclusive, tests: four thousand dollars ($4,000).

(8) Between 500,001 and 1,000,000, inclusive, tests: seven thousand two hundred dollars ($7,200).

(9) More than 1,000,000 tests: eight thousand six hundred thirty dollars ($8,630) plus four hundred twenty dollars ($420) for every 500,000 tests over 1,000,000, up to a maximum of 15,000,000 tests.

(h) A clinical laboratory performing tests or examinations classified as of moderate or of high complexity under CLIA and a clinical laboratory

with a certificate issued under subdivision (c) of Section 1223 shall pay an annual renewal fee based on the number of tests it performed in the preceding calendar year, as follows:

(1) Less than 2,001 tests: three hundred thirty-five dollars ($335).

(2) Between 2,001 and 10,000, inclusive, tests: one thousand one hundred dollars ($1,100).

(3) Between 10,001 and 25,000, inclusive, tests: one thousand eight hundred dollars ($1,800).

(4) Between 25,001 and 50,000, inclusive, tests: two thousand two hundred dollars ($2,200).

(5) Between 50,001 and 75,000, inclusive, tests: two thousand seven hundred dollars ($2,700).

(6) Between 75,001 and 100,000, inclusive, tests: three hundred three hundred dollars ($3,300).

(7) Between 100,001 and 500,000, inclusive, tests: four thousand dollars ($4,000).

(8) Between 500,001 and 1,000,000, inclusive, tests: seven thousand two hundred dollars ($7,200).

(9) More than 1,000,000 tests per year: eight thousand six hundred thirty dollars ($8,630) plus four hundred twenty dollars ($420) for every 500,000 tests over 1,000,000, up to a maximum of 15,000,000 tests.

(i) The application fee for a trainee's license is forty-five dollars ($45).

(j) The annual renewal fee for a trainee's license is forty-five dollars ($45).

(k) The application fee for a duplicate license is five dollars ($5).

(l) The personnel licensing delinquency fee is equal to the annual renewal fee.

(m) The director may establish a fee for examinations required under this chapter. The fee shall not exceed the total cost to the department in conducting the examination.

(n) A clinical laboratory subject to registration under paragraph (2) of subdivision (a) of Section 1265 and performing only those clinical laboratory tests or examinations considered waived under CLIA shall pay an annual fee of one hundred fifty-five dollars ($155). A clinical laboratory subject to registration under paragraph (2) of subdivision (a) of Section 1265 and performing only provider-performed microscopy, as defined under CLIA, shall pay an annual fee of two hundred thirty-five dollars ($235). A clinical laboratory performing both waived and provider-performed microscopy shall pay an annual registration fee of two hundred thirty-five dollars ($235).

(o) The costs of the department in conducting a complaint investigation, imposing sanctions, or conducting a hearing under this chapter shall be paid by the clinical laboratory. The fee shall be no greater than the fee the laboratory would pay under CLIA for the same type of activities and shall not be payable if the clinical laboratory would not be required to pay those fees under CLIA.

(p) The state, a district, city, county, city and county, or other political subdivision, or any public officer or body shall be subject to the payment of fees established pursuant to this chapter or regulations adopted thereunder.

(q) In addition to the payment of registration or licensure fees, a clinical laboratory located outside the State of California shall reimburse the department for travel and per diem to perform any necessary onsite inspections at the clinical laboratory in order to ensure compliance with this chapter.

(r) The department shall establish an application fee and a renewal fee for a medical laboratory technician license, the total fees collected not to exceed the costs of the department for the implementation and operation of the program licensing and regulating medical laboratory technicians pursuant to Section 1260.3.

(s) The costs of the department to conduct any reinspections to ensure compliance of a laboratory applying for initial licensure shall be paid by the laboratory. This additional cost for each visit shall be equal to the initial application fee and shall be paid by the laboratory prior to issuance of a license. The department shall not charge a reinspection fee if the reinspection is due to error or omission on the part of the department.

(t) A fee of twenty-eight dollars ($28) shall be assessed for approval of each additional location authorized by paragraph (2) of subdivision (d) of Section 1265.

(u) On or before July 1, 2013, the department shall report to the Legislature during the annual legislative budget hearing process the extent to which the state oversight program meets or exceeds federal oversight standards and the extent to which the federal Department of Health and Human Services is accepting exemption applications and the potential cost to the state for an exemption.

SEC. 4. Section 1300.1 of the Business and Professions Code is amended to read:

1300.1. (a) The application, registration, certification, and license fees specified in Section 1300 shall be adjusted annually in the manner specified in Section 100450 of the Health and Safety Code. The adjustments shall be rounded off to the nearest whole dollar amount.

(b) This section shall become operative on January 1, 2020.

SEC. 5. Section 1625.6 of the Business and Professions Code is amended to read:

1625.6. (a) In addition to the actions authorized under Section 1625, a dentist may independently prescribe and administer influenza and COVID-19 vaccines, consistent with recommendations adopted pursuant to Section 120164 of the Health and Safety Code, to persons 3 years of age or older.

(b) In order to prescribe and administer a vaccine described in subdivision (a), a dentist shall do all of the following:

(1) Complete an immunization training program biennially that is either offered by the CDC or taken through a registered provider approved by the board that, at a minimum, includes vaccine administration, prevention and management of adverse reactions, and maintenance of vaccine records.

(2) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider, if applicable, and entering in the information in the appropriate immunization registry designated by the Immunization Branch of the State Department of Public Health.

(c) The board may adopt regulations to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 180-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 240 days.

SEC. 6. Section 2473 of the Business and Professions Code is amended to read:

2473. (a) A doctor of podiatric medicine may independently prescribe and administer influenza and COVID-19 vaccines, consistent with recommendations adopted pursuant to Section 120164 of the Health and Safety Code, to persons three years of age or older.

(b) In order to prescribe and administer a vaccine described in subdivision (a), a doctor of podiatric medicine shall do all of the following:

(1) Complete an immunization training program biennially that is either offered by the CDC or taken through a registered provider approved by the board that, at a minimum, includes vaccine administration, prevention and management of adverse reactions, and maintenance of vaccine records.

(2) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider, if applicable, and entering in the information in the appropriate immunization registry designated by the Immunization Branch of the State Department of Public Health.

(c) The board may adopt regulations to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to address an emergency, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted for this purpose from the requirements of subdivision (b) of Section 11346.1 of the Government Code. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 180-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 240 days.

SEC. 7. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the diagnosis, prevention, treatment, and management of disorders and dysfunctions of the visual system, as authorized by this chapter, as well as the provision of habilitative

or rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eyes and their adnexa, including through the use of all topical and oral diagnostic pharmaceutical agents that are not controlled substances, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eyes, including the scope of their functions and general condition.

(3) The prescribing, using, or directing the use of any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing, fitting, or adaptation of contact and spectacle lenses to, the human eyes, including lenses that may be classified as drugs or devices by any law of the United States or of this state, and diagnostic or therapeutic contact lenses that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

(5) For an optometrist certified pursuant to Section 3041.3, diagnosing and preventing conditions and diseases of the human eyes and their adnexa, and treating nonmalignant conditions and diseases of the anterior segment of the human eyes and their adnexa, including ametropia and presbyopia:

(A) Using or prescribing, including for rational off-label purposes, topical and oral prescription and nonprescription therapeutic pharmaceutical agents that are not controlled substances and are not antiglaucoma agents or limited or excluded by subdivision (b). For purposes of this section, "controlled substance" has the same meaning as used in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.).

(B) Prescribing the oral analgesic controlled substance codeine with compounds, hydrocodone with compounds, and tramadol as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.), limited to three days, with referral to an ophthalmologist if the pain persists.

(C) If also certified under subdivision (c), using or prescribing topical and oral antiglaucoma agents for the medical treatment of all primary open-angle, exfoliation, pigmentary, and steroid-induced glaucomas in persons 18 years of age or over. In the case of steroid-induced glaucoma, the prescriber of the steroid medication shall be promptly notified if the prescriber did not refer the patient to the optometrist for treatment.

(D) If also certified under subdivision (d), independent initiation and administration of immunizations for influenza, herpes zoster virus, pneumococcus, and SARS-CoV-2 in compliance with recommendations adopted pursuant to Section 120164 of the Health and Safety Code in persons 18 years of age or older.

(E) Utilizing the following techniques and instrumentation necessary for the diagnosis of conditions and diseases of the eye and adnexa:

(i) Laboratory tests or examinations ordered from an outside facility.

(ii) Laboratory tests or examinations performed in a laboratory with a certificate of waiver under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) (42 U.S.C. Sec. 263a; Public Law 100-578), which shall also be allowed for:

(I) Detecting indicators of possible systemic disease that manifests in the eye for the purpose of facilitating appropriate referral to or consultation with a physician and surgeon.

(II) Detecting the presence of SARS-CoV-2 virus.

(iii) Skin testing performed in an office to diagnose ocular allergies, limited to the superficial layer of the skin.

(iv) X-rays ordered from an outside facility.

(v) Other imaging studies ordered from an outside facility subject to prior consultation with an appropriate physician and surgeon.

(vi) Other imaging studies performed in an office, including those that utilize laser or ultrasound technology, but excluding those that utilize radiation.

(F) Performing the following procedures, which are excluded from restrictions imposed on the performance of surgery by paragraph (6) of subdivision (b), unless explicitly indicated:

(i) Corneal scraping with cultures.

(ii) Debridement of corneal epithelium not associated with band keratopathy.

(iii) Mechanical epilation.

(iv) Collection of blood by skin puncture or venipuncture for laboratory testing authorized by this subdivision.

(v) Suture removal subject to comanagement requirements in paragraph (7) of subdivision (b).

(vi) Treatment or removal of sebaceous cysts by expression.

(vii) Lacrimal punctal occlusion using plugs, or placement of a stent or similar device in a lacrimal canaliculus intended to deliver a medication the optometrist is certified to prescribe or provide.

(viii) Foreign body and staining removal from the cornea, eyelid, and conjunctiva with any appropriate instrument. Removal of corneal foreign bodies and any related stain shall, as relevant, be limited to that which is nonperforating, no deeper than the midstroma, and not reasonably anticipated to require surgical repair.

(ix) Lacrimal irrigation and dilation in patients 12 years of age or over, excluding probing of the nasolacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

(x) Administration of oral fluorescein for the purpose of ocular angiography.

(xi) Intravenous injection for the purpose of performing ocular angiography at the direction of an ophthalmologist as part of an active treatment plan in a setting where a physician and surgeon is immediately available.

(xii) Use of noninvasive devices delivering intense pulsed light therapy or low-level light therapy that do not rely on laser technology, limited to treatment of conditions and diseases of the adnexa.

(xiii) Use of an intranasal stimulator in conjunction with treatment of dry eye syndrome.

(G) Using additional noninvasive medical devices or technology that:

(i) Have received a United States Food and Drug Administration approved indication for the diagnosis or treatment of a condition or disease authorized by this chapter. A licensee shall successfully complete any clinical training imposed by a related manufacturer prior to using any of those noninvasive medical devices or technologies.

(ii) Have been approved by the board through regulation for the rational treatment of a condition or disease authorized by this chapter. Any regulation under this paragraph shall require a licensee to successfully complete an appropriate amount of clinical training to qualify to use each noninvasive medical device or technology approved by the board pursuant to this paragraph.

(b) Exceptions or limitations to the provisions of subdivision (a) are as follows:

(1) Treatment of the following is excluded from the practice of optometry in a patient under 18 years of age, unless explicitly allowed otherwise:

(A) Anterior segment inflammation, which shall not exclude treatment of:

(i) The conjunctiva.

(ii) Nonmalignant ocular surface disease, including dry eye syndrome.

(iii) Contact lens-related inflammation of the cornea.

(iv) An infection of the cornea.

(B) Conditions or diseases of the sclera.

(2) Use of any oral prescription steroid anti-inflammatory medication for a patient under 18 years of age shall be done pursuant to a documented, timely consultation with an appropriate physician and surgeon.

(3) Use of any nonantibiotic oral prescription medication for a patient under five years of age shall be done pursuant to a documented, prior consultation with an appropriate physician and surgeon.

(4) The following classes of agents are excluded from the practice of optometry unless they have an explicit United States Food and Drug Administration-approved indication for treatment of a condition or disease authorized under this section:

(A) Antiamoebics.

(B) Antineoplastics.

(C) Coagulation modulators.

(D) Hormone modulators.

(E) Immunomodulators.

(5) The following are excluded from authorization under subparagraph (G) of paragraph (5) of subdivision (a):

(A) A laboratory test or imaging study.

(B) Any noninvasive device or technology that constitutes surgery under paragraph (6).

(6) Performing surgery is excluded from the practice of optometry. "Surgery" means any act in which human tissue is cut, altered, or otherwise infiltrated by any means. It does not mean an act that solely involves the administration or prescribing of a topical or oral therapeutic pharmaceutical.

(7) (A) Treatment with topical and oral medications authorized in subdivision (a) related to an ocular surgery shall be comanaged with the ophthalmologist that performed the surgery, or another ophthalmologist designated by that surgeon, during the customary preoperative and postoperative period for the procedure. For purposes of this subparagraph, this may involve treatment of ocular inflammation in a patient under 18 years of age.

(B) Where published, the postoperative period shall be the "global" period established by the federal Centers for Medicare and Medicaid Services, or, if not published, a reasonable period not to exceed 90 days.

(C) Such comanaged treatment may include addressing agreed-upon complications of the surgical procedure occurring in any ocular or adnexal structure with topical and oral medications authorized in subdivision (a). For patients under 18 years of age, this subparagraph shall not apply unless the patient's primary care provider agrees to allowing comanagement of complications.

(c) An optometrist certified pursuant to Section 3041.3 shall be certified to medically treat authorized glaucomas under this chapter after meeting the following requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section before January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board.

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and who are not described in paragraph (2) or (3), submission of proof of satisfactory completion of the requirements for certification established by the board under Chapter 352 of the Statutes of 2008.

(d) An optometrist certified pursuant to Section 3041.3 shall be certified to administer authorized immunizations, as described in subparagraph (D) of paragraph (5) of subdivision (a), after the optometrist meets all of the following requirements:

(1) Completes an immunization training program endorsed by the federal Centers for Disease Control and Prevention (CDC) or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintains that training.

(2) Is certified in basic life support.

(3) Complies with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(4) Applies for an immunization certificate in accordance with Section 3041.5.

(e) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(f) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

(g) For the purposes of this chapter, all of the following definitions shall apply:

(1) "Adnexa" means the eyelids and muscles within the eyelids, the lacrimal system, and the skin extending from the eyebrows inferiorly, bounded by the medial, lateral, and inferior orbital rims, excluding the intraorbital extraocular muscles and orbital contents.

(2) "Anterior segment" means the portion of the eye anterior to the vitreous humor, including its overlying soft tissue coats.

(3) "Ophthalmologist" means a physician and surgeon, licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, specializing in treating eye disease.

(4) "Physician and surgeon" means a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(5) "Prevention" means use or prescription of an agent or noninvasive device or technology for the purpose of inhibiting the development of an authorized condition or disease.

(6) "Treatment" means use of or prescription of an agent or noninvasive device or technology to alter the course of an authorized condition or disease once it is present.

(h) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 8. Section 3041.5 of the Business and Professions Code is amended to read:

3041.5. (a) A person requesting to be certified to administer immunizations pursuant to Section 3041 shall apply for a certificate from the board pursuant to an application that shall be in substantially the following form:

"Application for Optometrists to Administer Immunizations

Per California Business and Professions Code §3041(g), you must have a current California Optometrist License and have a Therapeutic Pharmaceutical Agents (TPA) license type to be eligible for a certificate to administer immunizations. "Immunization" means the administration of immunizations for influenza, herpes zoster virus, pneumococcus, and SARS-CoV-2, consistent with recommendations adopted pursuant to Section 120164 of the Health and Safety Code, for persons 18 years of age or older.

If eligible, you must also meet and maintain the following requirements for an immunization certificate:

1. Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintain that training.

2. Be certified in basic life support.

3. Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the California State Department of Public Health.

To apply for an immunization certificate, provide documentation for items #1 and #2 above with your application. All documentation must be provided, or the application will be rejected.

First, Middle, and Last Name:_____

Email address:_____

License No.:_____

1. I declare under penalty of perjury under the laws of the State of California that the information provided on this form and the attached documents or other requested proof of completion is true and accurate. I understand and agree that any misstatements of material facts may be cause for denial of the Application for Optometrists to Administer Immunizations and disciplinary action by the California State Board of Optometry.

AND

2. I declare under penalty of perjury under the laws of the State of California that I will comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the California State Department of Public Health.

Optometrist Signature: _____
Date: _____"

(b) The application for an immunization certificate set forth in subdivision (a) shall be accompanied by an application fee of fifty dollars ($50), or a fee in an amount as determined by the board, not to exceed the reasonable cost of administering this section.

(c) After the effective date of this section, the board may modify the Application for Optometrists to Administer Immunizations set forth in subdivision (a) by regulation in accordance with Section 3025.

SEC. 9. Section 4052.05 is added to the Business and Professions Code, to read:

4052.05. A pharmacist may independently initiate and administer an immunization that, on January 1, 2025, had in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, regardless of whether the immunization is recommended for routine use, or as modified or supplemented by the State Department of Public Health pursuant to Section 120164 of the Health and Safety Code, to individuals three years of age or older.

SEC. 10. Section 48980.4 of the Education Code is amended to read:

48980.4. (a) (1) Until June 30, 2026, the notification required pursuant to Section 48980 for pupils admitted to, or advancing to, grade 6 shall include a notification to the pupil's parent or guardian containing a statement about the state's public policy described in subdivision (a) of Section 120336 of the Health and Safety Code, advising that the pupil adhere to current immunization guidelines, as recommended by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians, regarding full human papillomavirus (HPV) immunization before admission or advancement to the grade 8.

(2) Beginning July 1, 2026, the notification required pursuant to Section 48980 for pupils admitted to, or advancing to, grade 6 shall include a notification to the pupil's parent or guardian containing a statement about the state's public policy described in subdivision (a) of Section 120336 of the Health and Safety Code, advising that the pupil adhere to current immunization guidelines, as recommended by the State Department of Public Health, in accordance with Section 120164 of the Health and Safety Code, regarding full human papillomavirus (HPV) immunization before admission or advancement to the grade 8.

(b) The notification sent pursuant to subdivision (a) shall conform to the notification requirements outlined in this article.

(c) The notification sent pursuant to subdivision (a) shall also include the statement specified in subdivision (c) of Section 120336 of the Health and Safety Code.

SEC. 11. Section 100503.6 is added to the Government Code, to read:

100503.6. (a) If a qualified health plan is required to cover state-mandated gender-affirming care benefits determined to be in addition to essential health benefits pursuant to Section 18031(d)(3)(B) of Title 42 of the United States Code, the Exchange shall provide payments to issuers of qualified health plans offered through the Exchange to defray the costs of offering those benefits to qualified health plan enrollees.

(b) In accordance with Section 155.170 of Title 45 of the Code of Federal Regulations, the payments required by subdivision (a) shall equal the cost of the additional required benefits reported to the Exchange.

(c) The payments required under subdivision (a) shall only be made upon appropriation by the Legislature. The payments shall not be made from the California Health Trust Fund established by Section 100520.

(d) Subject to an appropriation by the Legislature, the payments shall be made for plan years beginning on or after January 1, 2026.

(e) This section does not create an entitlement program of any kind, appropriate any funds, require the Legislature to appropriate any funds, or increase or decrease taxes owed by a taxpayer.

(f) The Director of the Department of Managed Health Care may issue guidance regarding gender-affirming care benefits subject to this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

SEC. 12. Section 100520.5 of the Government Code is amended to read:

100520.5. (a) The Health Care Affordability Reserve Fund is hereby created in the State Treasury.

(b) Notwithstanding any other law, the Controller may use the funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381.

(c) Upon the enactment of the Budget Act of 2021, and upon order of the Director of Finance, the Controller shall transfer three hundred thirty-three million four hundred thirty-nine thousand dollars ($333,439,000) from the General Fund to the Health Care Affordability Reserve Fund.

(d) Upon appropriation by the Legislature, the Health Care Affordability Reserve Fund shall be utilized, in addition to any other appropriations made by the Legislature for the same purpose, for the purpose of health care affordability programs, and benefit programs pursuant to Section 100503.6, operated by the California Health Benefit Exchange.

(e) (1) The California Health Benefit Exchange shall, in consultation with stakeholders and the Legislature, develop options for providing cost sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians. On or before January 1, 2022, the Exchange shall report those developed options to the Legislature, Governor, and the Healthy California for All Commission, established pursuant to Section 1001 of the Health and Safety Code, for consideration in the 2022–23 budget process.

(2) In developing the options, the Exchange shall do all of the following:

(A) Include options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs.

(B) Include options to provide zero deductibles for all Covered California enrollees with income under 400 percent of the federal poverty level and upgrading those with income between 200 percent and 400 percent, inclusive, of the federal poverty level to gold-tier cost sharing.

(C) Address any operational issues that might impede implementation of enhanced cost-sharing reductions for the 2023 calendar year.

(D) Maximize federal funding and address interactions with federal law regarding federal cost-sharing reduction subsidies.

(3) The Exchange shall make the report publicly available on its internet website.

(4) The Exchange shall submit the report in compliance with Section 9795 of the Government Code.

(f) Upon order of the Department of Finance, a loan of six hundred million dollars ($600,000,000) is authorized from the Health Care Affordability Reserve Fund to the General Fund in the 2023–24 fiscal year. The loan shall be repaid in annual installments of two hundred million dollars ($200,000,000) over the 2026–27, 2027–28, and 2028–29 fiscal years.

SEC. 13. Section 1206 of the Health and Safety Code is amended to read:

1206. This chapter does not apply to the following:

(a) Except with respect to the option provided with regard to surgical clinics in paragraph (1) of subdivision (b) of Section 1204 and, further, with respect to specialty clinics specified in paragraph (2) of subdivision (b) of Section 1204, any place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license, regardless of the name used publicly to identify the place or establishment.

(b) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies, and any primary care clinic specified in subdivision (a) of Section 1204 that is directly conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city. This subdivision does not preclude the department from adopting regulations that utilize clinic licensing standards as eligibility criteria for participation in programs funded wholly or partially under Title XVIII or XIX of the federal Social Security Act.

(c) (1) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 or 5304 of Title 25 of the United States Code, that is located on land recognized as tribal land by the federal government.

(2) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 or 5304 of Title 25 of the United States Code, under a contract with the United States pursuant to the Indian Self-Determination and Education

Assistance Act (Public Law 93-638), regardless of the location of the clinic, except that if the clinic chooses to apply to the State Department of Public Health for a state facility license, then the State Department of Public Health will retain authority to regulate that clinic as a primary care clinic as defined by subdivision (a) of Section 1204.

(d) A clinic conducted, operated, or maintained as outpatient departments of hospitals.

(e) Any facility licensed as a health facility under Chapter 2 (commencing with Section 1250).

(f) Any freestanding clinical or pathological laboratory licensed under Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code.

(g) A clinic operated by, or affiliated with, any institution of learning that teaches a recognized healing art and is approved by the state board or commission vested with responsibility for regulation of the practice of that healing art.

(h) A clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week. An intermittent clinic as described in this subdivision shall, however, meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety.

(i) The offices of physicians in group practice who provide a preponderance of their services to members of a comprehensive group practice prepayment health care service plan subject to Chapter 2.2 (commencing with Section 1340).

(j) Student health centers operated by public institutions of higher education.

(k) Nonprofit speech and hearing centers, as defined in Section 1201.5. Any nonprofit speech and hearing clinic desiring an exemption under this subdivision shall make application therefor to the director, who shall grant the exemption to any facility meeting the criteria of Section 1201.5. Notwithstanding the licensure exemption contained in this subdivision, a nonprofit speech and hearing center shall be an organized outpatient clinic for purposes of qualifying for reimbursement as a rehabilitation center under the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(l) A clinic operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, that conducts medical research and health education and provides health care to its patients through a group of 40 or more physicians and surgeons, who are independent contractors representing not less than 10 board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic.

(m) Any clinic, limited to in vivo diagnostic services by magnetic resonance imaging functions or radiological services under the direct and

immediate supervision of a physician and surgeon who is licensed to practice in California. This shall not be construed to permit cardiac catheterization or any treatment modality in these clinics.

(n) A clinic operated by an employer or jointly by two or more employers for their employees only, or by a group of employees, or jointly by employees and employers, without profit to the operators thereof or to any other person, for the prevention and treatment of accidental injuries to, and the care of the health of, the employees comprising the group.

(o) A community mental health center, as defined in Section 5667 of the Welfare and Institutions Code.

(p) (1) A clinic operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, as an entity organized and operated exclusively for scientific and charitable purposes and that satisfied all of the following requirements on or before January 1, 2005:

(A) Commenced conducting medical research on or before January 1, 1982, and continues to conduct medical research.

(B) Conducted research in, among other areas, prostatic cancer, cardiovascular disease, electronic neural prosthetic devices, biological effects and medical uses of lasers, and human magnetic resonance imaging and spectroscopy.

(C) Sponsored publication of at least 200 medical research articles in peer-reviewed publications.

(D) Received grants and contracts from the National Institutes of Health.

(E) Held and licensed patents on medical technology.

(F) Received charitable contributions and bequests totaling at least five million dollars ($5,000,000).

(G) Provides health care services to patients only:

(i) In conjunction with research being conducted on procedures or applications not approved or only partially approved for payment (I) under the Medicare program pursuant to Section 1359y(a)(1)(A) of Title 42 of the United States Code, or (II) by a health care service plan registered under Chapter 2.2 (commencing with Section 1340), or a disability insurer regulated under Chapter 1 (commencing with Section 10110) of Part 2 of Division 2 of the Insurance Code; provided that services may be provided by the clinic for an additional period of up to three years following the approvals, but only to the extent necessary to maintain clinical expertise in the procedure or application for purposes of actively providing training in the procedure or application for physicians and surgeons unrelated to the clinic.

(ii) Through physicians and surgeons who, in the aggregate, devote no more than 30 percent of their professional time for the entity operating the clinic, on an annual basis, to direct patient care activities for which charges for professional services are paid.

(H) Makes available to the public the general results of its research activities on at least an annual basis, subject to good faith protection of proprietary rights in its intellectual property.

(I) Is a freestanding clinic, whose operations under this subdivision are not conducted in conjunction with any affiliated or associated health clinic or facility defined under this division, except a clinic exempt from licensure under subdivision (m). For purposes of this subparagraph, a freestanding clinic is defined as "affiliated" only if it directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, a clinic or health facility defined under this division, except a clinic exempt from licensure under subdivision (m). For purposes of this subparagraph, a freestanding clinic is defined as "associated" only if more than 20 percent of the directors or trustees of the clinic are also the directors or trustees of any individual clinic or health facility defined under this division, except a clinic exempt from licensure under subdivision (m). Any activity by a clinic under this subdivision in connection with an affiliated or associated entity shall fully comply with the requirements of this subdivision. This subparagraph does not apply to agreements between a clinic and any entity for purposes of coordinating medical research.

(2) By January 1, 2007, and every five years thereafter, the Legislature shall receive a report from each clinic meeting the criteria of this subdivision and any other interested party concerning the operation of the clinic's activities. The report shall include, but not be limited to, an evaluation of how the clinic impacted competition in the relevant health care market, and a detailed description of the clinic's research results and the level of acceptance by the payer community of the procedures performed at the clinic. The report shall also include a description of procedures performed both in clinics governed by this subdivision and those performed in other settings. The cost of preparing the reports shall be borne by the clinics that are required to submit them to the Legislature pursuant to this paragraph.

(q) A primary care clinic operated as part of a Program of All-Inclusive Care for the Elderly (PACE) organization, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations and approved by the State Department of Health Care Services pursuant to Section 14592 of the Welfare and Institutions Code, that exclusively serves PACE participants, as defined in Section 460.6 of Title 42 of the Code of Federal Regulations.

(1) A primary care clinic approved by the State Department of Health Care Services pursuant to Section 14592 of the Welfare and Institutions Code to operate exclusively as part of a PACE organization may provide services to individuals who are being assessed for eligibility to enroll in the PACE program for not more than 60 calendar days after an individual submits an application for enrollment.

(2) If the State Department of Health Care Services determines that a primary care clinic approved to operate exclusively as part of a PACE organization has provided services to individuals other than those enrolled in the PACE program, or who are being assessed for eligibility pursuant to paragraph (1), the clinic shall apply for licensure with the State Department

of Public Health. A clinic required to obtain licensure from the State Department of Public Health pursuant to this paragraph shall apply for the license not later than 60 calendar days following the determination by the State Department of Health Care Services described in this paragraph. The clinic shall not accept any new participants in the PACE program until licensure is obtained.

(3) This subdivision shall become operative only if the Director of Health Care Services determines, and communicates that determination in writing to the State Department of Public Health, that operating standards compliance programs consistent with subdivisions (d) and (e) of Section 14592 of the Welfare and Institutions Code have been established. A primary care clinic described in subdivision (c) of Section 14592 of the Welfare and Institutions Code shall remain under the oversight and regulatory authority of the State Department of Public Health until the Director of Health Care Services communicates their written determination to the State Department of Public Health.

(r) (1) A clinic, including any location thereof, operated by a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954, as amended, or a statutory successor thereof, as an entity organized and operated exclusively to provide health care services and health education services within the Los Angeles County Service Planning Area 6, is located in a Clinic Service Area, as defined in paragraph (3), and satisfies all of the following requirements:

(A) Provides health care services and health education services solely within a Clinic Service Area, as defined in paragraph (3).

(B) Provides health care services to patients through an independent agreement with a multispecialty medical group of 26 or more physicians and surgeons who represent not less than 10 board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic by July 1, 2021.

(C) Serves substantial beneficiaries of a "federal health care program," as that term is defined in subsection (f) of Section 1320a-7b of Title 42 of the United States Code and indigent and uninsured individuals pursuant to an authorized and adopted charity care policy.

(D) Participates in a graduate medical education program that is administered by the Martin Luther King, Jr. Community Hospital, as described in Section 14165.50 of the Welfare and Institutions Code, in furtherance of its charitable mission to reduce health care disparities in a Clinic Service Area, as defined in paragraph (3), through the training and retention of physicians and surgeons by 2022.

(2) (A) By July 1, 2022, and every five years thereafter, a clinic that is exempt from licensing provisions pursuant to this subdivision shall provide the Legislature with a report that includes all of the following:

(i) A copy of the current Community Health Needs Assessment, developed by the Martin Luther King, Jr. Community Hospital.

(ii) A community needs assessment for physicians and surgeons, including an analysis of the clinic's role in physician and surgeon recruitment and retention, and meeting the community needs for a physician and surgeon workforce.

(iii) A copy of the Martin Luther King, Jr. Community Hospital's most recent Internal Revenue Service Form 990, Schedule H, including a description of the federally-funded payer mix, and identification of the clinic as a component of the Martin Luther King, Jr. Community Hospital's community benefit activities.

(iv) The clinic's role in the hospital-sponsored graduate medical education program.

(v) An analysis of how the clinic impacted physicians and surgeons practicing or providing services in the Clinic Service Area prior to January 1, 2020.

(B) A report to be submitted pursuant to subparagraph (A) of paragraph (2) shall be submitted in compliance with Section 9795 of the Government Code.

(3) For purposes of this subdivision, "Clinic Service Area" means the geographic area within any ZIP Code that is located within six miles of the physical location of the Martin Luther King, Jr. Community Hospital, as described in Section 14165.50 of the Welfare and Institutions Code.

(s) (1) From May 15, 2028, to September 15, 2028, inclusive, a clinic that meets all of the following requirements:

(A) Approved by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

(B) Is either of the following:

(i) Conducted, operated, or maintained by a California licensed health care practitioner acting within the scope of their license.

(ii) Operated by or affiliated with a health facility, as defined in subdivision (a) or (b) of Section 1250.

(C) Provides health care services at either of the following:

(i) A competition, noncompetition, athlete village, training, or support site designated by the committee.

(ii) An event in this state sanctioned by the committee.

(2) This subdivision exempts a clinic from this chapter only for health care services provided at the locations described in subparagraph (C) of paragraph (1).

(3) For purposes of this subdivision, "committee" means the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

SEC. 14. Section 1261.3 of the Health and Safety Code is amended to read:

1261.3. (a) Notwithstanding any other provision of law, for a patient aged 50 years or older, a registered nurse or licensed pharmacist may administer in a skilled nursing facility, as defined in subdivision (c) of Section 1250, influenza and pneumococcal immunizations pursuant to standing orders and without patient-specific orders if all of the following criteria are met:

(1) The skilled nursing facility medical director, as defined in Section 72305 of Title 22 of the California Code of Regulations, has approved the immunization standing orders established by the facility.

(2) The standing orders meet the recommendations adopted by the State Department of Public Health pursuant to Section 120164.

(b) Nothing in this section amends, alters, or restricts the scope of registered nurse practice including, but not limited to, the scope of practice set forth in Article 2 (commencing with Section 2725) of Chapter 6 of Division 2 of the Business and Professions Code, the implementing regulations, and interpretative bulletins or practice advisories issued by the Board of Registered Nursing.

SEC. 15. Section 1342.2 of the Health and Safety Code is amended to read:

1342.2. (a) Notwithstanding any other law, a health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an enrollee as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(2) A health care service plan contract shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an enrollee, a health care service plan shall reimburse the provider of the testing according to either of the following:

(A) If the health plan has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health plan does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the plan may negotiate a rate with such provider.

(4) For an out-of-network provider with whom a health care service plan does not have a specifically negotiated rate for COVID-19 diagnostic and

screening testing and health care services related to testing, a plan shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee for services related to testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(6) Changes to a contract between a health care service plan and a provider delegating financial risk for diagnostic and screening testing related to a declared public health emergency shall be considered a material change to the parties' contract. A health care service plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(b) (1) A health care service plan contract that covers medical, surgical, and hospital benefits shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual enrollee:

(A) An evidence-based item or service that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(B) An immunization that had in effect on January 1, 2025 a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164, regardless of whether the immunization is recommended for routine use.

(2) The item, service, or immunization covered pursuant to paragraph (1) shall be covered upon operation of the act that amended this subdivision.

(3) Any modification or supplement to the recommendations described in paragraph (1) shall be covered or removed from coverage no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164.

(4) (A) A health care service plan subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the health care provider the amount of that lost cost sharing.

(C) With respect to an enrollee, a health care service plan shall reimburse the provider of the immunization according to either of the following:

(i) If the health plan has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health plan does not have a negotiated rate with such provider, the plan may negotiate a rate with such provider.

(D) A health care service plan shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(E) (i) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for an item, service, or immunization described in paragraph (1), a health care service plan shall reimburse the provider for all related items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for items, services, and immunizations described in subdivision (b), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(ii) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(5) A health care service plan subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (D) of paragraph (3).

(6) Changes to a contract between a health care service plan and a provider delegating financial risk for immunization related to a declared public health emergency, shall be considered a material change to the parties'

contract. A health plan shall not delegate the financial risk to a contracted provider for the cost of enrollee services provided under this section unless the parties have negotiated and agreed upon a new provision of the parties' contract pursuant to Section 1375.7.

(c) The director may issue guidance to health care service plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The department shall consult with the Department of Insurance in issuing the guidance specified in this subdivision.

(d) This section, excluding subdivision (h), shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020. Notwithstanding Section 1390, this subdivision does not create criminal liability for transactions that occurred before January 1, 2022.

(e) For purposes of this section:

(1) "Diagnostic testing" means all of the following:

(A) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

(B) Testing a person with symptoms consistent with COVID-19.

(C) Testing a person as a result of contact tracing efforts.

(D) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.

(E) Testing a person after an individualized clinical assessment by a licensed health care provider.

(2) "Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

(A) Workers in a workplace setting.

(B) Pupils, faculty, and staff in a school setting.

(C) A person before or after travel.

(D) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

(f) This section does not relieve a health care service plan from continuing to cover testing as required by federal law and guidance.

(g) The department shall hold health care service plans accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(h) (1) This subdivision applies to a health care service plan contract issued, amended, or renewed on or after the operative date of this subdivision that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, with respect to therapeutics for COVID-19

covered under the contract, which shall include therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care.

(2) A health care service plan shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the plan and provider have negotiated a rate. If the plan does not have a negotiated rate with a provider, the plan may negotiate a rate with the provider.

(3) For an out-of-network provider with whom a health care service plan does not have a negotiated rate for the therapeutics described in paragraph (1), a health care service plan shall reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics described in this subdivision.

(4) A health care service plan shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the health care service plan shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an enrollee, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a health care service plan shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(6) This section does not apply to a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 16. Section 1342.3 of the Health and Safety Code is amended to read:

1342.3. (a) A health care service plan contract that covers medical, surgical, and hospital benefits, excluding a specialized health care service plan contract, shall cover, without cost sharing and without prior authorization or other utilization management, the costs of the following

health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(1) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease and that is either of the following:

(A) An item or service that, as of January 1, 2025, had in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(B) An immunization that, as of January 1, 2025, had in effect a recommendation of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(2) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(3) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(b) (1) The item, service, or immunization covered pursuant to paragraph (1) of subdivision (a) shall be covered upon operation of the act that added this paragraph.

(2) Any modification or supplement to the recommendations described in subparagraphs (A) or (B) of paragraph (1) of subdivision (a) shall be covered or removed from coverage no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164.

(c) For purposes of this section, "health care service plan" includes a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. The State Department of Health Care Services shall seek any federal approvals it deems necessary to implement this section. This section applies to a Medi-Cal managed care plan contract only to the extent that the State Department of Health Care Services obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

SEC. 17. Section 1347.8 of the Health and Safety Code is amended to read:

1347.8. (a) (1) Beginning on July 1, 2023, and annually thereafter, a health care service plan providing a qualified health plan through the Exchange shall report to the director the total amount of funds maintained in a segregated account pursuant to subsection (b) of Section 1303 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(2) This annual report shall contain the ending balance of the account and the total dollar amount of claims paid during the reporting year. This report shall also include any related documentation required by the director.

(b) For purposes of this section:

(1) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(2) "Qualified health plan" has the same meaning as defined in Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(c) Annually from the 2025–26 fiscal year to the 2028–29 fiscal year, inclusive, and upon receipt of the required annual report, the director shall order the transfer of funds from each qualified health plan's segregated account with a positive balance, and each qualified health plan shall complete the transfer, to the Abortion Access Fund established in Section 127641, as follows:

(1) On or before October 30, 2025, up to the total amount provided by the California Health Benefit Exchange to qualified health plans pursuant to Section 100503.5 of the Government Code as of July 1, 2025, not to exceed 75 percent of the amount of the ending balance of the qualified health plan's segregated account as of July 1, 2025.

(2) On or before September 1, 2026, and each year thereafter through the 2028–29 fiscal year, up to the total amount provided by the California Health Benefit Exchange to qualified health plans pursuant to Section 100503.5 of the Government Code as of July 1 of that year, not to exceed 50 percent of the amount of the ending balance of a qualified health plan's segregated account that exceeds claims paid in the prior plan year.

SEC. 18. Section 1367.002 of the Health and Safety Code is amended to read:

1367.002. (a) A group or individual nongrandfathered health care service plan contract shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(2) Immunizations that had in effect on January 1, 2025, a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164 with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration, as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164.

(5) For the purposes of this section:

(A) The recommendations of the United States Preventive Services Task Force as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164, regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) For the purposes of this section, a health care service plan contract shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health care service plan contract from providing coverage for preventive items or services in addition to those required by subdivision (a).

(c) A health care service plan shall provide coverage pursuant to subdivision (a) for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health care service plan that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a plan year shall provide coverage through the last day of the plan year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the plan year.

(2) Notwithstanding paragraph (1) and consistent with the authority granted to the State Department of Public Health pursuant to Section 120164, if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, a health care service plan is not required to cover the item or service through the last day of the plan year.

(d) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this chapter, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 as added by Section 3 of Chapter 486 of the

Statutes of 2021 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

(e) This section does not apply to a specialized health care service plan that does not cover an essential health benefit, as defined in Section 1367.005. This section shall only apply to a health savings account-eligible health care service plan to the extent it does not fail to be treated as a high deductible health plan under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Insurance if it adopts regulations to implement this section.

SEC. 19. Section 1367.3 of the Health and Safety Code is amended to read:

1367.3. (a) Every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall offer benefits for the comprehensive preventive care of children. This section shall apply to children 17 and 18 years of age, except as provided in subparagraph (D) of paragraph (2) of subdivision (b). Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to a plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described herein.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a physician and surgeon affiliated with the plan, if the screening is prescribed by a health care provider affiliated with the plan.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

SEC. 20. Section 1367.35 of the Health and Safety Code is amended to read:

1367.35. (a) On and after January 1, 1993, every health care service plan that covers hospital, medical, or surgical expenses on a group basis shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under terms and conditions agreed upon between the group subscriber and the plan. Every plan shall communicate the availability of these benefits to all group contractholders and to all prospective group contractholders with whom they are negotiating. This section shall apply to each plan that, by rule or order of the director, has been exempted from subdivision (i) of Section 1367, insofar as that section and the rules thereunder relate to the provision of the preventive health care services described in this section.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for all of the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

SEC. 21. Section 1797.11 is added to the Health and Safety Code, to read:

1797.11. (a) (1) Notwithstanding any other law, the licensure, certification, or accreditation requirements of this division shall not apply to any Emergency Medical Technician (EMT-I), Advanced Emergency Medical Technician (EMT-II), or Emergency Medical Technician-Paramedic (EMT-P), or similar emergency medical services (EMS) provider licensed or certified as an EMT-I, EMT-II, EMT-P, or similar EMS provider in another state or territory of the United States, who provides EMS for which they are licensed, if they are authorized by the chief medical officer pursuant

to subdivision (b) to provide EMS at sites in this state sanctioned by the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games and associated with the 2028 Olympic and Paralympic Games.

(2) For purposes of this subdivision, "similar EMS provider" means an EMS provider that meets both of the following requirements:

(A) Licensed or certified in a state or territory of the United States that uses a license categorization that differs from this state.

(B) Licensed or certified to provide services similar to those provided by an EMT-I, EMT-II, or EMT-P licensed or certified in this state.

(b) The chief medical officer (CMO) shall do both of the following:

(1) Authorize EMS personnel under this section, based on system needs and informed by committee needs, qualifications of the emergency medical services personnel, and public safety considerations.

(2) Be medical control for any EMS personnel who are authorized under paragraph (1) of this subdivision.

(c) To be authorized by the CMO under this section, and before being deployed by the CMO, EMS personnel shall provide the CMO a valid copy of a professional license or certification and photograph identification issued by the state or territory in which the EMS personnel holds a license or certification.

(d) Emergency medical services providers authorized by the CMO to provide health care pursuant to this section shall not be liable on account of any act or omission taken in good faith while engaged in the provision of services authorized pursuant to this section. As used in this subdivision, "good faith" shall not include willful misconduct, gross negligence, or recklessness.

(e) Emergency medical services providers authorized by the CMO to provide health care pursuant to this section shall be authorized to perform the California basic scope of practice for an EMT-I, EMT-II, and EMT-P, as defined in Title 22 of Division 9 of the California Code of Regulations, if the provider has successfully completed the training to perform these skills and they are within the scope of practice for the state in which they are licensed or certified.

(f) Sites that may be sanctioned by the committee include competition, noncompetition, athlete village, training, or support sites in this state.

(g) Authorization under this section shall be valid from May 15, 2028, to September 15, 2028, inclusive, or until authorization is otherwise withdrawn by the CMO.

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

(1) "Chief medical officer" or "CMO" means the chief medical officer of the Emergency Medical Services Authority.

(2) "Committee" means the Los Angeles Organizing Committee for the 2028 Olympic and Paralympic Games.

SEC. 22. Section 11756.8 of the Health and Safety Code is repealed.

SEC. 23. Section 100425 of the Health and Safety Code is amended to read:

100425. (a) The fees or charges for the issuance or renewal of any permit, license, registration, or document pursuant to Sections 1676, 1677, 2805, 11839.25, 103625, 106700, 106890, 106925, 107080, 107090, 107095, 107160, 110210, 110470, 110471, 111130, 111140, 111630, 111923.5, 111923.6, 112405, 112510, 112750, 112755, 113060, 113065, 114065, 115035, 115065, 115080, 117923, 117995, 118045, 118210, and 118245 shall be adjusted annually by the percentage change printed in the Budget Act for those items appropriating funds to the state department. After the first annual adjustment of fees or charges pursuant to this section, the fees or charges subject to subsequent adjustment shall be the fees or charges for the prior calendar year. The percentage change shall be determined by the Department of Finance, and shall include at least the total percentage change in salaries and operating expenses of the state department. However, the total increase in amounts collected under this section shall not exceed the total increased cost of the program or service provided.

(b) The state department shall publish annually a list of the actual numerical fee charges for each permit, license, certification, or registration governed by this section.

(c) This adjustment of fees and publication of the fee list shall not be subject to the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) With respect to the fees or charges pursuant to Section 103625, the actual dollar fee or charge shall be rounded to the nearest whole dollar.

SEC. 24. Section 100450 of the Health and Safety Code is amended to read:

100450. (a) The fees or charges required to accompany an application for the issuance or renewal of any license pursuant to Section 1300 of the Business and Professions Code or pursuant to Sections 1616 or 1639.5 shall be adjusted annually pursuant to Section 1300.2 of the Business and Professions Code. The fees or charges subject to adjustment pursuant to this subdivision shall be the fees or charges that would have been payable in the prior calendar year without regard to the provisions of subdivision (b).

(b) The annual adjustment for fees or charges assessed under subdivision (a) shall be determined by the department so that license fee revenues cover the estimated licensing program costs pursuant to Section 1300.2 of the Business and Professions Code.

(c) The department shall by January 1 of each year publish a list of actual numerical fee charges as adjusted pursuant to this section. This adjustment of fees and the publication of the fee list shall not be subject to the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 25. Section 104151 of the Health and Safety Code is amended to read:

104151. Notwithstanding Section 10231.5 of the Government Code, each year, by no later than January 10 and concurrently with the release of the May Revision, the State Department of Health Care Services shall

provide the fiscal committees of the Legislature with an estimate package for the Every Woman Counts Program. This estimate package shall include all significant assumptions underlying the estimate for the Every Woman Counts Program's current-year and budget-year proposals, and shall contain concise information identifying applicable estimate components, such as caseload; a breakout of costs, including, but not limited to, clinical service activities, including office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services; policy changes; contractor information; General Fund, special fund, and federal fund information; and other assumptions necessary to support the estimate.

SEC. 26. Section 120164 is added to the Health and Safety Code, to read:

120164. (a) Consistent with subdivision (b), the list of immunizations, items, and services that were recommended by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA), and that were in effect on January 1, 2025, shall serve as the baseline recommendations for purposes of this section.

(b) The State Department of Public Health may modify or supplement the baseline recommendations described in subdivision (a). In making modifications or supplements, the department shall take into consideration guidance and recommendations from additional medical and scientific organizations, including, but not limited to, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

(c) In modifying or supplementing the baseline recommendations, the department may also incorporate subsequent evidence-based recommendations issued by the USPSTF, ACIP, or HRSA, to the extent the department determines those recommendations are consistent with the purposes of this section and promote public health.

(d) Publishing the baseline recommendations or any modification or supplement adopted pursuant to this section shall be exempt from the administrative regulation and rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The department shall publish the recommendations of immunizations, items, and services, and publish any updates, modifications, or supplements adopted pursuant to this section. Any modification or supplement shall be deemed effective on the date of publication. The recommendations and schedules shall be filed with the Secretary of State and published in the California Code of Regulations.

SEC. 27. Section 120336 of the Health and Safety Code is amended to read:

120336. (a) Pupils in the state are advised, as described in subdivision (b), to adhere to current immunization guidelines, as recommended by the Advisory Committee on Immunization Practices (ACIP) of the federal

Centers for Disease Control and Prevention (CDC) as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians, regarding full human papillomavirus (HPV) immunization before admission or advancement to grade 8 of any private or public elementary or secondary school.

(b) Upon a pupil's admission or advancement to grade 6, the governing authority of any private or public elementary or secondary school shall submit to the pupil and their parent or guardian a notification containing a statement about the state's public policy described in subdivision (a) and advising that the pupil adhere to current HPV immunization guidelines, as described in subdivision (a), before admission or advancement to grade 8, in compliance with the notification requirements of Article 4 (commencing with Section 48980) of Chapter 6 of Part 27 of Division 4 of Title 2 of the Education Code.

(c) The notification sent pursuant to subdivision (b) shall also include a statement, as determined by the department, summarizing the recommended ages for the HPV vaccine and scientific rationale for vaccination at those ages, based on guidance issued by ACIP of the CDC as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians. The notification shall further state the following:

"HPV vaccination can prevent over 90 percent of cancers caused by HPV. HPV vaccines are very safe, and scientific research shows that the benefits of HPV vaccination far outweigh the potential risks."

(d) This section does not apply to a pupil in a home-based private school.

(e) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 28. Section 120336 is added to the Health and Safety Code, to read:

120336. (a) Pupils in the state are advised, as described in subdivision (b), to adhere to current immunization guidelines, as recommended by the State Department of Public Health, in accordance with Section 120164, regarding full human papillomavirus (HPV) immunization before admission or advancement to grade 8 of any private or public elementary or secondary school.

(b) Upon a pupil's admission or advancement to grade 6, the governing authority of any private or public elementary or secondary school shall submit to the pupil and their parent or guardian a notification containing a statement about the state's public policy described in subdivision (a) and advising that the pupil adhere to current HPV immunization guidelines, as described in subdivision (a), before admission or advancement to grade 8, in compliance with the notification requirements of Article 4 (commencing with Section 48980) of Chapter 6 of Part 27 of Division 4 of Title 2 of the Education Code.

(c) The notification sent pursuant to subdivision (b) shall also include a statement, as determined by the department, summarizing the recommended ages for the HPV vaccine and scientific rationale for vaccination at those ages, based on guidance issued by State Department of Public Health, in

accordance with Section 120164. The notification shall further state the following:

"HPV vaccination can prevent over 90 percent of cancers caused by HPV. HPV vaccines are very safe, and scientific research shows that the benefits of HPV vaccination far outweigh the potential risks."

(d) This section does not apply to a pupil in a home-based private school.

(e) This section shall be operative on July 1, 2026.

SEC. 29. Section 120372 of the Health and Safety Code is amended to read:

120372. (a) (1) By January 1, 2021, the department shall develop and make available for use by licensed physicians and surgeons an electronic, standardized, statewide medical exemption certification form that shall be transmitted directly to the department's California Immunization Registry (CAIR) established pursuant to Section 120440. Pursuant to Section 120375, the form shall be printed, signed, and submitted directly to the school or institution at which the child will attend, submitted directly to the governing authority of the school or institution, or submitted to that governing authority through the CAIR where applicable. Notwithstanding Section 120370, commencing January 1, 2021, the standardized form shall be the only documentation of a medical exemption that the governing authority may accept.

(2) At a minimum, the form shall require all of the following information:

(A) The name, California medical license number, business address, and telephone number of the physician and surgeon who issued the medical exemption, and of the primary care physician of the child, if different from the physician and surgeon who issued the medical exemption.

(B) The name of the child for whom the exemption is sought, the name and address of the child's parent or guardian, and the name and address of the child's school or other institution.

(C) A statement certifying that the physician and surgeon has conducted a physical examination and evaluation of the child consistent with the relevant standard of care and complied with all applicable requirements of this section.

(D) Whether the physician and surgeon who issued the medical exemption is the child's primary care physician. If the issuing physician and surgeon is not the child's primary care physician, the issuing physician and surgeon shall also provide an explanation as to why the issuing physician and not the primary care physician is filling out the medical exemption form.

(E) How long the physician and surgeon has been treating the child.

(F) A description of the medical basis for which the exemption for each individual immunization is sought. Each specific immunization shall be listed separately and space on the form shall be provided to allow for the inclusion of descriptive information for each immunization for which the exemption is sought.

(G) Whether the medical exemption is permanent or temporary, including the date upon which a temporary medical exemption will expire. A temporary

exemption shall not exceed one year. All medical exemptions shall not extend beyond the grade span, as defined in Section 120370.

(H) An authorization for the department to contact the issuing physician and surgeon for purposes of this section and for the release of records related to the medical exemption to the department, the Medical Board of California, and the Osteopathic Medical Board of California.

(I) A certification by the issuing physician and surgeon that the statements and information contained in the form are true, accurate, and complete.

(3) An issuing physician and surgeon shall not charge for either of the following:

(A) Filling out a medical exemption form pursuant to this section.

(B) A physical examination related to the renewal of a temporary medical exemption.

(b) Commencing January 1, 2021, if a parent or guardian requests a licensed physician and surgeon to submit a medical exemption for the parent's or guardian's child, the physician and surgeon shall inform the parent or guardian of the requirements of this section. If the parent or guardian consents, the physician and surgeon shall examine the child and submit a completed medical exemption certification form to the department. A medical exemption certification form may be submitted to the department at any time.

(c) By January 1, 2021, the department shall create a standardized system to monitor immunization levels in schools and institutions as specified in Sections 120375 and 120440, and to monitor patterns of unusually high exemption form submissions by a particular physician and surgeon.

(d) (1) The department, at a minimum, shall annually review immunization reports from all schools and institutions in order to identify medical exemption forms submitted to the department and under this section that will be subject to paragraph (2).

(2) A clinically trained immunization department staff member, who is either a physician and surgeon or a registered nurse, shall review all medical exemptions from any of the following:

(A) Schools or institutions subject to Section 120375 with an overall immunization rate of less than 95 percent.

(B) Physicians and surgeons who have submitted five or more medical exemptions in a calendar year beginning January 1, 2020.

(C) Schools or institutions subject to Section 120375 that do not provide reports of vaccination rates to the department.

(3) (A) The department shall identify those medical exemption forms that do not meet applicable AAP criteria for appropriate medical exemptions. The department may contact the primary care physician and surgeon or issuing physician and surgeon to request additional information to support the medical exemption.

(B) Notwithstanding subparagraph (A), the department, based on the medical discretion of the clinically trained immunization staff member, may accept a medical exemption that is based on other contraindications or precautions, including consideration of family medical history, if the issuing

physician and surgeon provides written documentation to support the medical exemption that is consistent with the relevant standard of care.

(C) A medical exemption that the reviewing immunization department staff member determines to be inappropriate or otherwise invalid under subparagraphs (A) and (B) shall also be reviewed by the State Public Health Officer or a physician and surgeon from the department's immunization program designated by the State Public Health Officer. Pursuant to this review, the State Public Health Officer or physician and surgeon designee may revoke the medical exemption.

(4) Medical exemptions issued prior to January 1, 2020, shall not be revoked unless the exemption was issued by a physician or surgeon that has been subject to disciplinary action by the Medical Board of California or the Osteopathic Medical Board of California.

(5) The department shall notify the parent or guardian, issuing physician and surgeon, the school or institution, and the local public health officer with jurisdiction over the school or institution of a denial or revocation under this subdivision.

(6) If a medical exemption is revoked pursuant to this subdivision, the child shall continue in attendance. However, within 30 calendar days of the revocation, the child shall commence the immunization schedule required for conditional admittance under Chapter 4 (commencing with Section 6000) of Division 1 of Title 17 of the California Code of Regulations in order to remain in attendance, unless an appeal is filed pursuant to Section 120372.05 within that 30-day time period, in which case the child shall continue in attendance and shall not be required to otherwise comply with immunization requirements unless and until the revocation is upheld on appeal.

(7) (A) If the department determines that a physician's and surgeon's practice is contributing to a public health risk in one or more communities, the department shall report the physician and surgeon to the Medical Board of California or the Osteopathic Medical Board of California, as appropriate. The department shall not accept a medical exemption form from the physician and surgeon until the physician and surgeon demonstrates to the department that the public health risk no longer exists, but in no event shall the physician and surgeon be barred from submitting these forms for less than two years.

(B) If there is a pending accusation against a physician and surgeon with the Medical Board of California or the Osteopathic Medical Board of California relating to immunization standards of care, the department shall not accept a medical exemption form from the physician and surgeon unless and until the accusation is resolved in favor of the physician and surgeon.

(C) If a physician and surgeon licensed with the Medical Board of California or the Osteopathic Medical Board of California is on probation for action relating to immunization standards of care, the department and governing authority shall not accept a medical exemption form from the physician and surgeon unless and until the probation has been terminated.

(8) The department shall notify the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, of any physician

and surgeon who has five or more medical exemption forms in a calendar year that are revoked pursuant to this subdivision.

(9) Notwithstanding any other provision of this section, a clinically trained immunization program staff member who is a physician and surgeon or a registered nurse may review any exemption in the CAIR or other state database as necessary to protect public health.

(e) The department, the Medical Board of California, and the Osteopathic Medical Board of California shall enter into a memorandum of understanding or similar agreement to ensure compliance with the requirements of this section.

(f) In administering this section, the department and the independent expert review panel created pursuant to Section 120372.05 shall comply with all applicable state and federal privacy and confidentiality laws. The department may disclose information submitted in the medical exemption form in accordance with Section 120440, and may disclose information submitted pursuant to this chapter to the independent expert review panel for the purpose of evaluating appeals.

(g) The department shall establish the process and guidelines for review of medical exemptions pursuant to this section. The department shall communicate the process to providers and post this information on the department's website.

(h) If the department or the California Health and Human Services Agency determines that contracts are required to implement or administer this section, the department may award these contracts on a single-source or sole-source basis. The contracts are not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, or Sections 4800 to 5180, inclusive, of the State Administrative Manual as they relate to approval of information technology projects or approval of increases in the duration or costs of information technology projects.

(i) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement and administer this section through provider bulletins, or similar instructions, without taking regulatory action.

(j) For purposes of administering this section, the department and the California Health and Human Services Agency appeals process shall be exempt from the rulemaking and administrative adjudication provisions in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 30. Section 120372.05 of the Health and Safety Code is amended to read:

120372.05. (a) A medical exemption revoked pursuant to Section 120372 may be appealed by a parent or guardian to the Secretary of California

Health and Human Services. Parents, guardians, or the physician who issued the medical exemption may provide necessary information for purposes of the appeal.

(b) The secretary shall establish an independent expert review panel, consisting of three licensed physicians and surgeons who have relevant knowledge, training, and experience relating to primary care or immunization to review appeals. The agency shall establish the process and guidelines for the appeals process pursuant to this section, including the process for the panel to contact the issuing physician and surgeon, parent, or guardian. The agency shall post this information on the agency's internet website. The agency shall also establish requirements, including conflict-of-interest standards, consistent with the purposes of this chapter, that a physician and surgeon shall meet in order to qualify to serve on the panel.

(c) The independent expert review panel shall evaluate appeals consistent with the American Academy of Pediatrics guidelines or the relevant standard of care, as applicable.

(d) The independent expert review panel shall submit its determination to the secretary. The secretary shall adopt the determination of the independent expert review panel and shall promptly issue a written decision to the child's parent or guardian. The decision shall not be subject to further administrative review.

(e) A child whose medical exemption revocation pursuant to subdivision (d) of Section 120372 is appealed under this section shall continue in attendance and shall not be required to commence the immunization required for conditional admittance under Chapter 4 (commencing with Section 6000) of Division 1 of Title 17 of the California Code of Regulations, provided that the appeal is filed within 30 calendar days of revocation of the medical exemption.

(f) For purposes for administering this section, the department and the California Health and Human Services Agency appeals process shall be exempt from the rulemaking and administrative adjudication provisions in the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 31. Section 120390.6 of the Health and Safety Code is amended to read:

120390.6. (a) It is the public policy of the state that pupils who are 26 years of age or younger are advised to adhere to current immunization guidelines, as recommended by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention as of January 1, 2025, the American Academy of Pediatrics, and the American Academy of Family Physicians, regarding full human papillomavirus (HPV) immunization before first-time enrollment at an institution of the California State University, the University of California, or the California Community Colleges.

(b) This section shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 32. Section 120390.6 is added to the Health and Safety Code, to read:

120390.6. (a) It is the public policy of the state that pupils who are 26 years of age or younger are advised to adhere to current immunization guidelines, as recommended by the department, in accordance with Section 120164, regarding full human papillomavirus (HPV) immunization before first-time enrollment at an institution of the California State University, the University of California, or the California Community Colleges.

(b) This section shall become operative on July 1, 2026.

SEC. 33. Section 120392.2 of the Health and Safety Code is amended to read:

120392.2. (a) Each year, commencing October 1 to the following April 1, inclusive, every health care facility, as defined in subdivision (a) of Section 120392, shall offer, pursuant to Section 120392.4, immunizations for influenza and pneumococcal disease to residents, 65 years of age or older, receiving services at the facility consistent with recommendations adopted pursuant to Section 120164 and the latest recommendations of appropriate entities for the prevention, detection, and control of influenza outbreaks in California long-term care facilities.

(b) Each health care facility, as defined in subdivision (a) of Section 120392, shall offer, pursuant to Section 120392.4, pneumococcal vaccine to all new admittees to the health care facility, consistent with the immunization recommendations adopted pursuant to Section 120164.

(c) The facility shall be reimbursed the standard Medi-Cal rate for an immunization provided to a Medi-Cal recipient, unless the Medi-Cal recipient is also a Medicare recipient whose coverage includes reimbursement for the immunization.

SEC. 34. Section 120392.3 of the Health and Safety Code is amended to read:

120392.3. (a) The department shall provide appropriate flu vaccine to local governmental or private, nonprofit agencies at no charge in order that the agencies may provide the vaccine, at a minimal cost, at accessible locations. The department and the California Department of Aging shall prepare, publish, and disseminate information regarding the immunization recommendations adopted pursuant to Section 120164 or other criteria in order to ensure that the vaccination program is efficient and effective in meeting public health goals. Any guidance issued pursuant to this subdivision shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). In the absence of guidance from the department, local agencies shall be guided by the influenza recommendations of the federal Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices as of January 1, 2025, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, or the American Academy of Family Physicians.

(b) The department may provide appropriate vaccine that prevents other respiratory infections to local governmental or private, nonprofit agencies at no charge in order that the agencies may provide the vaccine, at a minimal cost, at accessible locations for groups identified as high risk by the department.

(c) The program shall be designed to use voluntary assistance from public or private sectors in administering the vaccines. However, local governmental or private, nonprofit agencies may charge and retain a fee not exceeding two dollars ($2) per person to offset administrative operating costs.

(d) Except when the department determines that it is not feasible to use federal funds due to excessive administrative costs, the department shall seek and use available federal funds to the maximum extent possible for the cost of the vaccine, the cost of administering the vaccine, and the minimal fee charged under this section, including reimbursement under the Medi-Cal program for persons eligible therefor to the extent permitted by federal law.

(e) A private, nonprofit volunteer agency whose involvement with an immunization program governed by this section is limited to the provision of a clinic site or promotional and logistical support pursuant to subdivision (c), or any employee or member thereof, shall not be liable for any injury caused by an act or omission in the administration of the vaccine or other immunizing agent, if the immunization is performed pursuant to this section in conformity with applicable federal, state, or local governmental standards and the act or omission does not constitute willful misconduct or gross negligence. As used in this subdivision, "injury" includes the residual effects of the vaccine or other immunizing agent. It is the intent of the Legislature in adding this subdivision to affect only the liability of private, nonprofit volunteer agencies and their members that are not health facilities, as defined in Section 1250.

(f) This section shall not be construed to require the physical presence of a directing or supervising physician, or the examination by a physician of persons to be tested or immunized.

SEC. 35. Section 120392.6 of the Health and Safety Code is amended to read:

120392.6. No person who has been offered the vaccine as required under this chapter may receive either an influenza vaccine or pneumococcal vaccine pursuant to this chapter if any of the following conditions exists:

(a) The vaccine is medically contraindicated, as described in the product labeling approved by the federal Food and Drug Administration.

(b) Receipt of the vaccine is against the resident's personal beliefs.

(c) Receipt of the vaccine is against the resident's wishes, or, if the person lacks the capacity to make medical decisions, is against the wishes of the person legally authorized to make medical decisions on the resident's behalf.

SEC. 36. Section 120392.9 of the Health and Safety Code is amended to read:

120392.9. Pursuant to its standardized procedures and if it has the vaccine in its possession, each year, commencing October 1 to the following April 1, inclusive, a general acute care hospital, as defined in subdivision (a) of

Section 1250, shall offer, prior to discharge, immunizations for influenza and pneumococcal disease to inpatients, 65 years of age or older, consistent with recommendations adopted pursuant to Section 120164 or the recommendations of appropriate entities for the prevention, detection, and control of influenza outbreaks in California general acute care hospitals.

SEC. 37. Section 120393 of the Health and Safety Code is amended to read:

120393. (a) The State Department of Public Health shall post educational information, in accordance with the latest recommendations adopted pursuant to Section 120164, regarding influenza disease and the availability of influenza vaccinations on the department's internet website. It is the intent of the Legislature to increase the average number of Californians who receive an influenza vaccination.

(b) The educational information posted on the department's internet website pursuant to subdivision (a) shall include, but not be limited to, all of the following:

(1) The health benefits of an influenza vaccination.

(2) That the influenza vaccination may be a covered benefit for those with health insurance coverage.

(3) That influenza vaccinations may be available for a minimal fee to those individuals who do not have health insurance coverage.

(4) The locations where free or low-cost vaccinations are available.

(c) The department may use additional available resources to educate the public about the information described in subdivision (b), including public service announcements, media events, public outreach to individuals and groups who are susceptible to influenza, and any other preventive and wellness education efforts recommended by public health officials.

SEC. 38. Section 120455 of the Health and Safety Code is amended to read:

120455. (a) Notwithstanding any other law, a person shall not be liable for any injury caused by an act or omission in prescribing, dispensing, ordering, furnishing, or in the administration of a vaccine or other immunizing agent, including the residual effects of the vaccine or immunizing agent, if the immunization is required by state law, administered in accordance with guidance from the State Department of Public Health pursuant to Section 120164, or given as part of an outreach program pursuant to Sections 120400 through 120415, inclusive, and the act or omission does not constitute willful misconduct or gross negligence.

(b) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

SEC. 39. Section 120455 is added to the Health and Safety Code, to read:

120455. (a) A person shall not be liable for any injury caused by an act or omission in the administration of a vaccine or other immunizing agent to a minor, including the residual effects of the vaccine or immunizing agent, if the immunization is either required by state law, or given as part of an outreach program pursuant to Sections 120400 through 120415, inclusive,

and the act or omission does not constitute willful misconduct or gross negligence.

(b) This section shall become operative on January 1, 2030.

SEC. 40. Section 124981 of the Health and Safety Code is amended to read:

124981. (a) A person shall not use the title of genetic counselor unless the person has applied for and obtained a license from the department.

(b) The applicant for a genetic counselor license shall meet minimum qualifications that include, but are not limited to, both of the following:

(1) Has earned a master's degree or above from a program specializing in or having substantial course content in genetics.

(2) Has demonstrated competence by an examination administered or approved by the department.

(c) The license shall be valid for three years unless at any time during that period it is revoked or suspended. The license may be renewed prior to the expiration of the three-year period.

(d) To qualify to renew the license, a licenseholder shall have completed 45 hours of continuing education units during the three-year license renewal period. At least 30 hours of the continuing education units shall be in genetics.

(e) (1) The fee for an original license and license renewal shall be three hundred dollars ($300).

(2) (A) The department may adjust these fees to an amount not to exceed five hundred dollars ($500).

(B) The department shall solicit input from affected stakeholders before raising fees under this subdivision.

SEC. 41. Section 124982 of the Health and Safety Code is amended to read:

124982. (a) The department shall issue a temporary genetic counselor license to a person to practice as a licensed genetic counselor who meets all of the following:

(1) The requirements for licensure set forth in subdivision (b) of Section 124981, except passing the certification examination as required by paragraph (2) of subdivision (b) of Section 124981.

(2) Either of the following requirements:

(A) The person meets the requirements to apply for and has applied for the first available certification examination offered. The department may require an applicant for a temporary genetic counselor license to provide documentation of acceptance for the examination.

(B) The person meets the requirements to apply for the certification examination and plans to apply to sit for the examination in the year following the year of the first available examination. The department shall require the applicant to provide documentation showing registration for the examination, when the documentation is received by the applicant. After the applicant takes the examination, the department shall require the applicant to provide documentation showing that the applicant took the examination.

(3) (A) The fee for a temporary license shall be three hundred dollars ($300).

(B) (i) The department may adjust this fee to an amount not to exceed five hundred dollars ($500).

(ii) The department shall solicit input from affected stakeholders before raising fees under this paragraph.

(b) A temporary genetic counselor license shall be valid for 24 months and shall not be extended or renewed.

(c) Notwithstanding subdivision (a), a temporary license issued pursuant to this section shall expire upon any of the following events, whichever occurs earlier:

(1) The issuance of a license pursuant to Section 124981.

(2) Thirty days after notification of the department that an applicant has failed the certification examination.

(3) The expiration date on the temporary license.

(d) A person holding a temporary genetic counselor license issued pursuant to this section, shall be required to work under the supervision of a licensed genetic counselor or a licensed physician and surgeon.

(e) The department may revoke the temporary license of a genetic counselor licensed pursuant to this section if the person has been convicted of a felony charge that is substantially related to the qualifications, functions, or duties of a genetic counselor. A plea of guilty or nolo contendere to a felony charge shall be deemed a conviction for the purposes of this subdivision.

SEC. 42. Chapter 6.1 (commencing with Section 127640) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

Chapter 6.1. Reproductive Health Protection

127640. For purposes of this chapter:

(a) "Abortion" has the same meaning as defined in Section 123464.

(b) "Department" means the Department of Health Care Access and Information, or any other entity within, and as designated by, the California Health and Human Services Agency.

(c) "Fund" means the Abortion Access Fund established pursuant to Section 127641.

127641. (a) The Abortion Access Fund is hereby established in the State Treasury.

(b) Notwithstanding any other law, all of the following apply:

(1) The fund is a special fund, permanently separate and apart from the General Fund or any other state fund or account.

(2) Notwithstanding Section 16305.7 of the Government Code, any interest or dividends earned on moneys in the fund shall be retained in the fund and used solely as set forth in this chapter.

(3) The purpose of the fund is to provide funding for abortion services, including for abortion services funded through grants to provide abortion access.

(4) The moneys in the fund are continuously appropriated to the department without regard to fiscal year for the purposes of this chapter.

127642. (a) The department shall distribute moneys in the fund for the purpose of funding abortion services.

(b) The department may carry out the program described in this chapter through grants and contracts, including exclusive or nonexclusive contracts, or amending existing contracts, on a bid or negotiated basis. Contracts and grants entered into or amended pursuant to this chapter shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual.

(c) Contracts, grants, and related information created pursuant to this chapter shall not be made public and are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(d) In administering this chapter, the department shall be exempt from the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

127643. This chapter shall become inoperative on July 1, 2029, and, as of January 1, 2030, is repealed.

SEC. 43. Section 10110.7 of the Insurance Code is amended to read:

10110.7. (a) This section, except for subdivision (i), applies to a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health insurance policy and a policy that provides excepted benefits as described in Sections 2722 (42 U.S.C. Sec. 300gg-21) and 2791 (42 U.S.C. Sec. 300gg-91) of the federal Public Health Service Act, subject to Section 10198.61.

(b) Notwithstanding any other law, a disability insurance policy shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to the diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an insured as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(2) A disability insurance policy shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an insured, a health insurer shall reimburse the provider of the testing according to either of the following:

(A) If the health insurer has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the insurer may negotiate a rate with such provider.

(4) For an out-of-network provider with whom an insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, an insurer shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured for services related to testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured.

(5) Beginning six months after the federal public health emergency expires, an insurer shall no longer be required to cover the cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(c) (1) A disability insurance policy shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual insured:

(A) An evidence-based item or service that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(B) An immunization that as of January 1, 2025, had in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code, regardless of whether the immunization is recommended for routine use.

(2) The items, services, and immunizations described in paragraph (1) that were in effect as of January 1, 2025, shall be covered upon the enactment of the act that added this paragraph.

(3) Any modification or supplement to the recommendations described in paragraph (1) shall be covered no later than 15 business days after the date on which the State Department of Public Health publishes the updated recommendations pursuant to Section 120164 of the Health and Safety Code.

(4) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(5) (A) A disability insurance policy subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) A disability insurance policy shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(C) With respect to an insured, a health insurer shall reimburse the provider of the immunization according to either of the following:

(i) If the health insurer has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health insurer does not have a negotiated rate with such provider, the insurer may negotiate a rate with such provider.

(D) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for an item, service, or immunization described in paragraph (1), an insurer shall reimburse the provider for all such items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for items, services, and immunizations described in paragraph (1), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(E) Beginning six months after the federal public health emergency expires, an insurer shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover any items or services that are necessary for the furnishing of the items,

services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(6) A disability insurer subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (B) of paragraph (5).

(d) The commissioner may issue guidance to insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this subdivision.

(e) This section, excluding subdivision (i), shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

(f) For purposes of this section:

(1) "Diagnostic testing" means all of the following:

(A) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

(B) Testing a person with symptoms consistent with COVID-19.

(C) Testing a person as a result of contact tracing efforts.

(D) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.

(E) Testing a person after an individualized clinical assessment by a licensed health care provider.

(2) "Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

(A) Workers in a workplace setting.

(B) Pupils, faculty, and staff in a school setting.

(C) A person before or after travel.

(D) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

(g) This section does not relieve an insurer from continuing to cover testing as required by federal law and guidance.

(h) The department shall hold insurers accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(i) (1) This subdivision applies to a disability insurance policy issued, amended, or renewed on or after the operative date of this subdivision that covers hospital, medical, surgical, or prescription drug benefits, excluding a specialized health insurance policy that provides coverage only for dental or vision benefits, with respect to therapeutics for COVID-19 covered under the policy, which shall include therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care.

(2) A disability insurer shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the insurer and provider have negotiated a rate. If the insurer does not have a negotiated rate with a provider, the insurer may negotiate a rate with the provider.

(3) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for the therapeutics described in paragraph (1), a disability insurer shall reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for therapeutics described in this subdivision.

(4) A disability insurer shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the disability insurer shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a disability insurer shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

SEC. 44. Section 10110.75 of the Insurance Code is amended to read:

10110.75. (a) This section applies to a disability insurance policy that provides coverage for hospital, medical, surgical, or prescription drug benefits, excluding a specialized health insurance policy that provides coverage only for dental or vision benefits.

(b) (1) A disability insurance policy shall cover, without cost sharing and without prior authorization or other utilization management requirements, the costs of the following health care services to prevent or

mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(A) An item or service that, as of January 1, 2025, had in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(B) An immunization that, as of January 1, 2025, had in effect a recommendation of the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(C) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(D) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(2) The items, services, and immunizations described in subparagraphs (A) and (B) of paragraph (1) that were in effect as of January 1, 2025, shall be covered upon enactment of the act that amended this section.

(3) Any modification or supplement to the recommendations described in subparagraphs (A) or (B) of paragraph (1) that is adopted pursuant to Section 120164 of the Health and Safety Code shall be covered no later than 15 business days after the date on which the State Department of Public Health publishes the updated schedule pursuant to Section 120164 of the Health and Safety Code.

(4) The item, service, or immunization covered pursuant to paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians or the State Department of Public Health makes a recommendation relating to the item, service, or immunization.

SEC. 45. Section 10112.2 of the Insurance Code is amended to read:

10112.2. (a) A group or individual nongrandfathered health insurance policy shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(2) Immunizations that had in effect on January 1, 2025, a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention or any modification

or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code.

(5) For the purposes of this section:

(A) The recommendations of the United States Preventive Services Task Force as of January 1, 2025, or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) For the purposes of this section, a health insurance policy shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health insurance policy from providing coverage for preventive items or services in addition to those required by subdivision (a).

(c) A health insurer shall provide coverage pursuant to subdivision (a) for policy years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health insurer that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a policy year shall provide coverage through the last day of the policy year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the policy year.

(2) Notwithstanding paragraph (1) and consistent with the authority granted to the State Department of Public Health pursuant to Section 120164

of the Health and Safety Code, if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a policy year, a health insurer is not required to cover the item or service through the last day of the policy year.

(d) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this part, including, but not limited to, Section 10123.18 on cervical cancer screening, Section 10123.1933 on prophylaxis of HIV infection, Section 10123.207 on colorectal cancer screening, and Section 10123.208 on home test kits for sexually transmitted diseases.

(e) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined in Section 10112.27. This section shall only apply to a health savings account-eligible health insurance policy to the extent it does not fail to be treated as a high deductible health insurance policy under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Managed Health Care if it adopts regulations to implement this section.

(g) The commissioner may exercise the authority provided by this code and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section and all sections related to preventive services, including those referenced herein. If the commissioner assesses a civil penalty for a violation, any hearing that is requested by the insurer may be conducted by an administrative law judge of the Administrative Hearing Bureau of the department under the formal procedure of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. A civil penalty shall not exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, shall not exceed ten thousand dollars ($10,000) for each violation. This subdivision does not impair or restrict the commissioner's authority pursuant to another provision of this code or the Administrative Procedure Act.

SEC. 46. Section 10123.5 of the Insurance Code is amended to read:

10123.5. (a) On or after January 1, 1993, every insurer issuing group disability insurance that covers hospital, medical, or surgical expenses shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under those terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of these benefits to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable California regulations.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

SEC. 47. Section 10123.55 of the Insurance Code is amended to read:

10123.55. (a) On or after January 1, 1993, every insurer issuing group disability insurance that covers hospital, medical, or surgical expenses shall offer benefits for the comprehensive preventive care of children 17 and 18 years of age under those terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of these benefits to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The Recommended Childhood Immunization Schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations subject to this subparagraph may be modified or supplemented by the State Department of Public Health pursuant to Section 120164.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable California regulations.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

SEC. 48. Section 30461.6 of the Revenue and Taxation Code is amended to read:

30461.6. (a) Notwithstanding Section 30461, the board shall transmit the revenue derived from the increase in the cigarette tax rate of one mill ($0.001) per cigarette imposed by Section 30101 on and after January 1, 1994, to the Treasurer to be deposited in the State Treasury to the credit of the Breast Cancer Fund, which fund is hereby created. The Breast Cancer Fund shall consist of two accounts: the Breast Cancer Research Account and the Breast Cancer Control Account. The revenues deposited in the fund shall be divided equally between the two accounts.

(b) The moneys in the accounts within the Breast Cancer Fund shall, upon appropriation by the Legislature, be allocated as follows:

(1) The moneys in the Breast Cancer Research Account shall be allocated for research with respect to the cause, cure, treatment, earlier detection, and prevention of breast cancer as follows:

(A) Ten percent to the Cancer Surveillance Section of the State Department of Health Care Services for the collection of breast cancer-related data and the conduct of breast cancer-related epidemiological research by the state cancer registry established pursuant to Section 103885 of the Health and Safety Code.

(B) Ninety percent to the Breast Cancer Research Program, that is hereby created at the University of California, for the awarding of grants and contracts to researchers for research with respect to the cause, cure, treatment, prevention, and earlier detection of breast cancer and with respect to the cultural barriers to accessing the health care system for early detection and treatment of breast cancer.

(2) The moneys in the Breast Cancer Control Account shall be allocated to the Breast Cancer Control Program, that is hereby created for the provision of early breast cancer detection services for uninsured and underinsured women. The Breast Cancer Control Program shall be established in the State

Department of Health Care Services and shall be administered in coordination with the breast and cervical cancer control program established pursuant to Public Law 101-354.

(c) The early breast cancer detection services provided by the Breast Cancer Control Program shall include all of the following:

(1) Screening, including mammography, of women for breast cancer as an early detection health care measure.

(2) After screening, medical referral of screened women and services necessary for definitive diagnosis, including nonradiological techniques or biopsy.

(3) If a positive diagnosis is made, then assistance and advocacy shall be provided to help the person obtain necessary treatment.

(4) Outreach and health education activities to ensure that uninsured and underinsured women are aware of and appropriately utilize the services provided by the Breast Cancer Control Program.

(d) (1) Any entity funded by the Breast Cancer Control Program shall coordinate with other local providers of breast cancer screening, diagnostic, followup, education, and advocacy services to avoid duplication of effort. Any entity funded by the program shall comply with any applicable state and federal standards regarding mammography quality assurance.

(2) To the extent required or permitted by federal law, a provider of breast cancer screening or diagnostic services may employ digital mammography technology for the purposes of mammography screening and diagnostic procedures that are conducted prior to January 1, 2014, when film, otherwise known as analog, mammography technology is unavailable. To the extent required or permitted by federal law and notwithstanding paragraph (3) of subdivision (a) of Section 14105.18 of the Welfare and Institutions Code, the payment rate for all mammography screening that is conducted prior to January 1, 2014, shall be limited to the Medi-Cal payment rate for film mammography screening.

(e) Notwithstanding Section 10231.5 of the Government Code, each year, the State Department of Health Care Services shall submit an annual report about the Breast Cancer Control Program, including information described in subdivision (f), to the fiscal and appropriate policy committees of the Legislature and to other appropriate entities. The department shall submit the report, in accordance with Section 9795 of the Government Code, no later than February 28 each fiscal year.

(f) Any entity funded by the Breast Cancer Control Program shall collect data and maintain records that are determined by the State Department of Health Care Services to be necessary to facilitate the department's ability to monitor and evaluate the effectiveness of the program entities and the program. The costs associated with the report described in subdivision (e) shall be paid from the allocation made pursuant to paragraph (2) of subdivision (b). The report shall describe the activities and effectiveness of the program and shall include, but not be limited to, the following types of information:

(1) The number of recipients served.

(2) The ethnic, geographic, and age breakdown.
(3) The breast and cervical cancer stages of presentation.
(4) The breast and cervical cancer diagnostic and treatment status.
(5) Program caseload.
(6) Estimated clinical claims and expenditures.
(7) Program activities and monitoring data.
(8) A breakdown of expenditures for clinical service activities, including, but not limited to, office visits and consults, screening mammograms, diagnostic mammograms, diagnostic breast procedures, case management, and other clinical services.

(g) The Breast Cancer Control Program shall be conducted in consultation with the Breast Cancer Research Program created pursuant to subparagraph (B) of paragraph (1) of subdivision (b).

(h) In implementing the Breast Cancer Control Program, the State Department of Health Care Services may appoint and consult with an advisory panel appointed by the Director of Health Care Services and consisting of one ex officio, nonvoting member from the Breast Cancer Research Program, breast cancer researchers, and representatives from voluntary, nonprofit health organizations, health care professional organizations, breast cancer survivor groups, and breast cancer and health care-related advocacy groups. It is the intent of the Legislature that breast cancer-related survivors and advocates and health advocates for low-income women compose at least one-third of the advisory panel. It is also the intent of the Legislature that the State Department of Health Care Services collaborate closely with the panel.

(i) It is the intent of the Legislature in enacting the Breast Cancer Control Program to decrease cancer mortality rates attributable to breast cancer among uninsured and underinsured women, with special emphasis on low-income, Native American, and minority women. It is also the intent of the Legislature that the communities served by the Breast Cancer Control Program reflect the ethnic, racial, cultural, and geographic diversity of the state and that the Breast Cancer Control Program fund entities where uninsured and underinsured women are most likely to seek their health care.

(j) The State Department of Health Care Services or any entity funded by the Breast Cancer Control Program shall collect personal and medical information necessary to administer this program from any individual applying for services under the program. The information shall be confidential and shall not be disclosed other than for purposes directly connected with the administration of this program or except as otherwise provided by law or pursuant to prior written consent of the subject of the information.

The State Department of Health Care Services or any entity funded by the Breast Cancer Control Program may disclose the confidential information to medical personnel and fiscal intermediaries of the state to the extent necessary to administer this program, and to other state public health agencies or medical researchers when the confidential information is

necessary to carry out the duties of those agencies or researchers in the investigation, control, or surveillance of breast cancer.

(k) The State Department of Health Care Services shall adopt regulations to implement this act in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of implementing regulations shall be deemed an emergency and shall be considered as necessary for the immediate preservation of the public peace, health and safety, or general welfare, within the meaning of Section 11346.1 of the Government Code. Emergency regulations adopted pursuant to this section shall remain in effect for no more than 180 days.

(l) It is the intent of the Legislature in enacting this section that this section supersede and be operative in place of Section 30461.6 of the Revenue and Taxation Code as added by Chapter 660 of the Statutes of 1993.

(m) To implement the Breast Cancer Control Program, the State Department of Health Care Services may contract, to the extent permitted by Section 19130 of the Government Code, with public and private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary. However, the Medi-Cal program's fiscal intermediary shall only be utilized if services provided under the program are specifically identified and reimbursed in a manner that does not claim federal financial reimbursement. Any contracts with, and the utilization of, the Medi-Cal program's fiscal intermediary shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code. Contracts to implement the Breast Cancer Control Program entered into by the State Department of Health Care Services with entities other than the Medi-Cal program's fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 49. Section 5961.4 of the Welfare and Institutions Code is amended to read:

5961.4. (a) As a component of the initiative, the State Department of Health Care Services shall develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student 25 years of age or younger at a schoolsite.

(b) The department shall develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors.

(c) (1) Commencing January 1, 2024, and subject to subdivision (h), each Medi-Cal managed care plan and Medi-Cal behavioral health delivery system, as applicable, shall reimburse providers of medically necessary outpatient mental health or substance use disorder treatment provided at a schoolsite to a student 25 years of age or younger who is an enrollee of the plan or delivery system, in accordance with paragraph (2), but only to the extent the Medi-Cal managed care plan or Medi-Cal behavioral delivery system is financially responsible for those schoolsite services under its approved managed care contract with the department.

(2) Providers of medically necessary schoolsite services described in this section shall be reimbursed, at a minimum, at the fee schedule rate or rates developed pursuant to subdivision (a), regardless of network provider status.

(d) (1) The department may contract with an entity to administer the school-linked statewide behavioral health provider network in accordance with this subdivision.

(2) The entity that administers the school-linked statewide behavioral health provider network shall do all of the following:

(A) Create and administer a process for enrolling and credentialing all eligible practitioners and providers seeking to provide medically necessary schoolsite services described in this section.

(B) Create and administer a process for the submission and reimbursement of claims eligible to be reimbursed pursuant to this section, which may include resolving disputes related to the school-linked statewide all-payer fee schedule and administering fee collection pursuant to subdivision (g).

(C) (i) Create and administer a mechanism for the sharing of data between the entity contracted pursuant to this subdivision and a health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule that is necessary to facilitate timely claims processing, payment, and reporting, avoid duplication of claims, allow for tracking of grievance remediation, and to facilitate coordination of care and continuity of care for enrollees.

(ii) Clause (i) includes requiring the entity that administers the school-linked statewide behavioral health provider network to automate, to the maximum extent possible, matching student records with health plan enrollment information, in order to reduce or eliminate the administrative burden of collecting health plan enrollment data from individual students and families on local educational agencies and institutions of higher education.

(iii) The department shall require any entity administering the school-linked statewide behavioral health provider network to ensure both of the following:

(I) Claims submitted pursuant to Section 1374.722 of the Health and Safety Code, Section 10144.53 of the Insurance Code, and subdivisions (c) and (f) are properly reimbursed according to applicable claim payment deadlines.

(II) The deadline for a local educational agency or institutions of higher education to submit a retroactive claim for payment is the longer of the time permitted under either federal or state law.

(e) A provider or practitioner of medically necessary schoolsite services participating in the school-linked statewide behavioral health provider network described in this section shall do all of the following:

(1) Comply with all administrative requirements necessary to be enrolled and credentialed, as applicable, by the entity that administers the school-linked statewide behavioral health provider network.

(2) Submit all claims for reimbursement for services billed under the school-linked statewide all-payer fee schedule through the entity that administers the school-linked statewide behavioral health provider network.

(3) If a provider or practitioner of medically necessary schoolsite services has, or enters into, a direct agreement established with a health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services outside of the school-linked statewide all-payer fee schedule, they shall be allowed to bill for services provided directly under the terms of the established agreement.

(f) (1) A health care service plan, insurer, or Medi-Cal managed care plan that covers medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule, pursuant to Section 1374.722 of the Health and Safety Code, Section 10144.53 of the Insurance Code, and this section, shall comply with all administrative requirements necessary to cover and reimburse those services set forth by the entity that administers the school-linked statewide behavioral health provider network.

(2) If an agreement exists between a health care service plan, insurer, or Medi-Cal managed care plan and a provider or practitioner of medically necessary schoolsite services outside of the school-linked statewide all-payer fee schedule, the health care service plan, insurer, or Medi-Cal managed care plan shall do all of the following:

(A) At minimum, reimburse the contracted provider or practitioner at the school-linked statewide all-payer fee schedule rates.

(B) Provide to the department data deemed necessary and appropriate for program reporting and compliance purposes.

(C) Comply with all administrative requirements necessary to cover and reimburse medically necessary schoolsite services subject to the school-linked statewide all-payer fee schedule, as determined by the department.

(g) (1) The department shall establish and charge a fee to participating health care service plans, insurers, or Medi-Cal managed care plans to cover the reasonable cost of administering the school-linked statewide behavioral health provider network.

(2) The department shall set the fees in an amount that it projects is sufficient to cover all administrative costs incurred by the state associated with implementing this section and consider the assessed volume of claims and providers or practitioners of medically necessary schoolsite services that are credentialed and enrolled by the entity contracted pursuant to subdivision (d).

(3) The department shall not assess the fee authorized by this subdivision until the time that the contract between the department and the entity contracted pursuant to subdivision (d) commences.

(4) (A) The department may periodically update the amount and structure of the fees, as necessary, to provide sufficient funding for the purpose specified in this subdivision.

(B) The fees authorized in this paragraph shall be evaluated annually and based on the state’s projected costs for the forthcoming fiscal year.

(C) If the department proposes to increase the fees, it shall notify the Legislature of the proposed increase through the submission of the semiannual Medi-Cal estimate provided to the Legislature.

(5) (A) (i) The Behavioral Health Schoolsite Fee Schedule Administration Fund is hereby established in the State Treasury.

(ii) The department shall administer the Behavioral Health Schoolsite Fee Schedule Administration Fund consistent with this subdivision.

(B) All revenues, less refunds, derived from the fees authorized in this subdivision shall be deposited in the Behavioral Health Schoolsite Fee Schedule Administration Fund.

(C) The moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund shall be available upon appropriation by the Legislature and shall be used only for purposes of this subdivision.

(D) Notwithstanding Section 16305.7 of the Government Code, interest and dividends earned on moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund shall be retained in the fund and used solely for the purposes specified in this section.

(E) Notwithstanding any other provision of law, the Controller may use moneys in the Behavioral Health Schoolsite Fee Schedule Administration Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(F) Funds remaining in the Behavioral Health Schoolsite Fee Schedule Administration Fund at the end of a fiscal year shall be available for use in the following fiscal year and taken into consideration in establishment of fees for the subsequent fiscal year.

(h) This section shall be implemented only to the extent that the department obtains any necessary federal approvals, and federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(i) This section does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state and federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

(j) The California Health and Human Service Agency shall publish a policy manual to assist a local education agency with navigating the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Family Educational Rights and Privacy Act (20 U.S.C. Sec. 1232g) for purposes of participating in the school-linked statewide behavioral health provider network.

(k) (1) The State Department of Health Care Services shall, not less than twice a year, convene a working group of stakeholders to discuss the status of, and receive feedback regarding, implementation of the fee schedule. The

working group shall include, but is not limited to, representatives of all of the following:

(A) Medi-Cal managed care plans.

(B) Medi-Cal behavioral health plans.

(C) Health care service plans.

(D) Insurers.

(E) Behavioral health providers.

(F) Local educational agencies.

(G) Labor representatives of school employees.

(H) Members of the educational community.

(2) The department shall provide notice, and relevant updates and information on the status of the implementation of the fee schedule, to all of the following:

(A) The Assembly Committee on Budget.

(B) The Assembly Committee on Education.

(C) The Assembly Committee on Health.

(D) The Senate Committee on Budget and Fiscal Review.

(E) The Senate Committee on Education.

(F) The Senate Committee on Health.

(3) This subdivision shall become inoperative on July 1, 2030.

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

(1) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(2) "Institution of higher education" means the California Community Colleges, the California State University, or the University of California.

(3) "Local educational agency" means a school district, county office of education, charter school, the California Schools for the Deaf, and the California School for the Blind.

(4) "Medi-Cal behavioral health delivery system" has the meaning described in subdivision (i) of Section 14184.101.

(5) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9.

(6) "Schoolsite" has the meaning described in paragraph (6) of subdivision (b) of Section 1374.722 of the Health and Safety Code.

SEC. 50. Section 11265.8 of the Welfare and Institutions Code is amended to read:

11265.8. (a) All applicants for aid under this chapter, within 30 days of the determination of eligibility for Medi-Cal benefits under Chapter 7 (commencing with Section 14000), and 45 days for applicants already eligible for benefits under Chapter 7 (commencing with Section 14000), and all recipients of aid under this chapter within 45 days of a full or financial redetermination of eligibility for aid under this chapter, shall provide documentation that all children in the assistance unit not required to be

enrolled in school have received all age appropriate immunizations, unless it has been medically determined that an immunization for a child is not appropriate or the applicant or recipient has filed with the county welfare department an affidavit that the immunizations are contrary to the applicant's or recipient's beliefs. If the county determines that good cause exists for not providing the required documentation due to lack of reasonable access to immunization services, the period shall be extended by an additional 30 days. A circumstance that shall constitute good cause includes, but is not limited to, the applicant or recipient does not have reasonable access to immunization services due to a situation of domestic violence. If the documentation is not provided within the required time period, the needs of all parents or caretaker relatives in the assistance unit shall not be considered in determining the grant to the assistance unit under Section 11450 until the required documentation is provided. The department shall track and maintain information concerning the number of sanctions imposed under this section.

(b) At the time of application and at the next redetermination of eligibility for aid under this chapter, all applicants and recipients shall be given notice advising them of their obligation to secure the immunizations required in subdivision (a). The notice shall also contain all of the following:

(1) The Recommended Childhood Immunization Schedule, United States, and the Recommended Immunization Schedule for Children Not Immunized on Schedule in the First Year of Life, as appropriate, approved as of January 1, 2025, by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, and any modification or supplement thereto by the State Department of Public Health, including the recommended immunization schedule, in accordance with Section 120164 of Health and Safety Code. Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement any policy changes required pursuant to this paragraph by means of all-county letters or similar instructions from the department until regulations are adopted. These all-county letters or similar written instructions shall have the same force and effect as regulations until the adoption of regulations, which shall occur no later than June 30, 2027.

(2) A description of how to obtain the immunizations through a fee-for-service provider that accepts Medi-Cal, a Medi-Cal managed care plan, a county public health clinic, or any other source that may be available in the county as appropriate.

(3) A statement that the applicant or recipient may file an affidavit claiming that the immunizations are contrary to the applicant's or recipient's beliefs.

SEC. 51. Section 14005.27 of the Welfare and Institutions Code is amended to read:

14005.27. (a) Individuals enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the

Insurance Code on June 27, 2012, and who are determined eligible to receive benefits pursuant to subdivision (a) of Section 14005.26, or, effective January 1, 2014, subdivision (b) of Section 14005.26, shall be transitioned into Medi-Cal, pursuant to this section.

(b) To the extent necessary and for the purposes of carrying out the provisions of this section, in performing initial eligibility determinations for children enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, the department shall adopt the option pursuant to Section 1902(e)(13) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(13)) to allow the department or county human services departments to rely upon findings made by the Managed Risk Medical Insurance Board (MRMIB) regarding one or more components of eligibility. The department shall seek federal approval of a state plan amendment to implement this subdivision.

(c) To the extent necessary, the department shall seek federal approval of a state plan amendment or a waiver to provide presumptive eligibility for the optional targeted low-income category of eligibility pursuant to Section 14005.26 for individuals presumptively eligible for or enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code. The presumptive eligibility shall be based upon the most recent information contained in the individual's Healthy Families Program file. The timeframe for the presumptive eligibility shall begin no sooner than January 1, 2013, and shall continue until a determination of Medi-Cal eligibility is made, which determination shall be performed within one year of the individual's Healthy Families Program annual review date.

(d) (1) The California Health and Human Services Agency, in consultation with the Managed Risk Medical Insurance Board, the State Department of Health Care Services, the Department of Managed Health Care, and diverse stakeholders groups, shall provide the fiscal and policy committees of the Legislature with a strategic plan for the transition of the Healthy Families Program pursuant to this section by no later than October 1, 2012. This strategic plan shall, at a minimum, address all of the following:

(A) State, county, and local administrative components that facilitate a successful subscriber transition such as communication and outreach to subscribers and applicants, eligibility processing, enrollment, communication, and linkage with health plan providers, payments of applicable premiums, and overall systems operation functions.

(B) Methods and processes for diverse stakeholder engagement throughout the entire transition, including all phases of the transition.

(C) State monitoring of managed care health plans' performance and accountability for provision of services, and initial quality indicators for children and adolescents transitioning to Medi-Cal.

(D) Health care and dental delivery system components such as standards for informing and enrollment materials, network adequacy, performance measures and metrics, fiscal solvency, and related factors that ensure timely

access to quality health and dental care for children and adolescents transitioning to Medi-Cal.

(E) Inclusion of applicable operational steps, timelines, and key milestones.

(F) A time certain for the transfer of the Healthy Families Advisory Board, as described in Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, to the State Department of Health Care Services.

(2) The intent of this strategic plan is to serve as an overall guide for the development of each plan for each phase of this transition, pursuant to paragraphs (1) to (8), inclusive, of subdivision (e), to ensure clarity and consistency in approach and subscriber continuity of care. This strategic plan may also be updated by the California Health and Human Services Agency as applicable and provided to the Legislature upon completion.

(e) (1) The department shall transition individuals from the Healthy Families Program to the Medi-Cal program in four phases, as follows:

(A) Phase 1. Individuals enrolled in a Healthy Families Program health plan that is a Medi-Cal managed care health plan shall be enrolled in the same plan no earlier than January 1, 2013, pursuant to the requirements of this section and Section 14011.6, and to the extent the individual is otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200).

(B) Phase 2. Individuals enrolled in a Healthy Families Program managed care health plan that is a subcontractor of a Medi-Cal managed health care plan, to the extent possible, shall be enrolled into a Medi-Cal managed health care plan that includes the individuals' current plan pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than April 1, 2013.

(C) Phase 3. Individuals enrolled in a Healthy Families Program plan that is not a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal managed care plan shall be enrolled in a Medi-Cal managed care plan in that county. Enrollment shall include consideration of the individuals' primary care providers pursuant to the requirements of this section and Section 14011.6, and to the extent the individuals are otherwise eligible under this chapter and Chapter 8 (commencing with Section 14200). The transition of individuals described in this subparagraph shall begin no earlier than August 1, 2013.

(D) Phase 4.

(i) Individuals residing in a county that is not a Medi-Cal managed care county shall be provided services under the Medi-Cal fee-for-service delivery system, subject to clause (ii). The transition of individuals described in this subparagraph shall begin no earlier than September 1, 2013.

(ii) In the event the department creates a managed health care system in the counties described in clause (i), individuals residing in those counties shall be enrolled in managed health care plans pursuant to this chapter and Chapter 8 (commencing with Section 14200).

(2) For the transition of individuals pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), implementation plans shall be developed to ensure state and county systems readiness, health plan network adequacy, and continuity of care with the goal of ensuring there is no disruption of service and there is continued access to coverage for all transitioning individuals. If an individual is not retained with the individual's primary care provider, the implementation plan shall require the managed care plan to report to the department as to how continuity of care is being provided. Transition of individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) shall not occur until 90 days after the department has submitted an implementation plan to the fiscal and policy committees of the Legislature. The implementation plans shall include, but not be limited to, information on health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

(3) The following requirements shall be in place prior to implementation of Phase 1, and shall be required for all phases of the transition:

(A) Managed care plan performance measures shall be integrated and coordinated with the Healthy Families Program performance standards including, but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures, and measures indicative of performance in serving children and adolescents. These performance measures shall also be in compliance with all performance requirements under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and existing Medi-Cal managed care performance measurements and standards as set forth in this chapter and Chapter 8 (commencing with Section 14200), and all-plan letters, including, but not limited to, network adequacy and linguistic services, and shall be met prior to the transition of individuals pursuant to Phase 1.

(B) Medi-Cal managed care health plans shall allow enrollees to remain with their current primary care provider. If an individual does not remain with the current primary care provider, the plan shall report to the department as to how continuity of care is being provided.

(4) (A) As individuals are transitioned pursuant to subparagraphs (A), (B), (C), and (D) of paragraph (1), for individuals residing in all counties except the Counties of Sacramento and Los Angeles, their dental coverage shall transition to fee-for-service dental coverage and may be provided by their current provider if the provider is a Medi-Cal fee-for-service dental provider.

(B) For individuals residing in the County of Sacramento, their dental coverage shall continue to be provided by their current dental managed care plan if their plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they shall select a Medi-Cal dental managed care plan. If they do not choose a Medi-Cal dental managed care plan, they shall be assigned to a plan with preference to a plan with which their current provider is a contracted provider. Any children in the Healthy

Families Program transitioned into Medi-Cal dental managed care plans shall also have access to the beneficiary dental exception process, pursuant to Section 14089.09. Further, the Sacramento advisory committee, established pursuant to Section 14089.08, shall be consulted regarding the transition of children in the Healthy Families Program into Medi-Cal dental managed care plans.

(C) (i) For individuals residing in the County of Los Angeles, for purposes of continuity of care, their dental coverage shall continue to be provided by their current dental managed care plan if that plan is a Medi-Cal dental managed care plan. If their plan is not a Medi-Cal dental managed care plan, they may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal fee-for-service dental coverage.

(ii) It is the intent of the Legislature that children transitioning to Medi-Cal under this section have a choice in dental coverage, as provided under existing law.

(5) Dental health plan performance measures and benchmarks shall be in accordance with Section 14459.6.

(6) Medi-Cal managed care health and dental plans shall report to the department, as frequently as specified by the department, specified information pertaining to transition implementation, enrollees, and providers, including, but not limited to, grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks, including provider enrollment and disenrollment changes. The plans shall report this information by county, and in the format requested by the department.

(7) The department may develop supplemental implementation plans to separately account for the transition of individuals from the Healthy Families Program to specific Medi-Cal delivery systems.

(8) The department shall consult with the Legislature and stakeholders, including, but not limited to, consumers, families, consumer advocates, counties, providers, and health and dental plans, in the development of implementation plans described in paragraph (3) for individuals who are transitioned to Medi-Cal in Phase 2, Phase 3, and Phase 4, as described in subparagraphs (B), (C), and (D) of paragraph (1).

(9) (A) The department shall consult and collaborate with the Department of Managed Health Care in assessing Medi-Cal managed care health plan network adequacy in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) for purposes of the developed transition plans pursuant to paragraph (2) for each of the phases.

(B) For purposes of individuals transitioning in Phase 1, as described in subparagraph (A) of paragraph (1), network adequacy shall be assessed as described in this paragraph and findings from this assessment shall be provided to the fiscal and appropriate policy committees of the Legislature 60 days prior to the effective date of implementing this transition.

(f) (1) The department and MRMIB shall work collaboratively in the development of notices for individuals transitioned pursuant to paragraph (1) of subdivision (e).

(2) The state shall provide written notice to individuals enrolled in the Healthy Families Program of their transition to the Medi-Cal program at least 60 days prior to the transition of individuals in Phase 1, as described in subparagraph (A) of paragraph (1) of subdivision (e), and at least 90 days prior to transition of individuals in Phases 2, 3, and 4, as described in subparagraphs (B), (C), and (D) of paragraph (1) of subdivision (e).

(3) Notices developed pursuant to this subdivision shall ensure individuals are informed regarding the transition, including, but not limited to, how individuals' systems of care may change, when the changes will occur, and whom they can contact for assistance when choosing a Medi-Cal managed care plan, if applicable, including a toll-free telephone number, and with problems they may encounter. The department shall consult with stakeholders regarding notices developed pursuant to this subdivision. These notices shall be developed using plain language, and written translation of the notices shall be available for those who are limited English proficient or non-English speaking in all Medi-Cal threshold languages.

(4) The department shall designate department liaisons responsible for the coordination of the Healthy Families Program and may establish a children's-focused section for this purpose and to facilitate the provision of health care services for children enrolled in Medi-Cal.

(5) The department shall provide a process for ongoing stakeholder consultation and make information publicly available, including the achievement of benchmarks, enrollment data, utilization data, and quality measures.

(g) (1) In order to aid the transition of Healthy Families Program enrollees, MRMIB, on the effective date of the act that added this section and continuing through the completion of the transition of Healthy Families Program enrollees to the Medi-Cal program, shall begin requesting and collecting from health plans contracting with MRMIB pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, information about each health plan's provider network, including, but not limited to, the primary care and all specialty care providers assigned to individuals enrolled in the health plan. MRMIB shall obtain this information in a manner that coincides with the transition activities described in subdivision (d), and shall provide all of the collected information to the department within 60 days of the department's request for this information to ensure timely transitions of Healthy Families Program enrollees.

(2) The department shall analyze the existing Healthy Families Program delivery system network and the Medi-Cal fee-for-service provider networks, including, but not limited to, Medi-Cal dental providers, to determine overlaps of the provider networks in each county for which there are no Medi-Cal managed care plans or dental managed care plans. To the extent there is a lack of existing Medi-Cal fee-for-service providers available to serve the Healthy Families Program enrollees, the department shall work with the Healthy Families Program provider community to encourage participation of those providers in the Medi-Cal program, and develop a streamlined process to enroll them as Medi-Cal providers.

(3) (A) MRMIB, within 60 days of a request by the department, shall provide the department any data, information, or record concerning the Healthy Families Program as is necessary to implement the transition of enrollment required pursuant to this section.

(B) Notwithstanding any other law, all of the following shall apply:

(i) The term "data, information, or record" shall include, but is not limited to, personal information as defined in Section 1798.3 of the Civil Code.

(ii) Any data, information, or record shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and any other law, to the same extent that it was exempt from disclosure or privileged prior to the provision of the data, information, or record to the department.

(iii) The provision of this data, information, or record to the department shall not constitute a waiver of any evidentiary privilege or exemption from disclosure.

(iv) The department shall keep all data, information, or records provided by MRMIB confidential to the full extent permitted by law, including, but not limited to, the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), and consistent with MRMIB's contractual obligations to keep the data, information, or records confidential.

(h) This section shall be implemented only to the extent that all necessary federal approvals and waivers have been obtained and the enhanced rate of federal financial participation under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.) is available for targeted low-income children pursuant to that act.

(i) (1) (A) Except as provided in subparagraph (B), the department shall exercise the option pursuant to Section 1916A of the federal Social Security Act (42 U.S.C. Sec. 1396o-1) to impose premiums for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. The department shall not impose premiums under this subdivision for individuals described in subdivision (a) of Section 14005.26 whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. The department shall obtain federal approval for the implementation of this subdivision.

(B) Effective January 1, 2014, the family income range for the imposition of premiums pursuant to subparagraph (A) for individuals described in subdivision (a) or (b) of Section 14005.26 shall be above 160 percent and shall go up to and include 261 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64. The department shall not impose premiums for eligible individuals whose family income has been determined to be at or below 160 percent of the federal poverty level.

(2) All premiums imposed under this section shall equal the family contributions described in paragraph (2) of subdivision (d) of Section 12693.43 of the Insurance Code and shall be reduced in conformity with subdivisions (e) and (f) of Section 12693.43 of the Insurance Code.

(j) The department shall not enroll targeted low-income children described in this section in the Medi-Cal program until all necessary federal approvals and waivers have been obtained, or no sooner than January 1, 2013.

(k) (1) (A) Except as provided in subparagraph (B), to the extent the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is not fully operational, for the purposes of implementing this section, for individuals described in subdivision (a) whose family income has been determined to be at or below 150 percent of the federal poverty level, after application of the disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26, the department shall utilize the budgeting methodology for this population as contained in the November 2011 Medi-Cal Local Assistance Estimate for Medi-Cal county administration costs for eligibility operations.

(B) Effective January 1, 2014, the federal poverty level percentage used under subparagraph (A) for individuals described in subdivision (a) shall equal 160 percent of the federal poverty level as determined, counted, and valued in accordance with the requirements of Section 14005.64.

(2) (A) Except as provided in subparagraph (B), for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) of Section 14005.26 and whose family income is determined to be above 150 percent and up to and including 200 percent of the federal poverty level, after application of the income disregard pursuant to paragraph (2) of subdivision (a) of Section 14005.26. In developing an estimate for this activity, the department shall consider the projected number of final eligibility determinations each county will process and projected county costs. Within 60 days of the passage of the annual Budget Act, the department shall notify each county of their allocation for this activity based upon the amount allotted in the annual Budget Act for this purpose.

(B) Effective January 1, 2014, for purposes of implementing this section, the department shall include in the Medi-Cal Local Assistance Estimate an amount for Medi-Cal eligibility operations associated with the transfer of Healthy Families Program enrollees eligible pursuant to subdivision (a) or (b) of Section 14005.26 and whose family income is determined to be above 160 percent and up to and including 261 percent of the federal poverty level.

(l) When the new budget methodology pursuant to paragraph (6) of subdivision (a) of Section 14154 is fully operational, the new budget methodology shall be utilized to reimburse counties for eligibility determinations made for individuals pursuant to this section.

(m) Except as provided in subdivision (b), eligibility determinations and annual redeterminations made pursuant to this section shall be performed by county eligibility workers.

(n) In conducting the eligibility determinations for individuals pursuant to this section and Section 14005.26, the following reporting and performance standards shall apply to all counties:

(1) Counties shall report to the department, in a manner and for a time period determined by the department, in consultation with the County Welfare Directors Association, the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from the single point of entry (SPE).

(2) Notwithstanding any other law, the following performance standards shall be applied to counties for eligibility determinations for individuals eligible pursuant to this section:

(A) For children whose applications are received by the county human services department from the SPE, the following standards shall apply:

(i) Applications for children who are granted accelerated enrollment by the SPE shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(ii) Applications for children who are not granted accelerated enrollment by the SPE due to the existence of an already active Medi-Cal case shall be processed according to the timeframes specified in subdivision (d) of Section 14154.

(iii) For applications for children who are not described in clause (i) or (ii), 90 percent shall be processed within 10 working days of being received, complete and without client errors.

(iv) If an application described in this section also contains adults, and the adult applicants are required to submit additional information beyond the information provided for the children, the county shall process the eligibility for the child or children without delay, consistent with this section while gathering the necessary information to process eligibility for the adults.

(B) The department, in consultation with the County Welfare Directors Association, shall develop reporting requirements for the counties to provide regular data to the state regarding the timeliness and outcomes of applications processed by the counties that are received from the SPE.

(C) Performance thresholds and corrective action standards as set forth in Section 14154 shall apply.

(D) For applications received directly by the county, these applications shall be processed by the counties in accordance with the performance standards established under subdivision (d) of Section 14154.

(3) This subdivision shall be implemented no sooner than January 1, 2013.

(4) Twelve months after implementation of this section pursuant to subdivision (e), the department shall provide enrollment information regarding individuals determined eligible pursuant to subdivision (a) to the fiscal and appropriate policy committees of the Legislature.

(o) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, for purposes of this transition, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. It is the intent of the Legislature that the department be allowed temporary authority as necessary to implement program changes until completion of the regulatory process.

(2) To the extent otherwise required by Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall adopt emergency regulations implementing this section no later than July 1, 2014. The department may thereafter readopt the emergency regulations pursuant to that chapter. The adoption and readoption, by the department, of regulations implementing this section shall be deemed to be an emergency and necessary to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

(p) To implement this section, the department may enter into and continue contracts with the Healthy Families Program administrative vendor, for the purposes of implementing and maintaining the necessary systems and activities for providing health care coverage to optional targeted low-income children in the Medi-Cal program for purposes of accelerated enrollment application processing by single point of entry, noneligibility-related case maintenance and premium collection, maintenance of the Health-E-App web portal, call center staffing and operations, certified application assistant services, and reporting capabilities. To further implement this section, the department may also enter into a contract with the Health Care Options Broker of the department for purposes of managed care enrollment activities. The contracts entered into or amended under this section may initially be completed on a noncompetitive bid basis and are exempt from the Public Contract Code. Contracts thereafter shall be entered into or amended on a competitive bid basis and shall be subject to the Public Contract Code.

(q) (1) If at any time the director determines that this section or any part of this section may jeopardize the state's ability to receive federal financial participation under the federal Patient Protection and Affordable Care Act (Public Law 111-148), or any amendment or extension of that act, or any additional federal funds that the director, in consultation with the Department of Finance, determines would be advantageous to the state, the director shall give notice to the fiscal and policy committees of the Legislature and to the Department of Finance. After giving notice, this section or any part of this section shall become inoperative on the date that the director executes a

declaration stating that the department has determined, in consultation with the Department of Finance, that it is necessary to cease to implement this section or a part or parts thereof in order to receive federal financial participation, any increase in the federal medical assistance percentage available on or after October 1, 2008, or any additional federal funds that the director, in consultation with the Department of Finance, has determined would be advantageous to the state.

(2) The director shall retain the declaration described in paragraph (1), shall provide a copy of the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the declaration on the department's internet website.

(3) In the event that the director makes a determination under paragraph (1) and this section ceases to be implemented, the children shall be enrolled back into the Healthy Families Program.

SEC. 52. Section 14005.62 of the Welfare and Institutions Code, as added by Section 59 of Chapter 21 of the Statutes of 2025, is amended to read:

14005.62. (a) (1) Notwithstanding any other law, for an applicant or beneficiary whose eligibility is not determined using the modified adjusted gross income (MAGI)-based financial methods, as specified in Section 1396a(e)(14) of Title 42 of the United States Code, the department shall seek federal approval to implement a disregard of one hundred thirty thousand dollars ($130,000) in nonexempt property for a case with one member and sixty-five thousand dollars ($65,000) for each additional household member, up to a maximum of 10 members.

(2) This subdivision shall be implemented only after the director determines that systems have been programmed for the disregards specified in paragraph (1) and they communicate that determination in writing to the Department of Finance and no sooner than January 1, 2026.

(b) (1) 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 this section by means of county letters, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action. Such instructions shall include a list of all exempt property for use until such time that regulations are adopted.

(2) Within two years of implementing the requirements set forth in this subdivision, the department shall do both of the following:

(A) Adopt, amend, or repeal regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and this section.

(B) Update its notices and forms to reflect the consideration of assets and resources as described in subdivision (a).

(c) Upon operation of subdivision (a), the department shall make available, on a quarterly basis data, the number of Medi-Cal enrollees who lost eligibility due to the asset limit. The department shall consult with stakeholders to determine the appropriate data elements and level of detail, including, but not limited to, the reasons for termination.

(d) This section shall only be implemented to the extent consistent with federal law, upon the department obtaining any necessary federal approvals, and to the extent federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

(e) This section shall become operative on January 1, 2026.

SEC. 53. Section 14007.5 of the Welfare and Institutions Code is amended to read:

14007.5. (a) Persons who are not citizens or nationals of the United States shall be eligible for Medi-Cal, whether federally funded or state-funded, only to the same extent as permitted under federal law and regulations for receipt of federal financial participation under Title XIX of the federal Social Security Act, except as otherwise provided in this section and elsewhere in this chapter.

(b) In accordance with Section 1903(v)(1) of the federal Social Security Act (42 U.S.C. Sec. 1396b(v)(1)), a person who is not a citizen or a national of the United States shall only be eligible for the full scope of Medi-Cal benefits if the person has an immigration status described in Section 1641(b) of Title 8 of the United States Code. For purposes of this section, persons who are not citizens or nationals of the United States and who are "permanently residing in the United States under color of law" shall be interpreted to include all persons who are not citizens or nationals of the United States residing in the United States with the knowledge and permission of the United States Department of Homeland Security and whose departure the United States Department of Homeland Security does not contemplate enforcing and with respect to whom federal financial participation is not available under Title XIX of the federal Social Security Act.

(c) A person who has an immigration status described in Section 1641(b) of Title 8 of the United States Code, but who is subject to the limitation described in Section 1613(a) of Title 8 of the United States Code, or a person who is otherwise permanently residing in the United States under color of law, shall be eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (*l*).

(d) Any person who is not a citizen or national of the United States who is otherwise eligible for Medi-Cal services, but who does not meet the requirements under subdivision (b) or (c), shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law, except as described in Sections 14007.65, 14007.7, and 14007.8. For purposes of this section, the term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part. It is the intent of this section to entitle eligible individuals to inpatient and outpatient services

that are necessary for the treatment of the emergency medical condition in the same manner as administered by the department through regulations and provisions of federal law.

(e) (1) (A) No sooner than July 1, 2027, all individuals described in subdivisions (c) and (d), except for those individuals described in subparagraph (B), shall be required to pay a monthly premium as a condition of eligibility for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (*l*), if they are otherwise eligible for benefits under this chapter.

(B) The following individuals are not subject to the monthly premium requirements described in subparagraph (A):

(i) Individuals under 19 years of age.

(ii) Individuals over 59 years of age.

(iii) Individuals who are pregnant.

(2) Monthly premiums imposed under this subdivision shall be thirty dollars ($30) per beneficiary.

(3) An individual required to pay premiums pursuant to this subdivision, after no more than 90 days of nonpayment of the monthly premium, is only eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. All outstanding premium balances shall be paid in full as a condition of continued eligibility for the full scope of Medi-Cal benefits.

(4) The monthly premium requirements and service limitations described in paragraphs (1), (2), and (3) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(f) Pursuant to Section 14001.2, each county department shall require that each applicant for, or beneficiary of, Medi-Cal, including a child, shall provide their social security number account number, or numbers, if they have more than one social security number.

(g) (1) In order to be eligible for benefits under subdivision (b) or (c), an applicant or beneficiary shall present United States Citizenship and Immigration Services registration documentation or other proof of satisfactory immigration status from the United States Citizenship and Immigration Services.

(2) Any person who meets all other program requirements but who lacks documentation of United States Citizenship and Immigration Services registration or other proof of satisfactory immigration status shall be provided a reasonable opportunity to submit the evidence. For purposes of this paragraph, "reasonable opportunity" means 30 days or the time it actually takes the county to process the Medi-Cal application, whichever is longer.

(3) During the reasonable opportunity period under paragraph (2), the county department shall process the applicant's application for medical

assistance in a manner that conforms to its normal processing procedures and timeframes.

(h) (1) The county department shall grant only the Medi-Cal benefits set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 to any individual who, after 30 calendar days or the time it actually takes the county to process the Medi-Cal application, whichever is longer, has failed to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, or who is reported by the United States Citizenship and Immigration Services to lack a satisfactory immigration status for Medi-Cal purposes.

(2) If a person who is not a citizen or national of the United States has been receiving Medi-Cal benefits based on eligibility established prior to the effective date of this section and that individual, upon redetermination of eligibility for benefits, fails to submit documents constituting reasonable evidence indicating a satisfactory immigration status for Medi-Cal purposes, the county department shall discontinue the Medi-Cal benefits, except for the care and services set forth in subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8. The county department shall provide adequate notice to the individual of any adverse action and shall accord the individual an opportunity for a fair hearing if the individual requests one.

(i) To the extent permitted by federal law and regulations, a person who is not a citizen or national of the United States applying for services under subdivisions (b) and (c) shall be granted eligibility for the scope of services to which they would otherwise be entitled if, at the time the county department makes the determination about their eligibility, the person meets either of the following requirements:

(1) The person has not had a reasonable opportunity to submit documents constituting reasonable evidence indicating satisfactory immigration status.

(2) The person has provided documents constituting reasonable evidence indicating a satisfactory immigration status, but the county department has not received timely verification of the person's immigration status from the United States Citizenship and Immigration Services.

(3) The verification process shall protect the privacy of all participants. A person's immigration status shall be subject to verification by the United States Citizenship and Immigration Services, to the extent required for receipt of federal financial participation in the Medi-Cal program.

(j) If a person does not declare status as a lawful permanent resident or person permanently residing under color of law, or as a person legalized under Section 210, 210A, or 245A of the federal Immigration and Nationality Act (Public Law 82-414), Medi-Cal coverage under subdivision (d) of this section or in Section 14007.65, 14007.7, or 14007.8 shall be provided to the individual if they are otherwise eligible.

(k) If a person subject to this section is not fluent in English, the county department shall provide an understandable explanation of the requirements of this section in a language in which the person is fluent.

(l) (1) No sooner than July 1, 2026, all individuals described in subdivisions (c) and (d) who are 19 years of age or older shall not be eligible

for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) Paragraph (1) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(m) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section, in whole or in part, by means of plan or county letter, information notices, plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(n) Subdivisions (e) and (*l*) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

SEC. 54. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) An individual who is 25 years of age or younger, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivisions (b), (c), and (k), if they are otherwise eligible for benefits under this chapter.

(2) (A) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no sooner than May 1, 2022, an individual who is 50 years of age or older, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivisions (b), (c), and (k), if they are otherwise eligible for benefits under this chapter.

(B) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subparagraph, but no later than January 1, 2024, an individual who is 26 to 49 years of age, inclusive, and who does not have satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivisions (b), (c), and (k), if they are otherwise eligible for benefits under this chapter.

(b) (1) No sooner than January 1, 2026, an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who is otherwise eligible for Medi-Cal services pursuant to subdivision (d) of Section 14007.5, and who applies for Medi-Cal on or after January 1, 2026, shall only be eligible for medically necessary

pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) Notwithstanding paragraph (1), an individual who is 19 years of age or older, who does not have satisfactory immigration status as required by Section 14011.2, who was enrolled in full-scope Medi-Cal and was not pregnant, but loses coverage for full-scope Medi-Cal, shall be eligible to reenroll in full-scope Medi-Cal within three months from the date of disenrollment for full-scope Medi-Cal, pregnancy-only Medi-Cal, or postpartum Medi-Cal. Payment of outstanding premium balances prior to the initiation of the three-month cure period shall be a condition of reenrollment under this subdivision for individuals disenrolled from Medi-Cal due to nonpayment of premiums. For purposes of this paragraph, "full-scope Medi-Cal" means the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (k).

(3) Paragraphs (1) and (2) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(c) (1) No sooner than January 1, 2026, if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal on or after January 1, 2026, the individual shall only be eligible for medically necessary pregnancy-related services, and care and services necessary for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) No sooner than January 1, 2026, notwithstanding paragraph (1), if an individual described in subdivision (a) who is 19 years of age or older loses eligibility for full-scope Medi-Cal while pregnant, the individual shall remain eligible for the full scope of Medi-Cal benefits, subject to the service limitations described in subdivision (k), throughout the pregnancy and for 12 months after the pregnancy ends.

(3) Paragraphs (1) and (2) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(d) The department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

(e) To the extent permitted by state and federal law, an individual eligible for full-scope Medi-Cal pursuant to subdivision (a) shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

(f) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable. For purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.

(2) To the extent that federal financial participation is unavailable, the department shall implement this section using state funds appropriated for this purpose.

(g) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

(h) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(i) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from both of the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Review or approval of contracts by the Department of General Services.

(j) (1) (A) No sooner than July 1, 2027, all individuals described in subdivision (a), except for those individuals described in subparagraph (B), shall be required to pay a monthly premium as a condition of eligibility for Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) The following individuals are not subject to the monthly premium requirements described in subparagraph (A):

(i) Individuals under 19 years of age.

(ii) Individuals over 59 years of age.

(iii) Individuals who are pregnant.

(2) Monthly premiums imposed under this section shall be thirty dollars ($30) per beneficiary.

(3) An individual described in paragraph (1), after no more than 90 days of nonpayment of the monthly premium, will only be eligible for medically necessary pregnancy-related services, and care and services necessary for

the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law. All outstanding premium balances shall be paid in full as a condition of continued eligibility for full-scope Medi-Cal coverage, subject to the service limitations described in subdivision (k).

(4) The monthly premium requirements and service limitations described in paragraphs (1), (2), and (3) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(k) (1) No sooner than July 1, 2026, an individual who is 19 years of age or older, who is eligible for Medi-Cal benefits pursuant to subdivision (a), shall not be eligible for dental services set forth in this chapter, except for the treatment of an emergency medical condition and medical care directly related to the emergency, as defined in federal law.

(2) Paragraph (1) shall not apply to nonminor dependents, as defined in Section 11400, and individuals who but for their immigration status are eligible for Medi-Cal pursuant to Section 14005.28. These individuals shall remain eligible for the full scope of Medi-Cal benefits until their 26th birthday.

(l) Subdivisions (b), (c), (j), and (k) shall be implemented only after the director determines, and communicates in writing to the Department of Finance, that systems have been programmed for implementation.

SEC. 55. Section 14007.95 of the Welfare and Institutions Code is repealed.

SEC. 56. Section 14012.5 of the Welfare and Institutions Code is amended to read:

14012.5. (a) By July 1, 2007, the department shall implement a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income or asset documentation.

(b) The process shall apply to applicants and beneficiaries in the program described in Section 14005.30, the federal poverty level programs for infants, children and pregnant women, the Medically-Indigent and Medically-Needy Programs for children and families, and other similar programs designated by the department, in order to preserve family unity or simplify administration. The process shall not apply to applicants or beneficiaries whose eligibility is based on their status as aged, blind, or based upon a disability determination unless, to the extent possible, they are members of families in which a child, parent, or spouse of that person is also a Medi-Cal applicant or beneficiary.

(c) The director may modify or terminate the first phase of implementation not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the modification or termination and shall include all relevant data elements that are applicable to document the reasons

provided for said modifications or termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the director shall promptly provide any additional clarifying information regarding the first phase of implementation as requested.

(d) Following two years of operation in two counties and submission of the evaluation to the Legislature, the director, in consultation with the Department of Finance, shall determine whether to implement the self-certification process statewide. This determination shall be based on the outcomes of the evaluation, including the ability to increase enrollment of eligible children and families, and to maintain the overall integrity of the Medi-Cal program. Statewide implementation shall be contingent on a specific appropriation being provided for this purpose in the Budget Act or subsequent legislation.

(e) This section shall be implemented only if, and to the extent that, federal financial participation is available.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) The department, in consultation with the Department of Finance, counties, and other interested stakeholders, shall determine which types of assets and income are appropriate for self-certification under this section.

(h) Nothing in this section shall be read to preclude a county from requesting documentation from any applicant or beneficiary regarding any income or asset where a question arises about such income or asset during the county's determination or redetermination of eligibility following receipt of the application or annual redetermination form.

(i) Nothing in this section shall change the ability of the department to self-certify income, assets, or other program information to the extent allowed under state or federal law, waiver, or the state plan.

(j) (1) This section shall not be implemented if the voters approve Proposition 86, the tobacco tax initiative, at the statewide general election on November 7, 2006.

(2) Notwithstanding paragraph (1) if Proposition 86 is approved by the voters at the statewide general election on November 7, 2006, this section shall be implemented during the pendency of any legal action concerning the validity of the proposition.

SEC. 57. Section 14100.95 of the Welfare and Institutions Code is repealed.

SEC. 58. Section 14105.47 of the Welfare and Institutions Code is amended to read:

14105.47. (a) (1) The department shall establish a list of medical supplies. The list shall specify utilization controls to be applied to each medical supply product.

(2) The utilization controls specified shall include, but not be limited to, those provided by regulation of the department.

(3) The department shall notify providers at least 30 days prior to the effective date of a change in utilization controls.

(b) (1) The department shall establish a list of maximum allowable product costs (MAPCS) for medical supplies, which shall be published in provider bulletins.

(2) The department shall update existing MAPCS and establish additional MAPCS in accordance with all of the following:

(A) In establishing the MAPCS, the director shall assure that eligible persons shall receive medical supply products that are available to the public generally, without discrimination or segregation based purely on economic disability.

(B) All related medical supply products within each particular medical supply type available for retail distribution shall be reviewed by the department in consultation with representatives from the California Association of Medical Product Suppliers and the California Pharmacists Association.

(C) The department shall base MAPCS on the mean of the wholesale selling price of related medical supply products that are available in California. For purposes of this section, "wholesale selling price" means the price, including discounts and rebates, paid by a provider to a wholesaler, distributor, or manufacturer for a medical supply product.

(D) In establishing the MAPCS, the department shall consider the provider related costs of the product that include, but are not limited to, shipping, handling, storage, and delivery.

(E) The department shall notify Medi-Cal providers at least 30 days prior to the effective date of MAPCS.

(c) (1) In establishing the list of medical supplies, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers, or suppliers of medical supplies pursuant to Section 14105.3.

(2) To ensure that the health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating a decision to execute a contract, and when evaluating medical supplies for retention on, addition to, or deletion from, the list of medical supplies, consider all of the following criteria:

(A) The safety of the product.

(B) The effectiveness of the product.

(C) The essential need for the product.

(D) The potential for misuse of the product.

(E) The immediate or long-term cost effectiveness of the product.

(3) The deficiency of a product when measured by one of the criteria specified in paragraph (2) may be sufficient to support a decision that the product should be deleted from, should not be added to, or should not be retained on, the list of medical supplies. However, the superiority of a product under one criterion may be sufficient to warrant the addition or retention of the product, notwithstanding a deficiency in another criterion.

(4) In the evaluation of the effectiveness of a product, the department may require the manufacturer, distributor, dispenser, or supplier to submit its products to testing by an independent laboratory. For the purposes of this section, "independent laboratory" means an analytical laboratory that is not a subsidiary of, affiliated with, or on retainer for, the manufacturer, distributor, dispenser, or supplier. The department shall only utilize this paragraph involving products where there is a demonstrated experience of a significant variation in performance among the products subject to this particular contracting process.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, actions under this section shall not be subject to the Administrative Procedure Act or to the review and approval of the Office of Administrative Law.

SEC. 59. Section 14105.475 of the Welfare and Institutions Code is amended to read:

14105.475. (a) In maintaining the lists of medical supplies, incontinence medical supplies, and enteral nutrition products, the department may perform a review of, and contract for, various products in a specific product category.

(b) The department shall notify each manufacturer of products in the categories selected pursuant to Sections 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive.

(c) If, within 30 days of notification, a manufacturer does not enter into negotiations for a contract pursuant to those sections, the department may delete the products from their respective lists, or refuse to consider for addition, products of that manufacturer in the selected product categories.

(d) If, after 270 days from the initial notification, a contract is not executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department may delete the product from its respective list.

(e) If, within 270 days from the initial notification, a contract is executed for a product currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall retain the product on its respective list.

(f) If, within 270 days from the date of the initial notification, a contract is executed for a product not currently on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, the department shall add the product to its respective list.

(g) The department shall terminate all negotiations 270 days after the initial notification.

(h) The department may delete any product from its respective list at the expiration of the contract term or when the contract between the department and the manufacturer of that product is terminated.

(i) In the absence of a contract, the department may deem any product on the list of medical supplies, incontinence medical supplies, or enteral nutrition products, a nonbenefit of the program and delete that product from its respective list.

(j) Deletions made to the lists of medical supplies, incontinence supplies, and enteral nutrition products, shall become effective no sooner than 30 days after publication of the changes in provider bulletins.

(k) (1) A manufacturer of a medical supply, incontinence supply, or enteral nutrition product denied a contract pursuant to this section, or pursuant to Sections 14105.47, 14105.8, and Sections 14125 to 14125.9, inclusive, may file an appeal of that decision with the director within 30 calendar days of the department's written decision.

(2) The director shall issue a final decision on the appeal within 60 calendar days of the postmark date of the appeal.

(l) The department shall provide individual notice to Medi-Cal beneficiaries at least 60 calendar days prior to the effective date of the deletion or suspension of any product pursuant to this subdivision. The notice shall include a description of the beneficiary's right to a fair hearing and shall encourage the beneficiary to consult a physician to determine if an appropriate substitute product is available from Medi-Cal.

SEC. 60. Section 14124.11 of the Welfare and Institutions Code is amended to read:

14124.11. (a) The department shall establish a two-year pilot program to utilize the federal Public Assistance Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are enrolled in the Medi-Cal program and assist them in obtaining federal veteran health care benefits.

(b) The department shall select three consenting counties that have in operation a United States Department of Veterans Affairs (USDVA) medical center to participate in the pilot program.

(c) Under the pilot program, the department shall exchange information with PARIS and identify veterans and their dependents or survivors who are receiving Medi-Cal benefits in the pilot program counties.

(d) The department shall refer identified Medi-Cal beneficiaries who are receiving high-cost services, including long-term care, to county veteran service officers (CVSOs) to obtain information regarding, and assistance in obtaining, USDVA benefits.

(e) Prior to commencement of the pilot program, the department shall do all of the following:

(1) Enter into an agreement with the California Department of Veterans Affairs (CDVA) to perform CVSO outreach services in connection with the pilot program. The CDVA agreement shall contain performance standards that would allow the department to measure the effectiveness of the pilot program.

(2) Enter into any agreements that are required by the federal government to utilize the PARIS system.

(3) Perform any information technology activities that are necessary to utilize the PARIS system.

(f) If the department determines that the pilot program is cost effective, it may implement the program statewide at any time and continue operation of PARIS indefinitely.

(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, or make specific, this section by means of written directives without taking further regulatory action.

(h) The department shall implement the pilot program by July 1, 2009.

(i) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from the Public Contract Code and from Chapter 3 (commencing with Section 11250) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 61. Section 14132.995 is added to the Welfare and Institutions Code, to read:

14132.995. (a) Notwithstanding any other law, vaccines and immunizations are covered in accordance with a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians or any modification or supplement to that recommendation adopted pursuant to Section 120164 of the Health and Safety Code, with respect to the individual involved.

(b) This section shall be implemented only to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained.

(c) Notwithstanding any other law, the department, without taking any further regulatory action, may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions.

SEC. 62. Section 14146 of the Welfare and Institutions Code is amended to read:

14146. (a) (1) The department shall work with identified stakeholders to conduct a study to identify current requirements for medical interpretation services as well as education, training, and licensure requirements, analyze other state Medicaid programs, and make recommendations on strategies that may be employed regarding the provision of medical interpretation services for Medi-Cal beneficiaries who are limited English proficient (LEP), in compliance with applicable state and federal requirements.

(2) The study also shall assess and make recommendations based on pilot projects, studies, and available data that would further the objectives of this article, including funding for those activities and the allowable use of federal funding.

(b) (1) The department shall work with identified stakeholders to establish a pilot project concurrent with the study.

(2) A pilot project shall include up to four separate sites to evaluate the provision of medical interpretation services for LEP Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans and in fee-for-service Medi-Cal. In identifying sites, the department shall take into account the need for those services, the availability of a pool of medical interpreters that meet the

language needs of the Medi-Cal population for use by providers and managed care plans, and the studies and available data identified under paragraph (2) of subdivision (a).

(c) (1) The department may use or contract with an external vendor, vendors, or other contracted subject matter experts to implement the activities described in this section, including the pilot project. However, the vendor for the study shall not be used for the pilot project. The department shall consult with identified stakeholders regarding the draft initial scope of work that shall be used to seek and evaluate proposals pursuant to this section.

(2) At a minimum, the pilot project shall be designed to evaluate all of the following:

(A) Whether Medi-Cal beneficiary satisfaction is greater than for those beneficiaries without access to in-person medical interpretation.

(B) Whether the satisfaction of physicians and surgeons, nurse practitioners, physician assistants, and other health professionals acting within their scope of practice increases.

(C) Whether noncompliance with treatment regimens or avoidable medical errors are reduced.

(D) Whether disparities in care are reduced, with respect to LEP Medi-Cal beneficiaries compared with Medi-Cal beneficiaries who are proficient in English.

(E) Whether the Medi-Cal managed care plans identify improvements in quality of care.

(F) The utilization of medical interpreters by providers and Medi-Cal managed care plans.

(d) (1) Each year, commencing in 2017, during the annual state budget process, the department shall provide an update to the budget committees of the Legislature on the implementation of this article.

(2) Any report submitted under this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(e) (1) For activities under this section, the department may expend up to three million dollars ($3,000,000) under Provision 14 of Item 4260-101-0001 of Section 2.00 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016) for the support of activities related to a medical interpreters pilot project, study, or both. In addition, the department shall expend up to five million dollars ($5,000,000) for the pilot project under Provision 15 of Item 4260-101-0001 of Section 2.00 of the Budget Act of 2019 (Chapter 23 of the Statutes of 2019), which shall be available for expenditure, encumbrance, and liquidation until June 30, 2026.

(2) The department may seek any available federal funding for support of activities relating to medical interpretation services as provided under this section.

(3) Expenditure or encumbrance of the funds described in this subdivision is contingent upon approval by the Department of Finance.

SEC. 63. Section 14146.5 of the Welfare and Institutions Code is amended to read:

14146.5. This article shall become inoperative on July 1, 2026, and, as of January 1, 2027, is repealed.

SEC. 64. Section 14501 of the Welfare and Institutions Code is amended to read:

14501. The Office of Family Planning has all of the following functions, powers, and duties:

(a) To make available to citizens of the state of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families.

(b) To consult with state and local agencies that provide or administer family planning services and to participate in the formulation of regulations and other policy decisions governing the provision or administration of family planning services pursuant to state law or regulation.

(c) To establish goals and priorities for all state agencies providing or administering family planning services.

(d) To coordinate all family planning services and related programs conducted or administered by state agencies with the federal government so as to maximize the availability of these services by utilizing all available federal funds.

(e) To conduct a survey of all of the existing facilities within the state having to do with family planning and infertility and the rendering of advice and assistance on birth control techniques and information.

(f) To evaluate all existing programs and to establish in each county a viable program for the dispensation of family planning, infertility, and birth control information and techniques.

(g) To develop and administer scientific investigation into problems of infertility and existing and new family planning and birth control techniques.

(h) To survey, evaluate, and establish programs of professional education and training for physicians, nurses, medical and nursing students, and other health care practitioners in rendering advice on family planning, infertility, and birth control techniques and information.

(i) To enter into agreements with, and award grants to, individuals, colleges, universities, associations, corporations, municipalities, and other units of government as may be deemed necessary and advisable to carry out the general intent and purposes of this chapter, which may provide for payment by the state within the limit of funds available for material, equipment, and services.

(j) To post annual reports on its internet website, including, but not limited to, the subjects specified in subdivisions (a) to (i), inclusive.

(k) To annually update and analyze family planning data. The data shall include, but not be limited to, the following:

(1) Client number.

(2) Ethnicity.

(3) Family size.

(4) Method.

(5) Family income.

(6) Service type.

(7) Birthdate.
(8) Total billing amount.
(9) Pay source.
(10) Date of visit.
(11) Site number.
(12) County of residence.
(13) Updated estimates of women in need of subsidized family planning services from the federal government, when available, for all Office of Family Planning clinical service grantees by county of service, as well as statewide totals.

SEC. 65. Section 34 of Chapter 80 of the Statutes of 2005 is repealed.

SEC. 66. Section 67 of Chapter 758 of the Statutes of 2008 is repealed.

SEC. 67. Section 118 of Chapter 21 of the Statutes of 2025 is amended to read:

SEC. 118. (a) The State Department of Public Health may spend up to seventy-five million dollars ($75,000,000) from the AIDS Drug Assistance Program Rebate Fund to support current or eligible services and programs, consistent with Sections 120955, 120956, 120960, 120972, 120972.1, and 120972.2 of the Health and Safety Code and with the following:

(1) Beginning July 1, 2025, up to sixty-five million dollars ($65,000,000) is available to supplement or fund services, programs, or initiatives funded by the AIDS Drug Assistance Program Rebate Fund for which federal funding has been reduced or eliminated as a result of federal policy actions to cancel, delay, or reduce funding for HIV and AIDS prevention and treatment programs. Of this amount, up to eighteen million dollars ($18,000,000) is available for state operations.

(A) Upon notification to the department of federal action, or the nonreceipt of Notices of Award, that result in reductions to or elimination of federal funding for those services, programs, or initiatives, the department shall notify the Department of Finance. The Department of Finance shall authorize funding allocations that are equivalent to the amount, to the extent these amounts are within the amount of funds appropriated for this purpose, and correspond to services that would have otherwise been funded by the reduced or eliminated federal funds as soon as practicable, but no later than 30 days following notification from the department.

(B) (i) If the federal funding that was reduced or eliminated is restored by the federal government, funding made available under this paragraph shall be repaid to the AIDS Drug Assistance Program Rebate Fund within 180 days. A repayment process shall be established by the department, in consultation with the Department of Finance.

(ii) A local public health agency or community-based organization that has received funding made available under this paragraph shall not be required to repay the funding until it has received the restored federal funding.

(2) Beginning July 1, 2025, nine million dollars ($9,000,000) is available to fund state and local disease intervention specialists. Of this amount, up

to one million six hundred forty thousand dollars ($1,640,000) is available for state operations.

(3) Beginning July 1, 2025, one million dollars ($1,000,000) is available for the department to purchase rapid Hepatitis C Virus (HCV) testing equipment for distribution to local health departments and community-based organizations. The department shall establish a process for local health departments and community-based organizations to receive HCV testing equipment based on need in the specific geographic area.

(b) The department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts and grants entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, the State Administrative Manual, and the State Contracting Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(c) The department may, in consultation with the Department of Finance, use an alternative local fiscal agent that is not identified in this section, if necessary, to achieve the intended legislative purpose.

SEC. 68. The Legislature finds and declares that Section 42 of this act, which adds Section 127642 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest: In order to protect confidential and personal medical information, as well as the safety of medical providers, it is necessary that grants and contracts entered or amended pursuant to Section 127642 of the Health and Safety Code remain confidential.

SEC. 69. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, 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.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 70. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article

IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

O

CDPH Immunization Recommendations Under Assembly Bill 144

In accordance with California Health and Safety Code section 120164, the California Department of Public Health (CDPH) recommends the following immunizations, after taking into consideration guidance and recommendations from additional medical and scientific organizations, including, but not limited to, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

These recommendations pertain to all statutes in California law that reference California Health and Safety Code section 120164.

The consequences of Assembly Bill 144 (2025) include, but are not limited to:

- Health insurance plans regulated in California are required to cover immunizations recommended by CDPH.
- Persons providing immunizations in California as recommended by CDPH have liability protections.
- California pharmacists may administer immunizations recommended by CDPH to patients three years and older without a prescription from a physician.

2025-26 Respiratory Virus Vaccine Recommendations

Respiratory Syncytial Virus (RSV) activity remains elevated in California. CDPH has extended the recommendation of RSV immunization with monoclonal antibodies (nirsevimab and clesrovimab) of eligible infants and children through **April 30, 2026**. Insurance coverage of RSV immunization will continue.

Age/Condition	COVID-19	Influenza (Flu)	RSV
Children	• All 6-23 months • All 2-18 years with risk factors or never vaccinated against COVID-19 • All who are in close contact with others with risk factors [1] • All who choose protection [1]	• All 6 months and older [4]	• All younger than 8 months [2] • All 8-19 months with risk factors
Pregnancy	• All who are planning pregnancy, pregnant, postpartum, or lactating	• All who are planning pregnancy, pregnant, postpartum, or lactating	• 32-36 weeks gestational age [3]
Adults	• All 65 years and older • All younger than 65 years with risk factors • All who are in close contact with others with risk factors • All who choose protection	• All	• All 75 years and older [3] • All 50-74 years with risk factors [3]

[1] COVID-19 vaccine is available for persons 6 months and older.

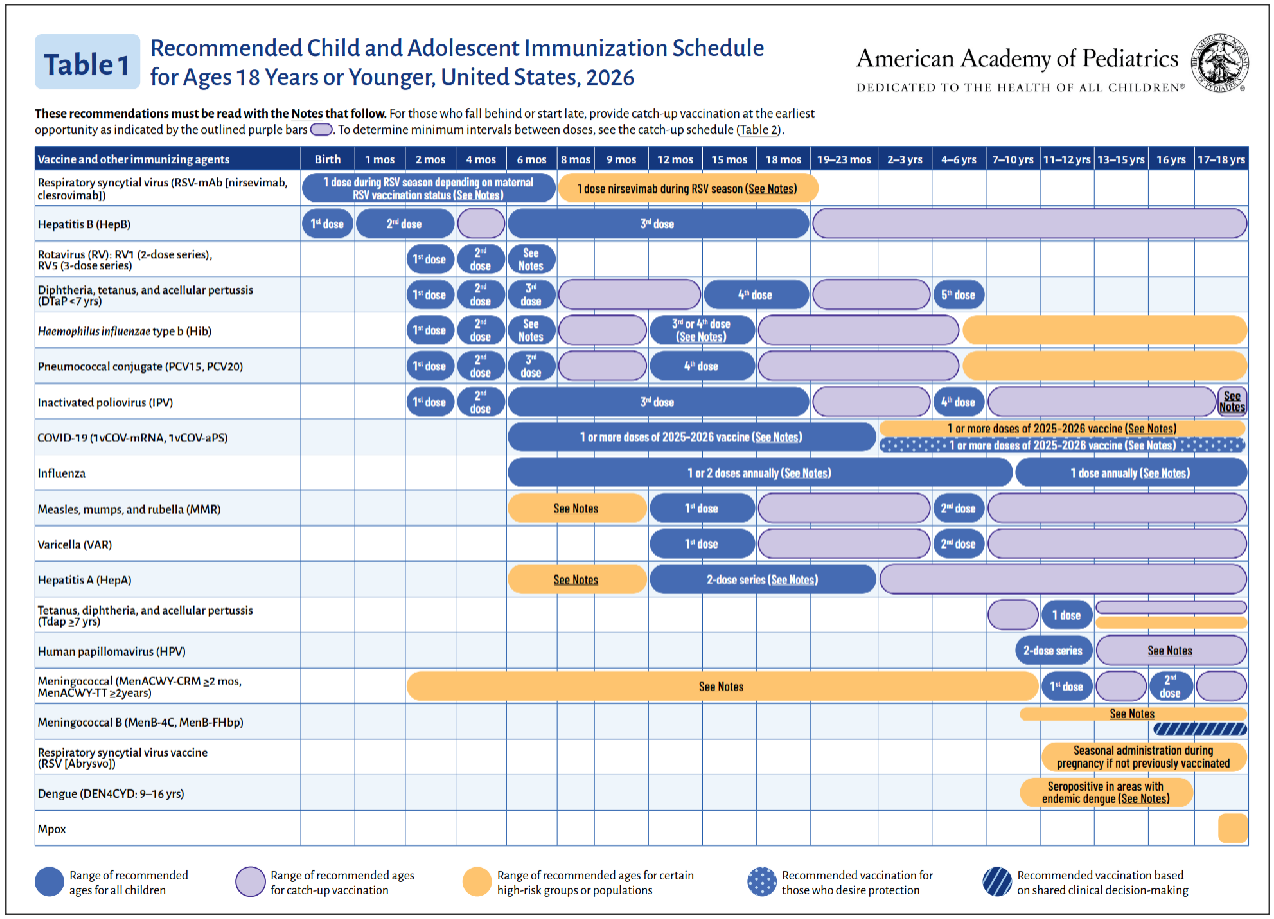
[2] Protect infants with either prenatal RSV vaccine or infant dose of nirsevimab or clesrovimab.

[3] RSV vaccination during pregnancy or for adults is currently recommended once rather than annually.

[4] Two doses given at least 4 weeks apart are recommended for ages 6 months-8 years who are getting flu vaccine for the first time.

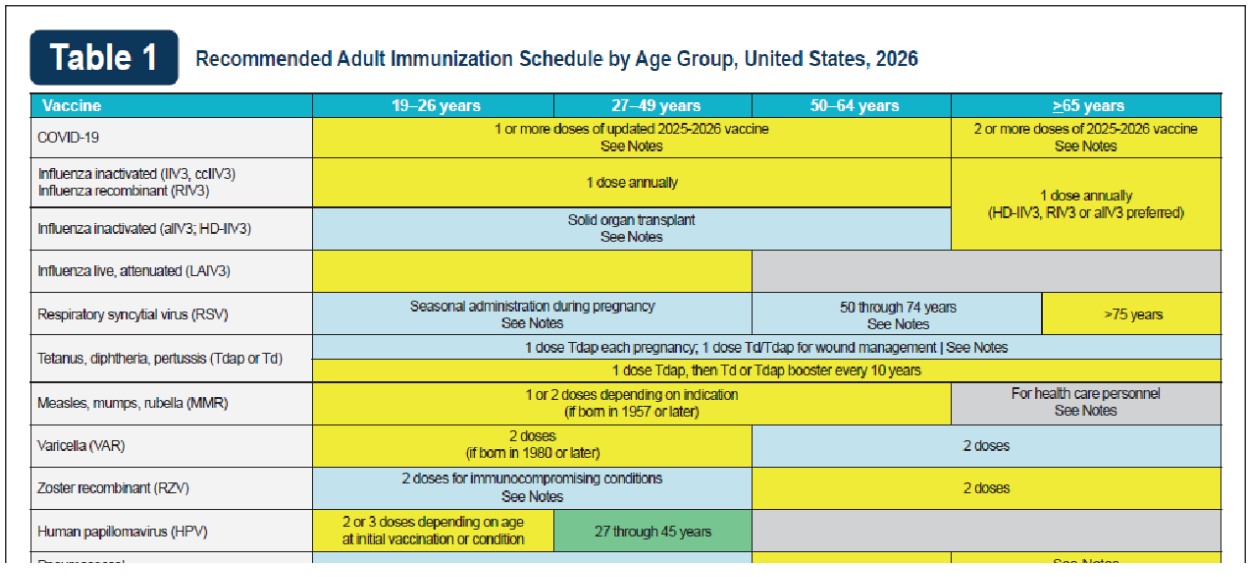
Children and adolescents through age 18 years

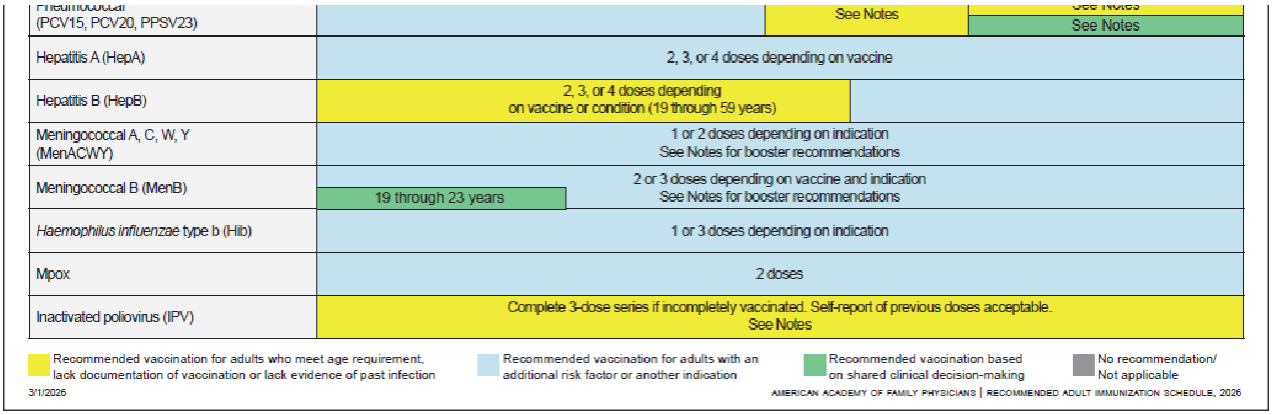
CDPH recommends immunization of children and adolescents in accordance with the American Academy of Pediatrics (AAP) immunization schedule (PDF) (version January 26, 2026).



Adults age 19 years and older

CDPH recommends immunization of adults in accordance with the American Academy of Family Physicians (AAFP) immunization schedule (PDF) (version March 1, 2026).





These are the California Department of Public Health Immunization Recommendations, as required under Assembly Bill 144 (2025) and California Health and Safety Code Section 120164. The new law creates a baseline immunization recommendation for California based on the federal Advisory Committee on Immunization Practices (ACIP) immunization recommendations in effect on January 1, 2025. CDPH is authorized to update recommendations as needed taking into consideration guidance from professional organizations, such as the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG). As ACIP and CDC publish new recommendations, refer to this webpage for official CDPH recommendations.

Page Last Updated : April 6, 2026

State of California

HEALTH AND SAFETY CODE

Section 120164

120164. (a) Consistent with subdivision (b), the list of immunizations, items, and services that were recommended by the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA), and that were in effect on January 1, 2025, shall serve as the baseline recommendations for purposes of this section.

(b) The State Department of Public Health may modify or supplement the baseline recommendations described in subdivision (a). In making modifications or supplements, the department shall take into consideration guidance and recommendations from additional medical and scientific organizations, including, but not limited to, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.

(c) In modifying or supplementing the baseline recommendations, the department may also incorporate subsequent evidence-based recommendations issued by the USPSTF, ACIP, or HRSA, to the extent the department determines those recommendations are consistent with the purposes of this section and promote public health.

(d) Publishing the baseline recommendations or any modification or supplement adopted pursuant to this section shall be exempt from the administrative regulation and rulemaking requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The department shall publish the recommendations of immunizations, items, and services, and publish any updates, modifications, or supplements adopted pursuant to this section. Any modification or supplement shall be deemed effective on the date of publication. The recommendations and schedules shall be filed with the Secretary of State and published in the California Code of Regulations.

(Added by Stats. 2025, Ch. 105, Sec. 26. (AB 144) Effective September 17, 2025.)

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 15.:** Presentation on Initiatives to Increase Access to Oral Health Providers – *California Dental Association (CDA)*

Background

Representatives from California Dental Association (CDA) will provide a presentation on initiatives to increase access to oral health providers.

Action Requested

No action is requested.

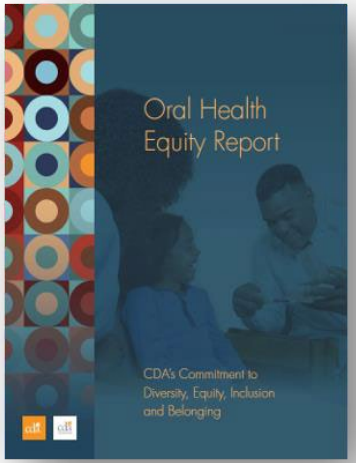
CDA & Access to Dental Care
2026 and Beyond

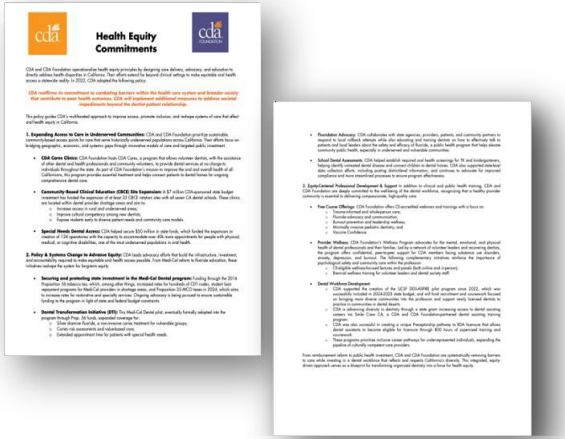
Overview

- CDA Oral Health Equity and Care Access
- CA Partnership on Oral Health
- Medi-Cal Dental Program
- 2026 Access Advocacy Efforts

CDA Oral Health Equity and Care Access

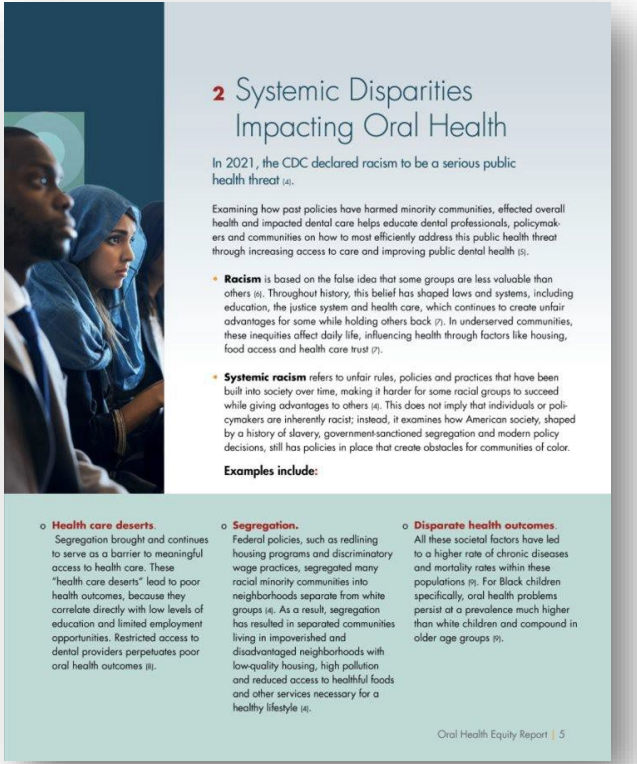
CDA Health Equity Commitment





Report Contents

- Overview
- Systemic disparities impacting patient oral health
- Diversity in the dental profession
- Actionable next steps
- Resources



2 Systemic Disparities Impacting Oral Health

In 2021, the CDC declared racism to be a serious public health threat (4).

Examining how past policies have harmed minority communities, effected overall health and impacted dental care helps educate dental professionals, policymakers and communities on how to most efficiently address this public health threat through increasing access to care and improving public dental health (5).

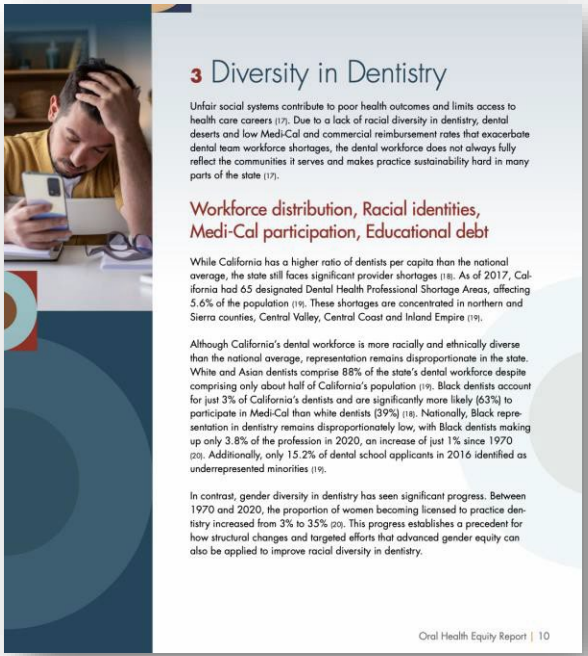
- **Racism** is based on the false idea that some groups are less valuable than others (6). Throughout history, this belief has shaped laws and systems, including education, the justice system and health care, which continues to create unfair advantages for some while holding others back (7). In underserved communities, these inequities affect daily life, influencing health through factors like housing, food access and health care trust (7).
- **Systemic racism** refers to unfair rules, policies and practices that have been built into society over time, making it harder for some racial groups to succeed while giving advantages to others (4). This does not imply that individuals or policymakers are inherently racist; instead, it examines how American society, shaped by a history of slavery, government-sanctioned segregation and modern policy decisions, still has policies in place that create obstacles for communities of color.

Examples include:

- **Health care deserts.** Segregation brought and continues to serve as a barrier to meaningful access to health care. These "health care deserts" lead to poor health outcomes, because they correlate directly with low levels of education and limited employment opportunities. Restricted access to dental providers perpetuates poor oral health outcomes (8).
- **Segregation.** Federal policies, such as redlining housing programs and discriminatory wage practices, segregated many racial minority communities into neighborhoods separate from white groups (4). As a result, segregation has resulted in separated communities living in impoverished and disadvantaged neighborhoods with low-quality housing, high pollution and reduced access to healthful foods and other services necessary for a healthy lifestyle (4).
- **Disparate health outcomes.** All these societal factors have led to a higher rate of chronic diseases and mortality rates within these populations (9). For Black children specifically, oral health problems persist at a prevalence much higher than white children and compound in older age groups (9).

Oral Health Equity Report | 5

Commitment to Diversity in Dental Professions



3 Diversity in Dentistry

Unfair social systems contribute to poor health outcomes and limits access to health care careers (17). Due to a lack of racial diversity in dentistry, dental deserts and low Medi-Cal and commercial reimbursement rates that exacerbate dental team workforce shortages, the dental workforce does not always fully reflect the communities it serves and makes practice sustainability hard in many parts of the state (17).

Workforce distribution, Racial identities, Medi-Cal participation, Educational debt

While California has a higher ratio of dentists per capita than the national average, the state still faces significant provider shortages (18). As of 2017, California had 65 designated Dental Health Professional Shortage Areas, affecting 5.6% of the population (19). These shortages are concentrated in northern and Sierra counties, Central Valley, Central Coast and Inland Empire (19).

Although California's dental workforce is more racially and ethnically diverse than the national average, representation remains disproportionate in the state. White and Asian dentists comprise 88% of the state's dental workforce despite comprising only about half of California's population (19). Black dentists account for just 3% of California's dentists and are significantly more likely (63%) to participate in Medi-Cal than white dentists (39%) (18). Nationally, Black representation in dentistry remains disproportionately low, with Black dentists making up only 3.8% of the profession in 2020, an increase of just 1% since 1970 (20). Additionally, only 15.2% of dental school applicants in 2016 identified as underrepresented minorities (19).

In contrast, gender diversity in dentistry has seen significant progress. Between 1970 and 2020, the proportion of women becoming licensed to practice dentistry increased from 3% to 35% (20). This progress establishes a precedent for how structural changes and targeted efforts that advanced gender equity can also be applied to improve racial diversity in dentistry.

Oral Health Equity Report | 10

- Economic burden of dental professional education
- As of 2017, CA had 65 designated Dental Health Professional Shortage Areas
- Black dentists account for just 3% of California's dentists, with only a 1% increase since 1970
- Gender diversity in dentistry has seen significant progress, growing from 3% to 35% of dentists since 1970

CDA Specialty Dental Clinic Grant

CDA led successful push for historic program serving patients with special health care needs in California

March 5, 2025 9 5552

QUICK SUMMARY: Dental schools, nonprofit organizations and individual dentists in 10 California counties have been awarded $47.2 million in Specialty Dental Clinic Grant funds to develop or expand dental operatories and other facilities to serve patients with special health care needs. CDA proposed the program in 2022, then fought to preserve the allocated state budget funds for the program. Read about the 13 grant recipients and how the program will improve access to care.

- $47.2 million in Specialty Dental Clinic Grant funds to develop or expand dental operatories and other facilities to **serve patients with special health care needs**
- 13 grant recipients across 10 CA Counties
- Recipients received between $2.2-$5 million each

CBCE Grant

California dental students and underserved communities benefit from Community-Based Clinical Education Funds

July 21, 2025 4 3844

Quick Summary: California's dental schools are merging professional training with community service thanks to grants funded by California's Office of Oral Health in partnership with the CDA Foundation to expand clinical rotation sites to underserved communities.

- CDA advocated for funding from the budget surplus in 2022 to establish new CBCE rotations between dental schools and community dental clinics
- The strong partnership between CDA and OOH support ongoing initiatives
- **25 clinic partnerships** funded!

DHCS Loan Repayment for Dental Education

- Loan Repayment Grant: $300,000 in exchange for a five-year Medi-Cal service obligation
- 5 cohorts between 2018-2019
- Proposition 56 allocated **$340 million for loan repayment** to increase access to care for Medi-Cal beneficiaries

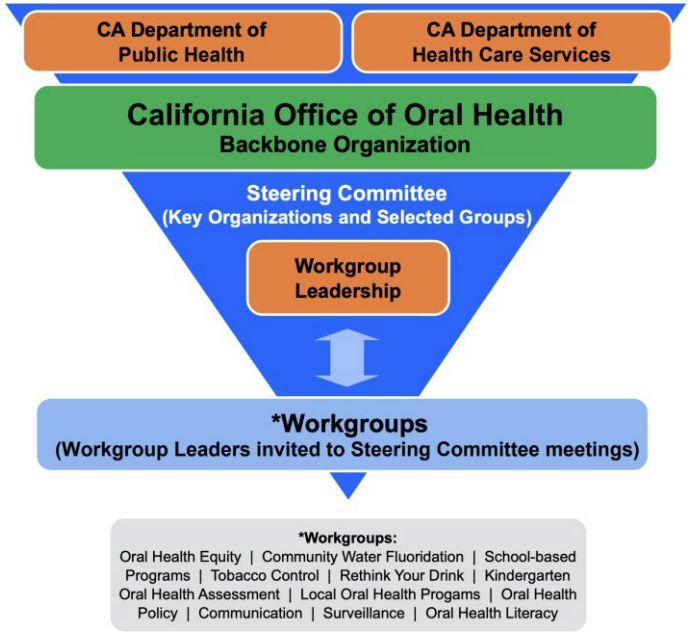
Cohort 5 Distribution of Funds by Dental Specialty[1]

General Dentistry	$5,089,700
Pediatric Dentistry	$2,332,311
Endodontics	$600,000
Orthodontics	$498,394
Dental Anesthesiology	$300,000
Oral and Maxillofacial Surgery	$300,000
Orofacial Pain	$294,162
Total	**$9,414,567**

California Partnership on Oral Health

California Partnership on Oral Health

- Established by the California Department of Public Health's Office of Oral Health to ensure implementation of the California Oral Health Plan
- CDA staff chair the Policy Workgroup and Emergency Department Ad-Hoc Workgroup for Non-traumatic Dental Conditions
- Elevate oral health as a priority and advance equity with interprofessional leaders across the state
- CDA is also on the School-Based Oral Health Workgroup and Fluoridation Workgroup

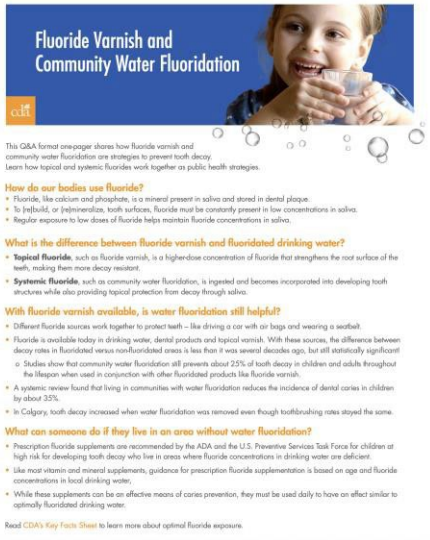


Fluoride and Fluoridation

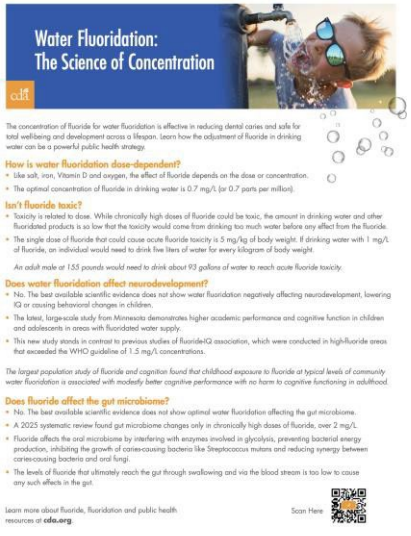
CDA is a state leader in developing fluoridation resources and advocating for this evidence-based public health program

Key Facts Sheet

Cost of Fluoridation



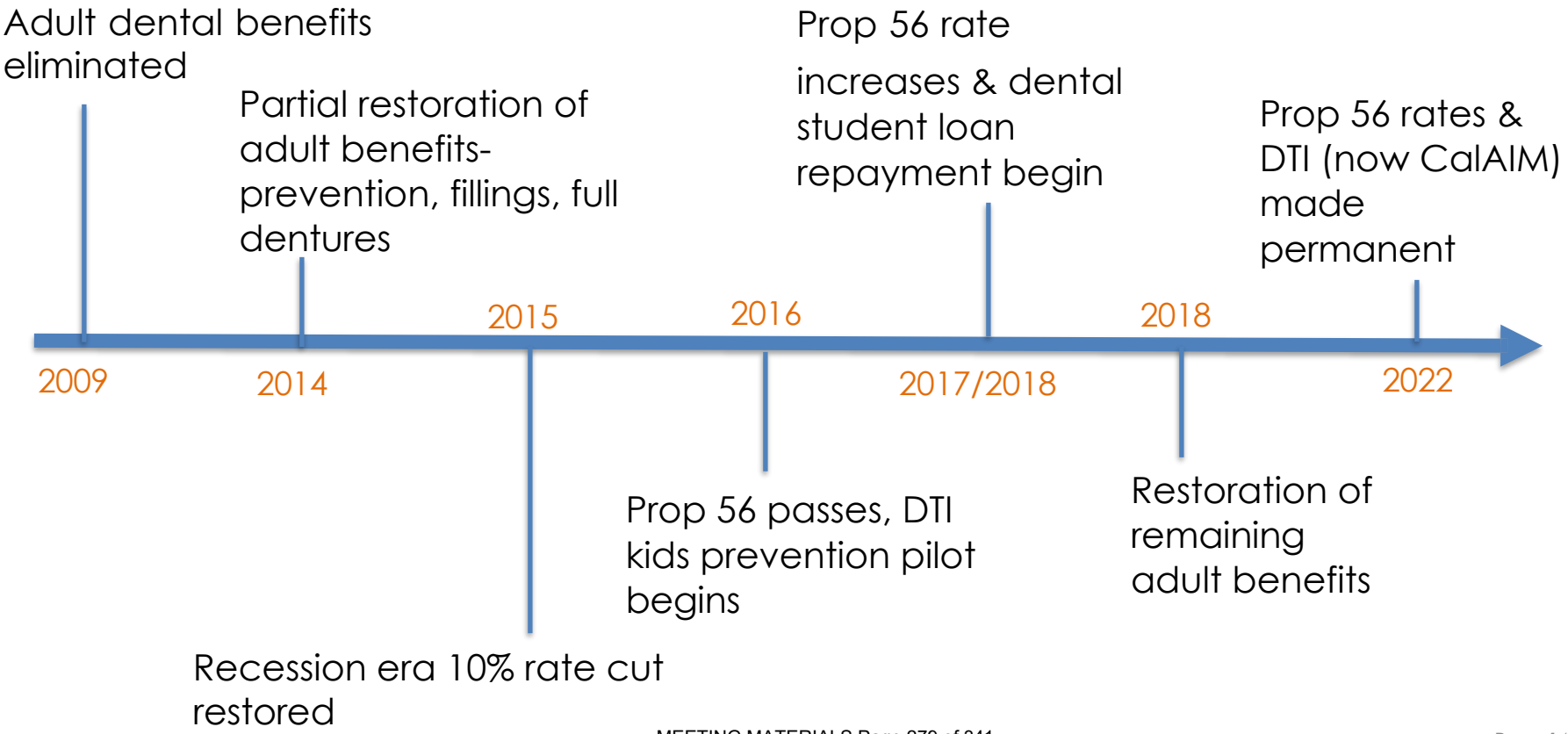
Topical & Systemic



Concentration

A Brief History of Medi-Cal Dental

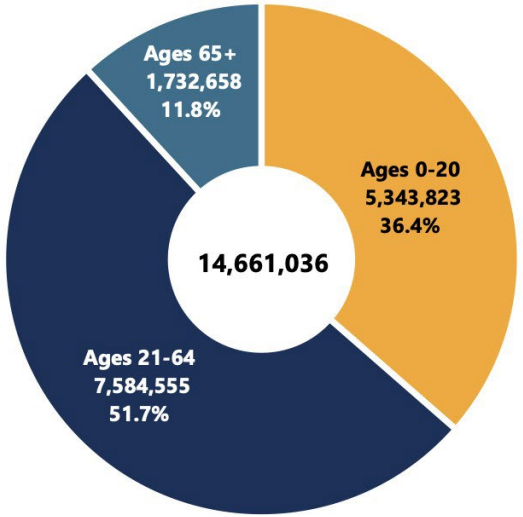
Medi-Cal Timeline



Medi-Cal, CA's largest plan

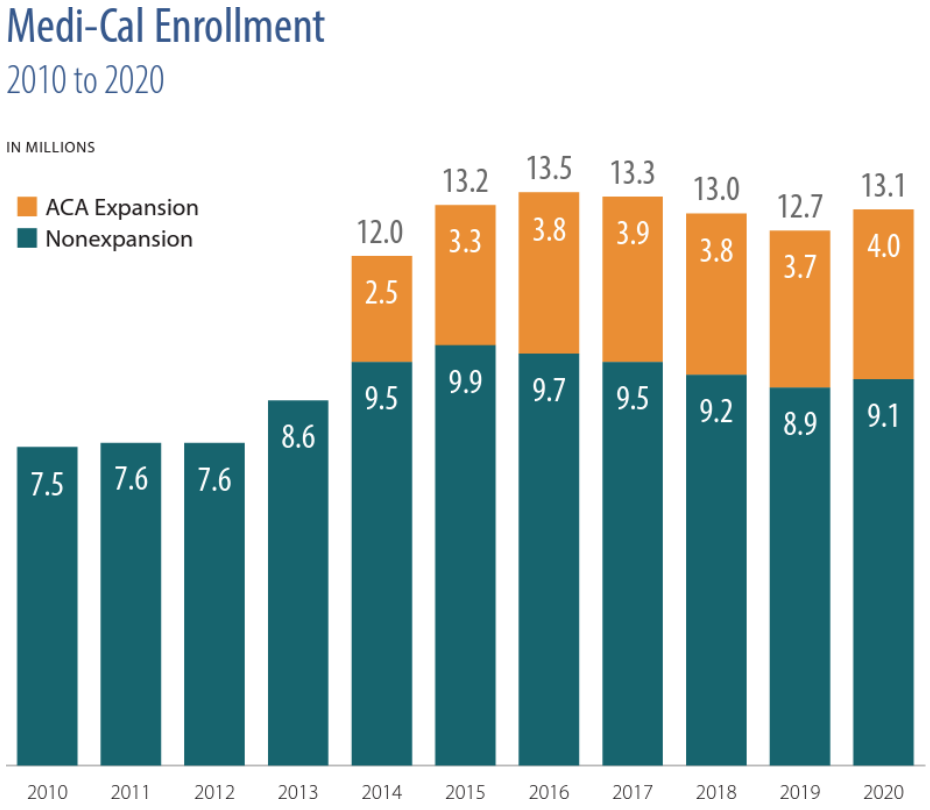
Certified Eligible Statistics – Medi-Cal Population
November 2025 (Date Represented: August 2025)

Figure 4: Distribution of Medi-Cal Certified Eligibles, by Age Group – August 2025



- Major changes under ACA
- 14.6 million people enrolled in Medi Cal
- 1 in 3 Californians
- 50% of all kids
- 43% of people with disabilities
- 1 in 6 CA workers aged 19 to 64

Medi-Cal, CA's largest plan



- Major changes under ACA
- ~14.5 million people enrolled in Medi-Cal
- 1 in 3 Californians
- 50% of all kids

CHCF, Medi-Cal Facts and Figures: Essential Source of Coverage for Millions: 2021

Dental Transformation Initiative: 2016-2021

Multi-pronged pilot program included coverage for:

Silver diamine fluoride – a topical application that can treat and prevent cavities in vulnerable populations including young children, the elderly and persons with intellectual or developmental disabilities.

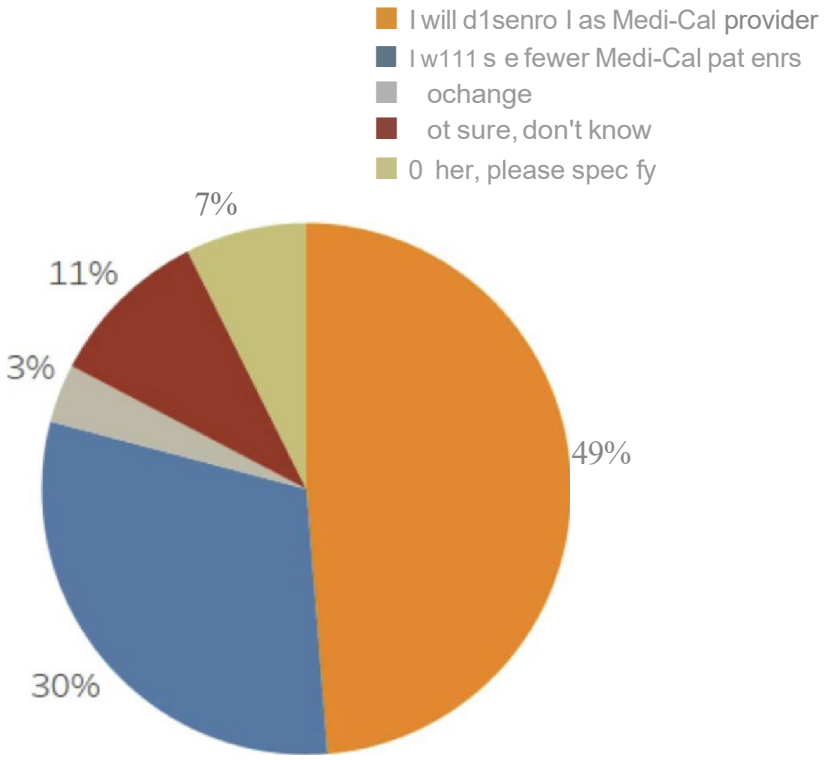
Caries (cavity) risk assessment, which allows a dentist to assess and manage caries risk and emphasizes preventive services in lieu of more invasive and costly procedures for very young children.

Extended time to render dental services to patients with special health needs.

Medi-Cal Dental Program Funding

- Covers 14.5 million Californians – largest dental plan in the state
- Major progress for Medi-Cal Dental in recent years
  - 34% increase in Medi-Cal dentists; 27% increase in annual dental office visits
- Latest federal budget bill (H.R. 1) slashes Medicaid spending by $1 trillion over the next ten years, which will amount to an estimated 20% reduction in federal funding for California.
- The 2025-26 state budget preserves Medi-Cal Dental funding through July 1, 2026. H.R. 1 will force the state to make significant budget adjustments.
- **Bottom line: Major uncertainty for Medi-Cal patients and dentists right now. Important year ahead for Medi-Cal Dental budget advocacy.**

Poll: Nearly half of Medi-Cal dentists said they would disenroll if Medi-Cal rate cuts take effect; 1 in 3 said they would see fewer Medi-Cal n1en1bers



Coalition to Save Medi-Cal Dental

For Immediate Release
January 6, 2026

Contact: Molly Weedn
molly@weednpa.com

Broad and Diverse Coalition of 50+ Groups Call on State Legislature and Newsom Administration to Stop Devastating $1B Cuts to Medi-Cal Dental

Coalition to Save Our Dental Care brings dozens of providers, labor and workforce advocates, and children's advocacy organizations together urging lawmakers to stop the cuts that will impact millions of Californians

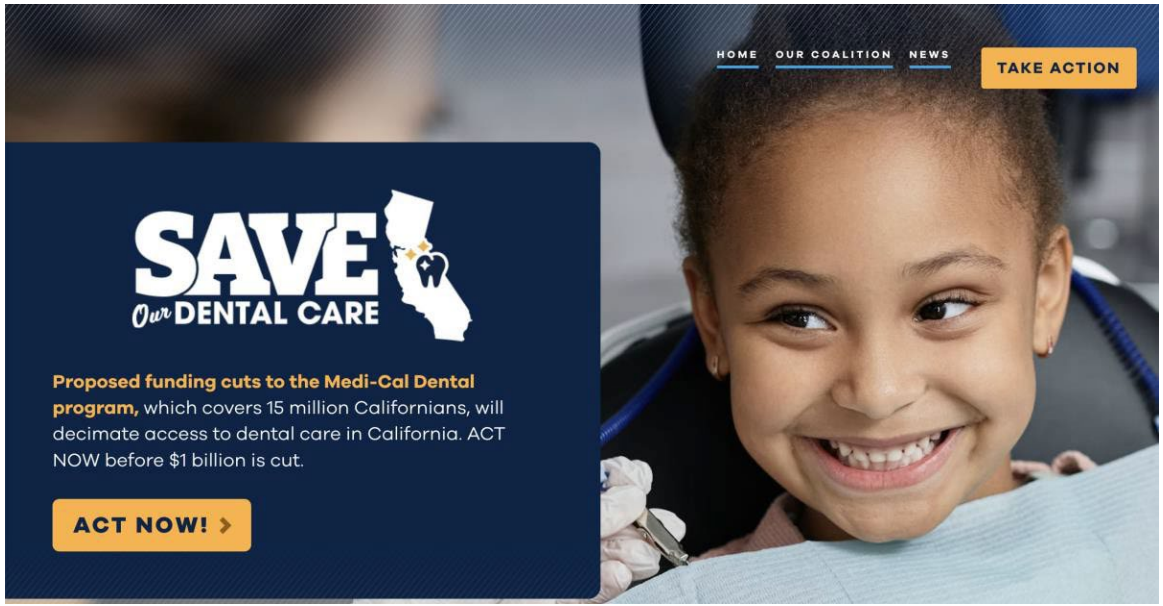
SACRAMENTO, CA - Ahead of the unveiling of the 2026-2027 state budget, more than 50 groups have joined together in support of preserving essential dental care across the state. Last year, lawmakers stayed a $1 billion cut to the program for one year, but one third of funding for the Medi-Cal Dental program is set to be eliminated on July 1, 2026, which would bring the program to 1990s funding levels and would have catastrophic impacts on millions of patients.

Dental funding makes up just 1.5% of Medi-Cal program funding, but is facing 15% of Medi-Cal budget cuts. These cuts also leave federal matching funds on the table, costing California approximately $576 million.

California would drop to the 48th lowest Medicaid dental reimbursement rates for children in the country.

- Statewide, over 80 organizations have joined including CavityFree SF
- Representing patients, safety net organizations, medical and dental groups, payers and others
- Calling on Legislature to reject the Prop 56 cut
  - $362 million state funding (with $576 million federal matching funds)
  - Totaling approximately $1 billion.
- Includes calls to action to directly contact your legislators, receive news and information and download flyers with QR codes to post in office locations

Visit www.saveourdentalcare.org



Save Our Dental Care

HR1 and Student Loan Financing

- HR 1 contains numerous tax provisions with a direct impact on dentists and dental practices
- Elimination of Grad PLUS starting July 2026
- Grad PLUS loans, which allow students to borrow up to the full cost of dental school, were eliminated.
- New loan caps: Without access to Grad PLUS loans, students will be limited to borrowing $50,000 per year and $200,000 total in unsubsidized federal loans.
- Many dental schools cost $300K - $500K+ in total.

September 9, 2025

Office of Postsecondary Education
U.S. Department of Education
400 Maryland Avenue SW
Washington, DC 20202

Re: Docket ID ED-2025-OPE-0016 Proposed Amendments to the Public Service Loan Forgiveness Program

To Whom It May Concern:

California Dental Association
1201 K Street, Sacramento, CA 95814
800.232.7645 · cda.org

Key Provisions of H.R.1 and its Impact on Dentistry in California

H.R.1 [P.L. 119-21] also referred to as the "One Big Beautiful Bill" Act makes substantial changes to the federal government's business tax and Medicaid policies. This document outlines the major changes to applicable business taxes, impacts on the state's Medi-Cal program and budget, student loans, and other provisions impacting dentistry.

Business Tax Provisions

The act contains numerous tax provisions with a direct impact on dentists and dental practices. These include multiple extended, reauthorized, or new deductions, and new or improved research, education, and investment incentives.

Provisions that will impact dental practices, dental students, and the dental workforce include:

- **Pass-Through Entity Tax (PTET) Deduction** has been fully restored after ADA and CDA advocacy, guaranteeing tax parity for small business dental practices, and protecting dentists from a 1.5 - 5% tax hike.
- **$40,000 Individual State and Local Tax (SALT)** Deduction cap provides substantial tax relief to dentists with practices organized as pass-through entities (90% of all practices). The full SALT cap is available to households with a Modified Adjusted Gross Income (MAGI) less than $500,000, after which the deduction begins to phase out. The higher SALT limit remains in place until 2030.
- **Other significant changes include:** the 20% Small Business Income Deduction was made permanent, a 100% bonus depreciation has been restored and made retroactive, new domestic research deductions, 21% corporate tax rate extension, postsecondary credentialing expenses to be treated as education expenses, and depreciable business asset expensing has been increased.

Impacts on Medi-Cal and State Budget

The Department of Health Care Services estimates that H.R.1 may result in as many as 3.4 million Medi-Cal members losing coverage and a loss of over $30 billion in federal funding. That represents a nearly 20% reduction in federal funding for Medi-Cal. The state will be faced with incredibly large and difficult budget choices. Questions remain around the timing of cuts. While many of the cuts impacting Medi-Cal will not take effect for a few years, there is potential CMS regulatory action around existing managed care organization (MCO) taxes, like the one Prop 35 is based on, that could be more immediate and particularly relevant to California.

Provisions that will directly affect Medi-Cal Dentists:

- The new law requires by October 1, 2028, that states impose co-pays up to $35 per service for Medi-Cal enrollees with incomes 100% to 138% of the federal poverty level. The amount will be determined by the state and go into effect October 1, 2028.
- New provisions imposing work requirements and six-month eligibility checks are likely to result in existing Medi-Cal

2026 Access Advocacy Efforts

2026 CDA-Sponsored Legislative Advocacy

- AB 1629 (Haney): Dental Insurance Access & Accountability
- AB 2029 (Sharp-Collins): Dental Insurance Transparency Standards
- AB 1952 (Berman): Dental Hygienist Licensure Pathway for Internationally Trained Dentists
- AB 350 (Bonta): Fluoride Varnish Coverage

Questions?

Thank You

CDA Staff Contacts

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CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 21.:** Board President's Report on Closed Session Items

Background

Dr. Lilia Larin, President of the Dental Board of California, will provide a verbal report on closed session items.

Action Requested

No action requested.

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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 22.a.:** 2026 Tentative Legislative Calendar – Information Only

Background

The 2026 Tentative Legislative Calendar is being provided for information only. The 2026 Tentative Calendar is compiled by the Office of the Assembly Chief Clerk and the Office of the Secretary of the Senate.

Action Requested

No action requested.

2026 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE AND THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised September 29, 2025

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

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

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				

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		

MAY

S	M	T	W	TH	F	S
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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						

*Holiday schedule subject to Senate Rules committee approval.

DEADLINES

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

Jan. 5 **Legislature reconvenes** (J.R. 51(a)(4)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12 (a)).

Jan. 16 Last day for **policy committees** to hear and report to fiscal committees **fiscal bills** introduced in their house in the odd-numbered year (J.R. 61(b)(1)).

Jan. 19 Martin Luther King, Jr. Day.

Jan. 23 Last day for any committee to hear and report to the **Floor** bills introduced in that house in the odd-numbered year (J.R. 61(b)(2)). Last day to **submit bill requests** to the Office of Legislative Counsel.

Jan. 31 Last day for each house **to pass bills introduced** in that house in the odd-numbered year (Art. IV, Sec. 10(c)), (J.R. 61(b)(3)).

Feb. 16 Presidents' Day.

Feb. 20 Last day for bills to be **introduced** (J.R. 61(b)(4)), (J.R. 54(a)).

Mar. 26 **Spring Recess** begins upon adjournment (J.R. 51(b)(1)).

Mar. 30 Cesar Chavez Day observed.

Apr. 6 Legislature reconvenes from **Spring Recess** (J.R. 51(b)(1)).

Apr. 24 Last day for **policy committees** to hear and report to fiscal committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).

May 1 Last day for **policy committees** to hear and report to the Floor **non-fiscal bills** introduced in their house (J.R. 61(b)(6)).

May 8 Last day for **policy committees** to meet prior to June 1 (J.R. 61(b)(7)).

May 15 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61 (b)(8)). Last day for **fiscal committees** to meet prior to June 1 (J.R. 61 (b)(9)).

May 25 Memorial Day.

May 26 – 29 Floor Session only. No committees, other than conference or Rules committees, may meet for any purpose (J.R. 61(b)(10)).

May 29 Last day for each house to pass bills introduced in that house (J.R. 61(b)(11)).

2026 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE AND THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised September 29, 2025

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				

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	

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					

June 1 Committee meetings may resume (J.R. 61(b)(12)).

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

June 25 Last day for a legislative measure to qualify for the Nov. 3 General Election ballot (Elections Code Sec. 9040).

July 2 Last day for **policy committees** to meet and report bills (J.R. 61(b)(13)). **Summer Recess** begins upon adjournment of session, provided Budget Bill has passed (J.R. 51(b)(2)).

July 3 Independence Day observed.

Aug. 3 Legislature reconvenes from **Summer Recess** (J.R. 51(b)(2)).

Aug. 14 Last day for **fiscal committees** to meet and report bills to the Floor (J.R. 61(b)(14)).

Aug. 17 – 31 **Floor Session only**. No committee, other than conference and Rules committees, may meet for any purpose (J.R. 61(b)(15)).

Aug. 21 Last day to **amend** on the Floor (J.R. 61(b)(16)).

Aug. 31 Last day for **each house to pass bills** (Art. IV, Sec. 10(c)), (J.R. 61(b)(17)). **Final recess** begins upon adjournment. (J.R. 51(b)(3)).

*Holiday schedule subject to Senate Rules committee approval.

IMPORTANT DATES OCCURRING DURING FINAL RECESS

2026

Sept. 30 Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor's possession on or after Sept. 1 (Art. IV, Sec. 10(b)(2)).

Nov. 3 General Election.

Nov. 30 Adjournment *sine die* at midnight (Art. IV, Sec. 3(a)).

Dec. 7 12 Noon convening of the 2027-28 Regular Session (Art. IV, Sec. 3(a)).

2027

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

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MEMORANDUM

DATE	April 30, 2026
TO	Members of the Dental Board of California
FROM	Brant Nelson, Legislative and Regulatory Specialist Dental Board of California
SUBJECT	**Agenda Item 22.b.:** Legislation of Interest

Background

During the 2025 legislative year, the Dental Board of California (Board) identified bills that would impact the Board and healing arts boards in general. Board members and staff actively participated in the legislative process by communicating with legislators and their staff and taking positions on proposed legislation. Summaries of the bills tracked by the Board during the first year of the 2025-2026 legislative session have been compiled into the Legislative Summary for 2025 available on the Board's website.

In the California State Legislature, bills that pass out of their house of origin move to the next house (e.g., from the Assembly to the Senate, or vice versa) for consideration. In 2025, the California legislative house of origin deadline was June 6, 2025, but no bills are automatically "dead" because 2025 was the first year of a two-year legislative session. Bills not passed by the house of origin deadline, or were held in the second house, became "two-year bills" and have a second chance to advance in 2026, with the deadline to pass out of their house of origin by the end of January 2026, and the deadline to pass out of the second house by July 2026 for non-fiscal bills, and August 2026 for fiscal bills.

For the 2026 legislative year, Board staff continue to track bills that impact the Board, the Department of Consumer Affairs (DCA), healing arts boards and their respective licensees, and all licensing boards. This memorandum includes information regarding each bill's status, location, date of introduction, date of last amendment, and a summary. Legislation is amended, statuses are updated, and analyses are added frequently; thus, hyperlinks are provided throughout this document to ensure Board members and the public have access to the most up-to-date information. The information below was based on legislation, statuses, and analyses (if any) publicly available on April 24, 2026.

Please note that due to the volume of new 2026 bills for Board consideration, they are organized and presented in three separate distinct sections, described further below.

Discussion

First for consideration is a Board staff recommended "consent calendar" of *SUPPORT* position bills. Second, for consideration is a Board staff recommended "consent calendar" of *WATCH* position bills. Lastly, for discussion and consideration are 2026 priority bills that will be individually presented by Board staff with recommended positions. The Board will adopt positions on each priority bill separately.

Consent calendar bill positions will be adopted as one motion for all bills. Board members can "extract" any consent calendar item for any reason, including position change, question, concern, etc. Each extracted bill will be added to the category of bills that will be presented for discussion and Board consideration and bill positions adopted on an individual bill basis.

i. 2026 Legislative Consent Calendar for Board Consideration – Staff Recommendation *SUPPORT*

A. Assembly Bill (AB) 1670 (Arambula, 2026) Medi-Cal: Dental Care
B. AB 1671 (Tangipa, 2026) Rural Medical Services Grant Program
C. AB 2140 (Johnson, 2026) Healing Arts: Reports: Claims Against Licensees
D. Senate Bill (SB) 944 (Wiener, 2026) Medi-Cal: Acupuncture
E. SB 1137 (Valladares, 2026) Personal Income Tax: Deduction: Medical Expenses
F. SB 1146 (Gonzalez, 2026) Advertisement Claims: Health-Related Consumer Products and Services: Digital Replicas and Synthetic Performers
G. SB 1159 (Cabaldon, 2026) Artificial Intelligence: Transparency and Governance
H. Senate Resolution (SR) 82 (Pérez, 2026) Relative to Children's Dental Health Month

Action Requested

The Board is asked to consider moving one of the following motions on the staff recommended 2026 Legislative Consent Calendar with *SUPPORT* positions.

Option 1 (no changes to bills listed above): Move to adopt the 2026 Legislative Consent Calendar with *SUPPORT* positions on each bill listed under Items A through H.

Option 2 (remove one or more bills from the list above): Move to adopt the 2026 Legislative Consent Calendar with *SUPPORT* positions on [list each bill number to be included on the Support Consent Calendar (e.g., AB 1670, AB 1671, etc.)].

ii. 2026 Legislative Consent Calendar for Board Consideration – Staff Recommendation *WATCH*

A. AB 1558 (Arambula, 2026) Uniform Emergency Volunteer Health Practitioners Act
B. AB 1563 (Gabriel, 2026) Budget Act of 2026
C. AB 1578 (Jackson, 2026) State/Local Officials: Sexual Harassment Training and Education: Anti-hate Speech Training
D. AB 1629 (Haney, 2026) Dental Coverage
E. AB 1717 (Castillo, 2026) Medi-Cal Dental Reimbursement: House/Extended Care Facility Call
F. AB 1729 (Lee, 2026) State Employment: Telework Programs
G. AB 1775 (Ward, 2026) Veterans
H. AB 1821 (Pacheco, 2026) California Public Records Act: Agency Response Time
I. AB 1900 (Karla, 2026) Guaranteed Health Care for All
J. AB 1979 (Bonta, 2026) Health Care Services: Artificial Intelligence
K. AB 2029 (Sharp-Collins, 2026) Dental Plan Portal
L. AB 2292 (Ward, 2026) Disability Benefits: Certificates
M. AB 2551 (Elhawary, 2026) Health Care Coverage
N. AB 2668 (Fong, 2026) Acupuncture: License Requirements and Title Protection
O. SB 879 (Laird, 2026) Budget Act of 2026
P. SB 980 (Hurtado, 2026) Access to Medical Records
Q. SB 1150 (Jones, 2026) Cancer Data: Notifications
R. SB 1391 (Wahab, 2026) Department of Consumer Affairs: Retired Category Licenses
S. SB 1416 (Wahab, 2026) Physicians and Surgeons: Dentists: Unprofessional Conduct
T. SB 1422 (Durazo, 2026) Medi-Cal: Eligibility: Immigration Status
U. SB 1433 (Committee on Judiciary, 2026) Maintenance of the Codes

Action Requested

The Board is asked to consider moving one of the following motions on the staff recommended 2026 Legislative Consent Calendar with *WATCH* positions.

Option 1 (no changes to bills listed above): Move to adopt the 2026 Legislative Consent Calendar with *WATCH* positions on each bill listed under Items A through U.

Option 2 (remove one or more bills from the list above): Move to adopt the 2026 Legislative Consent Calendar with *WATCH* positions on [list each bill number to be included on the Watch Consent Calendar].

iii. 2025-2026 Two-Year Legislation for Information and Board Consideration

A. AB 280 (Aguiar-Curry, 2025) Health Care Coverage: Provider Directories – Board Position *WATCH*
B. AB 350 (Bonta, 2025) Health Care Coverage: Fluoride Treatments – Board Position *SUPPORT*
C. AB 371 (Haney, 2025) Dental Coverage – Board Position *WATCH (DEAD)*
D. AB 479 (Tangipa, 2025) Criminal Procedure: Vacatur Relief – Board Position *WATCH (DEAD)*
E. AB 485 (Ortega, 2025) Labor Commissioner: Unsatisfied Judgments: Nonpayment of Wages – Board Position *OPPOSE UNLESS AMENDED*
F. AB 667 (Solache, 2025) Professions and Vocations: License Examinations: Interpreters – Board Position *WATCH*
G. AB 787 (Papan, 2025) Provider Directory Disclosures – Board Position *WATCH*
H. AB 837 (Davies, 2025) Ketamine – Board Position *WATCH (DEAD)*
I. AB 872 (Blanca Rubio, 2025) Environmental Health: Product Safety Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS) – Board Position *WATCH (DEAD)*
J. AB 873 (Alanis, 2025) Dentistry: Dental Assistants – Board Position *SUPPORT IF AMENDED*
K. AB 966 (Carrillo, 2025) Dental Practice Act: Foreign Dental Schools – Board Position *OPPOSE UNLESS AMENDED (DEAD)*
L. AB 1107 (Flora, 2025) Cigarette and Tobacco Products Licensing Act of 2003: Nitrous Oxide: Licensure – Board Position *WATCH (DEAD)*
M. AB 1130 (Berman, 2025) Dentistry: Outreach and Support Program – Board Position *WATCH*
N. AB 1215 (Flora, 2025) Hospitals: Medical Staff Membership – Board Position *WATCH (DEAD)*
O. AB 1298 (Harabedian, 2025) The Department of Consumer Affairs – Board Position *WATCH (DEAD)*
P. AB 1307 (Ávila Farías, 2025) Licensed Dentists from Mexico Pilot Program – Board Position *OPPOSITION WITHDRAWN (WATCH)*
Q. AB 1431 (Tangipa, 2025) Personal Income Taxes: Credit: Medical Services: Rural Areas – Board Position *WATCH (DEAD)*
R. AB 1434 (Michelle Rodriguez, 2025) Health Care Boards: Workforce Data Collection – Board *Position WATCH (DEAD)*
S. AB 1461 (Essayli, 2025) Department of Consumer Affairs: Regulatory Boards – Board Position *WATCH (DEAD)*

Action Requested

The Board is asked to review and adopt/confirm positions on the 2025-2026 Two-Year Legislation for information and consideration. If the Board wishes to change a position on a bill, a potential motion would be: Move to [support, support if amended, watch, oppose, oppose unless amended] [insert bill number].

iv. 2026 Priority Legislation for Discussion and Board Consideration

A. AB 1760 (Arambula, 2026) Dentistry – *SPONSOR*
B. AB 1952 (Berman, 2026) Dentistry: Dental Hygienists: Licensure – Staff Recommendation *SUPPORT*
C. AB 2625 (Solache, 2026) Dental Practice Act: Foreign Dental Schools – Staff Recommendation *WATCH*
D. SB 936 (Blakespear, 2026) Nitrous Oxide: Sales – Staff Recommendation *SUPPORT*
E. SB 1311 (Wahab, 2026) Licensed Professions – Staff Recommendation *SUPPORT*
F. SB 1445 (Committee on Business, Professions and Economic Development, 2026) Healing Arts – Staff Recommendation *SUPPORT*

Action Requested

If desired, the Board may take one of the following actions regarding each bill:

Sponsor
Support
Support if amended
Oppose
Oppose unless amended

Alternatively, the Board may take no action, and the Board position would be to watch the bill.

Legislation Tracked by Dental Board of California (Board) Staff – 2025-2026 Legislative Session
2026 Legislative Year

i. 2026 Legislative Consent Calendar for Board Consideration – Staff Recommendation *SUPPORT*

AB 1670 (Arambula, 2026) Medi-Cal: Dental Care
Introduced: February 2, 2026
Last Amended: April 23, 2026
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: This bill would make behavior management and desensitization services without an accompanying dental procedure covered benefits under the Medi-Cal program, subject to utilization controls, when a patient's physical, behavioral, developmental, or emotional condition requires significant extra time, attention, or personnel, or requires such services preceding a dental visit, respectively, in order to safely deliver dental care. The bill would condition implementation of these provisions on the availability of federal financial participation and any necessary federal approvals having been obtained. The bill would, notwithstanding any other law, authorize the State Department of Health Care Services to implement, interpret, or make specific these provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking any further regulatory action. The primary goal is to improve access to care for patients with disabilities or high-anxiety conditions.

Currently, dentists often cannot bill for "Behavior Management" unless they complete a dental procedure. If a patient with a developmental disability is too distressed to allow the procedure to happen, the dentist cannot be reimbursed for the extra time and staff used during that "failed" attempt. Because these appointments are time-intensive and financially risky, many dentists are hesitant to see Medi-Cal patients with complex needs. The bill recognizes that some patients need several "acclimation" visits to get comfortable with the dental environment before a procedure can safely occur.

Staff Recommendation: Support

AB 1671 (Tangipa, 2026) Rural Medical Services Grant Program
Introduced: February 2, 2026
Last Amended: March 19, 2026
Location: Assembly Appropriations Committee
Status: Referred to Assembly Committee on Appropriations Suspense File

Summary: This bill would require the Office of Rural Health (ORH) within the California Health and Human Services Agency (CalHHS) to develop and administer, upon

appropriation by the Legislature, a competitive grant program for the delivery of medical services, as defined, including telehealth services, to individuals who reside in defined "rural areas" (as defined in Health and Safety Code section 50199.21). The bill would authorize a qualified provider, which includes dentists and dental hygienists, to apply to the office once per year for a grant of up to $10,000 in compensation for the delivery of medical services to individuals who reside in rural areas in California. The bill would require OHR to establish specified standards and procedures, including criteria and standards for eligibility and the measurement of outcomes achieved, and to publish this information on its website.

Staff Recommendation: Support

AB 2140 (Johnson, 2026) Healing arts: reports: claims against licensees
Introduced: February 18, 2026
Last Amended: N/A
Location: Assembly Business and Professions Committee
Status: Hearing canceled at the request of author

Summary: Existing law makes it a public offense punishable by a fine of not less than $50 or more than $500 for a licensee, who does not have malpractice insurance, to fail to report within 30 days a settlement, judgment, or arbitration award over $3,000 of a claim or action for damages for death or personal injury caused by negligence, error or omission in practice, or by the unauthorized rendering of professional services. This bill proposes to increase the minimum fine to $100. As the fine is for commission of a public offense, the Board does not collect that fine. (See Pen. Code, § 15.)

Staff Recommendation: Support

SB 944 (Wiener, 2026) Medi-Cal: acupuncture
Introduced: February 2, 2026
Last Amended: N/A
Location: Senate Appropriations Committee
Status: Referred to Senate Appropriations Committee Suspense File

Summary: This bill seeks to remove the requirement for federal matching funds for Medi-Cal acupuncture coverage to ensure this service remains a covered, permanent benefit. Acupuncture is often framed by proponents as a cost-effective alternative to opioids for chronic pain management.

In California, acupuncture is recognized within the dental practice framework under California Code of Regulations (CCR), title 16, section 1064, which allows dentists to practice acupuncture, specifically for dental-related conditions, after completing required training. Acupuncture is used as part of the practice of dentistry to treat conditions like temporomandibular joint (TMJ) pain, chronic facial pain, or dental anxiety. As of early

2026, Medi-Cal has historically covered up to two acupuncture services per month for adults, with additional sessions possible via prior authorization.

While 2025-26 budget reports initially listed the elimination of acupuncture as part of the DHCS proposed FY 2025-26 May Revision to address a $5.4 million deficit in 2024-25 and $13.1 million annually, legislative action aimed to protect it. According to a June 9, 2025, news release from Senator Scott Wiener's office, the Senate and Assembly reached an agreement to preserve acupuncture as a covered Medi-Cal benefit in the 2025-2026 budget, following the Governor's initial proposal to cut it.

Several California state agencies and health organizations, particularly those managing Medi-Cal, recognize acupuncture and other non-pharmacological treatments as critical components in the strategy to reduce reliance on opioids and fight the addiction crisis. The DHCS Opioid Response refers to the collective efforts DHCS has undertaken to address the opioid crisis, backed by over $1 billion in state funding since 2019; the initiative focuses on saving lives by increasing access to Medications for Addiction Treatment (MAT) and distributing life-saving reversal agents like naloxone. The core focus of the initiative is expanding Medication-Assisted Treatment (MAT), support for comprehensive, non-opioid pain management approaches—including acupuncture—integrated through broader state-level initiatives and Medi-Cal coverage.

Studies indicate that while dental opioid prescriptions for Medicaid (including California's Medi-Cal) patients have declined, they remain a significant source of initial opioid exposure, particularly among young adults. A 2018 study published in the highly prestigious, peer-reviewed JAMA Internal Medicine (and reported by Stanford Medicine) found that dentists were the primary source of opioid prescriptions for patients aged 10 to 19, accounting for nearly 31% of such prescriptions in 2009. The study also revealed that 6.8% of young people receiving initial dental prescriptions may develop sustained use, and dental opioid use is linked to higher overdose risks for patients and their families. Despite declines, dentists in the U.S. have historically been high prescribers to young people, with 12% of all opioid prescriptions being dental-related.

Staff Recommendation: Support

SB 1137 (Valladares, 2026) Personal income tax: deduction: medical expenses
Introduced: February 18, 2026
Last Amended: April 8, 2026
Location: Senate Revenue and Taxation Committee
Status: Hearing set for May 6, 2026

Summary: This bill addresses California personal income tax deductions for medical and dental expenses. Currently, taxpayers can deduct unreimbursed medical and dental expenses only if they exceed 7.5% of their federal adjusted gross income (AGI). By reducing the threshold from 7.5% to 4%, a larger portion of healthcare costs become

tax-deductible, providing greater relief for those with significant out-of-pocket medical expenses.

SB 1137 makes it so that you don't have to be wealthy or have a catastrophic medical event to see a tax benefit. It brings the tax break down to a level that a middle-class family with "normal" high medical costs (like braces, therapy, or high premiums) can actually reach. The bill could also benefit Individuals with high recurring costs (home health care, specialized equipment, or expensive prescriptions) that aren't fully covered by insurance—benefitting seniors and people with chronic illness.

This proposed deduction is helpful if, and only if, your total itemized expenses (medical + mortgage interest + charitable gifts + property taxes) exceed the California Standard Deduction of approximately $5,706 (Single) or $11,412 (Joint). It all comes down to the "Floor." To get any benefit, your expenses must beat the standard deduction. Most people think, "I don't itemize, so this medical bill change doesn't help me." But in California, you are twice as likely to itemize on your state return as you are on your federal return.

- To beat the $31,500 federal floor, a married couple needs massive expenses (huge mortgage, huge charity, or catastrophic medical bills).
- To beat the $11,412 California floor, a couple only needs a moderate amount of expenses.

Example: Under current law, if a couple has $9,000 in property taxes and mortgage interest, they are currently taking the $11,412 standard deduction because they are $2,412 short. Under SB 1137, they could now count $4,000 in medical expenses (because the 4% threshold is so much lower), their total "itemized" list hits $13,000. They have now cleared the floor, they stop taking the standard deduction, and they start saving real money on their state taxes.

A 2025 UC Berkeley Labor Center report highlights that nearly four in ten Californians face medical debt, with high deductibles and unexpected costs trapping middle-class families despite having insurance. Studies from Third Way, a think tank that champions moderate policy ideas, indicate that households earning 200%–400% of the federal poverty level (middle-class) actually have the highest rates of medical debt. By lowering the tax threshold, the bill aims to prevent healthcare costs from becoming a debt trap.

Healthcare costs often rise faster than general inflation. Studies from the UC Berkeley Labor Center and KFF (Kaiser Family Foundation) show that California health care premiums and deductibles consistently rise faster than general inflation and wages. Over the last 20 years, family premiums for job-based coverage grew 129%, far outpacing the 69% inflation rate. For families already stretched by high gas and housing prices, a 7.5% "floor" acts as a penalty, forcing them to pay taxes on income that has already been spent on essential survival. Lowering the threshold to 4% allows taxpayers to keep more of their earnings to cover these rising costs. Medical debt is a leading cause of financial instability in California and putting cash back into the pockets of

families who have had a high-cost medical year (e.g., surgeries, braces, or emergency visits) is helpful. For those with ongoing needs (insulin, therapy, or home care), this bill turns a permanent financial burden into a consistent tax benefit.

Staff Recommendation: Support

SB 1146 (Gonzalez, 2026) Advertisement claims: health-related consumer products and services: digital replicas and synthetic performers
Introduced: February 18, 2026
Last Amended: March 25, 2026
Location: Senate Privacy, Digital Technologies, and Consumer Protection Committee
Status: Hearing set for April 27, 2026

Summary: This bill would make it unlawful for any person doing business in California and advertising to consumers to make a false or misleading advertising claim.

Existing law makes it unlawful for healing arts licensees, as specified, to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image to induce the provision of services or products in connection with their licensed professional practice or business.

This bill would require an advertisement that uses the image, audio, or video of a natural person that is generated or substantially altered using artificial intelligence or other computer technology to promote the sale of a health-related consumer product or service to include a clear and conspicuous disclosure that the image, audio, or video, of the person in the advertisement was generated or substantially altered by AI. The bill would require actions for relief brought pursuant to this bill to be prosecuted exclusively by the Attorney General or a district attorney.

Staff Recommendation: Support

SB 1159 (Cabaldon, 2026) Artificial intelligence: transparency and governance
Introduced: February 18, 2026
Last Amended: March 25, 2026
Location: Senate Floor
Status: Third reading

Summary: This bill would specify that, for purposes of the California Public Records Act, the Bagley-Keene Open Meeting Act, the Ralph M. Brown Act, the Political Reform Act of 1974, the Administrative Procedure Act, and CEQA, “person,” “interested person,” “participant,” “member of the public,” as applicable, and any other similar terms under each act referring to those who may engage with governmental agencies, do not

include artificial intelligence, as defined, systems, autonomous agents, robots, or other nonhuman entities, whether physical or digital.

The California Constitution explicitly states that all political power is inherent in the people, focusing on life, liberty, and the pursuit of safety. While technology evolves, constitutional state-level protections must be upheld to ensure technology serves the people of California.

Staff Recommendation: Support

SR 82 (Pérez, 2026) Relative to Children's Dental Health Month
Introduced: February 19, 2026
Last Amended: N/A
Location: Governor
Status: Enrolled

Summary: This Senate Resolution was read and adopted in the California State Senate on March 5, 2026, which officially recognizes and declares February 2026 as Children's Dental Health Month in California. The Senate members voted, and since it received 31 Ayes (and 0 Noes), it met the simple majority requirement (21 votes) to pass. Since the resolution was read and adopted in the California Senate, this is a completed legislative action.

A resolution is a formal statement of opinion or policy. While it doesn't "force" anyone to do anything under threat of law, it provides the official state "stamp of approval" for awareness campaigns, school programs, and public health initiatives. It also matters for the following reasons:

- It allows the state to issue press releases and encourages schools and health departments to prioritize dental screenings during February.
- It puts the Senate on the record acknowledging that tooth decay is a "significant public health problem," which can be cited in future debates for actual bills that involve spending or regulation.
- Resolutions like SR 82 are often data driven. The 2026 version specifically cites recent figures—for example, that "7 in 10 children have experienced tooth decay by the third grade" and that Medi-Cal provider rates have increased by 34% since 2017. A yearly resolution allows the Senate to update these facts and make a new case every year based on current data.
- Passing it annually gives a "Fresh" news cycle to the cause.
- Helps set the focus on dental health for children as a current priority as the 2026 resolution mentions specific concerns like "looming funding cuts" and "health equity disparities" that are relevant to the current 2026 budget cycle.

Staff Recommendation: Support

ii. 2026 Legislative Consent Calendar for Board Consideration – Staff Recommendation *WATCH*

AB 1558 (Arambula, 2026) Uniform Emergency Volunteer Health Practitioners Act
Introduced: January 8, 2026
Last Amended: N/A
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: AB 1558 the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) is as an upgrade to California's emergency response system. Currently, the state has a patchwork of rules for volunteers; this bill replaces that with a standardized, national framework. The bill would create a bridge for out-of-state healthcare professionals to work in California during a declared emergency by the Governor. Under current law, the process is often bogged down by state-specific license verifications. Under the bill, any health practitioner licensed and in good standing in another state is deemed "licensed" in California for the duration of a declared emergency, provided they are registered in an approved database. The provisions of the Act only activate when the Governor (or an authorized official) declares a state of emergency. Without a declaration of emergency, out-of-state dentists would still need a full California license to practice.

Under AB 1558, the deployment of a professional like a dentist would follow a "Chain of Authority" that does not exist as clearly today.

1. Registration (Pre-Emergency)
    - An out-of-state dentist doesn't wait for a fire to start; they register with a "Registration System" (like the Medical Reserve Corps). This system constantly pings their home state's board to ensure they haven't lost their license due to malpractice.

2. Deployment (During Emergency)
    - The dentist can be deployed directly through their registration system to a "Host Entity" (like a field hospital) as soon as the California emergency declaration is live.

3. Deployment (During Emergency)
    - When the Governor declares an emergency, the Emergency Medical Services Authority (EMSA) identifies a need for dental triage.
    - The dentist can be deployed directly through their registration system to a "Host Entity" (like a field hospital) as soon as the California state declaration is live.
    - Once deployed through DHV, volunteers are typically registered as Disaster Service Workers (DSW), which provides them with state-backed workers' compensation and limited liability protection.

4. Practice Limitations
    - The Board can "restrict or modify" what that dentist does.
    - The Board could narrowly tailor the language of what is permitted. If the emergency requires only basic triage, the Board can issue an order such as: *"Volunteer dentists may only perform emergency extractions and pain management; no restorative or cosmetic work is authorized."*
    - The volunteer is legally protected from "unauthorized practice" charges if they follow these Board-issued modifications.

5. Post-Emergency Accountability
   If a volunteer dentist from another state commits a gross error while in California:
    - The Board investigates.
    - The Board can issue an "administrative sanction" (such as a formal reprimand or a ban from practicing in California).
    - This sanction is legally binding and is sent to the other state's Dental Board, which could then take action against their primary license.

Board staff have concluded there is no fiscal impact to the Board due to these changes.

Staff Recommendation: Watch

AB 1563 (Gabriel, 2026) Budget Act of 2026
Introduced: January 9, 2026
Last Amended: N/A
Location: Assembly Budget Committee
Status: Assembly Budget Committee

Summary: The California Budget Act of 2026 appropriates funds for the 2026-27 fiscal year, building on Governor Newsom's budget proposal. The California budget process starts with the Governor's January proposal followed by review by the Legislative Analyst's Office (LAO), leading to legislative budget bills (Assembly and Senate versions) that get negotiated in conference committees, then passed by both houses for the Governor's signature by the June 15 deadline, with May Revision adjustments for revenue changes, culminating in the final Budget Act for the fiscal year starting July 1st.

Staff Comments: The California Budget Act of 2026 consisting of SB 879 and AB 1563 is the initial framework; the detailed Budget Act will emerge after legislative review, amendments, and the Governor's final approval, with specific agency funding details solidified later in 2026.

Staff Recommendation: Watch

AB 1578 (Jackson, 2026) State and local officials: sexual harassment training and education: anti-hate speech training.
Introduced: January 12, 2026

Last Amended: April 6, 2026
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: Existing law requires a specified employer with 5 or more employees to, by January 1, 2021, provide at least 2 hours of classroom or other effective interactive training and education regarding sexual harassment to all supervisory employees and at least one hour of classroom or other effective interactive training and education regarding sexual harassment to all nonsupervisory employees in California and, after that date, once every 2 years. Existing law requires an employer to include prevention of abusive conduct as a component of that training and education. Beginning on January 1, 2028, for an employer that is a state agency or local agency that the above-described training and education include, as a component of the training and education for elected officials, anti-hate speech training. This bill would specify that a state official or local official who serves more than one state agency or local agency only be required to receive the above-described training once every 2 years without regard to the number of state agencies or local agencies the official serves.

Staff Comments: The Department of Consumer Affairs and the Board might need to review and potentially update its internal policies, codes of conduct, and professional development programs to ensure they align with the new law's provisions regarding anti-hate speech.

Recommended Board Position: Watch

AB 1629 (Haney, 2026) Dental coverage
Introduced: January 26, 2026
Last Amended: March 18, 2026
Location: Assembly Appropriations Committee
Status: Referred to Assembly Appropriations Committee Suspense File

Summary: This bill would address requirements for health plans, insurers, and non-contracting providers. It includes mandates on payment predetermination, notification to enrollees about out-of-network costs, and requirements for non-contracting providers to disclose their status. The bill also would require the Department of Managed Health Care and the Department of Insurance to evaluate dental provider network adequacy.

Staff Recommendation: Watch

AB 1717 (Castillo, 2026) Medi-Cal dental reimbursement: house/extended care facility call
Introduced: February 4, 2026
Last Amended: April 23, 2026
Location: Assembly Appropriations Committee

Status: Assembly Appropriations Committee

Summary: This bill addresses Medi-Cal dental reimbursement for house/extended care facility calls. Under the Medi-Cal Dental Provider Handbook, the maximum allowance for a house/extended care facility call under a specified billing code is $20. This bill would require the State Department of Health Care Services (DHCS) to increase the Medi-Cal reimbursement base rate for a house/extended care facility call to reflect the reasonable travel costs for purposes of delivering dental services in the patient's private residence or applicable facility instead of the location of the dental provider. The bill would require that the rate be adjusted to a minimum of $120 per patient per date of service, with subsequent readjustments every 2 years to account for inflation and provider cost data. DHCS would be required to, every 2 years, report to the Legislature about the impact of the rate adjustments on access, utilization, and reductions in emergency department visits for dental conditions. The bill would condition implementation of these provisions on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.

Staff Recommendation: Watch

AB 1729 (Lee, 2026) State employment: telework programs
Introduced: February 5, 2026
Last Amended: April 8, 2026
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: This bill would address state employment telework programs. Existing law requires every state agency to develop and implement a telecommuting plan as part of its telecommuting program in work areas where telecommuting is identified as being both practical and beneficial to the organization. Existing law requires the Department of General Services (DGS) to establish a unit for purposes of overseeing telecommuting programs that is required to, among other things, develop and update policy, procedures, and guidelines to assist agencies in the planning and implementation of telecommuting programs. Existing law requires the department to establish criteria for evaluating the state's telecommuting program.

This bill would revise and recast those provisions. The bill would replace the term "telecommuting" with "telework," as defined. The bill would also require DGS to establish a telework dashboard that displays the cost-effectiveness and efficiency benefits of state telework programs, including documenting annual savings to the state of reduced office space and operating costs. The bill would additionally require each state agency, every 10 years, to evaluate its telework program to ensure that it aligns with the state agency's unique operational needs to carry out its programmatic missions and to help recruit and retain a qualified workforce. This bill would declare that it is to take effect immediately as an urgency statute.

Currently, as of February 2026, the telework policy for eligible employees at the Department of Consumer Affairs aligns with statewide guidelines, allowing up to 3 days of telework per week (with a default of 2 in-office days). This is set to change on July 1, 2026, when the Governor's Executive Order N-22-25 requiring 4 in-office days per week (1 telework day) takes effect, subject to any ongoing legislative or bargaining developments.

Staff Recommendation: Watch

AB 1775 (Ward, 2026) Veterans
Introduced: February 9, 2026
Last Amended: April 7, 2026
Location: Assembly Appropriations Committee
Status: Referred to Assembly Appropriations Committee Suspense File

Summary: This bill would amend existing law to expand the scope of military-related licensing priorities of Department of Consumer Affairs (DCA) boards and establish veteran grant programs administered by the Military Department.

Currently, DCA boards must expedite initial licensure for honorably discharged veterans. This bill would extend that mandate to include veterans discharged because of a specified executive order. The bill would require the Military Department, to implement the Veteran's Military Discharge Upgrade Grant Program, to prioritize veterans whose discharge status was linked to mental health conditions, traumatic brain injury, sexual assault/harassment, or sexual orientation.

Subject to legislative appropriation, the bill would direct the Military Department to create a new grant program to fund service providers offering free housing supports to veterans being discharged from service. Further, the bill would require the Military Department to develop specific criteria, procedures, and accountability measures for the program.

This bill would additionally require the Military Department, subject to an appropriation by the Legislature, to establish the Veteran's Housing and Supportive Services Grant Program to help fund service providers who, for at no cost, will provide housing supports for veterans being discharged from service.

Staff Recommendation: Watch

AB 1821 (Pacheco, 2026) California Public Records Act: agency response time
Introduced: February 11, 2026
Last Amended: April 6, 2026
Location: Assembly Floor
Status: Third Reading

Summary: This bill would change the California Public Records Act (CPRA) requirement for agency response.

Under the CPRA, public agencies are required to respond to records requests within a specific timeframe, which can be extended under "unusual circumstances."

- Initial Response (10 Days): Agencies must make a determination on a public records request within 10 calendar days. By the 10th day, the agency must send a written response stating if they have the records, decide if the records are public or if they are "exempt" (private, legal secrets, etc.). If they refuse to give something, they must cite the specific law that allows them to keep it secret, and if they do have the records and they are public they must give an estimated date of when they will be sent.
- Extension (14 Days): In "unusual circumstances" (e.g., needing to search field offices, voluminous records, or consultation), agencies can extend this deadline by an additional 14 calendar days.

This bill would instead require each agency to determine whether the request seeks copies of disclosable public records in possession of the agency and to promptly notify the person as described above within 10 business days of a request for a copy of records. The bill would instead authorize the time period for each agency to respond to be extended by no more than 14 business days.

Staff Recommendation: Watch

AB 1900 (Kalra, 2026) Guaranteed Health Care for All
Introduced: February 12, 2026
Last Amended: April 20, 2026
Location: Assembly Desk
Status: Introduced measure version corrected

Summary: This bill, known as the California Guaranteed Health Care for All Act (CalCare), would create a universal single-payer health care system in California. The bill is intentionally designed as a two-phase framework. It seeks to establish the "skeleton" of the program immediately while deferring the most radical financial shifts. The bill is the successor to previous efforts for single-payer healthcare and shares the same "CalCare" branding, but there are critical distinctions in the 2026 version.

The 2026 bill emphasizes a transition period where the initial costs are limited to convening the Board and Commission to build a transition plan, rather than assuming immediate full-scale enrollment. This bill frames itself as being introduced as a response to recent significant federal budget cuts in the "One Big Beautiful Bill Act" (OBBBA), also known as H.R. 1, (referenced as a $1 trillion cut context in the bill's introduction). The bill would place a heavy emphasis on the legal path to federal funding. It would explicitly require the CalCare Board to seek Affordable Care Act waivers and other federal approvals to reroute Medicare and Medicaid money. The bill’s goal is to

decouple the state's dental and medical care from federal budget shifts by moving everything into a state-controlled Trust Fund.

Prior bills proposing the CalCare system (such as AB 1400 (Kalra, 2022) and AB 2200 (Kalra, 2024)) failed due to a combination of staggering cost estimates, a lack of a clear funding mechanism, and division within the Legislature.

Staff Recommendation: Watch

AB 1979 (Bonta, 2026) Health care services: artificial intelligence
Introduced: February 13, 2026
Last Amended: April 23, 2026
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. Existing law deems a business that offers a mental health digital service or reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a provider of health care subject to the requirements of the CMIA. The bill would additionally deem a business that offers a healthcare chatbot, as defined, to a consumer for the above-described purposes to be a provider of health care subject to the requirements of the CMIA.

Existing law requires a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person, except as specified.

This bill would require a health facility, clinic, physician's office, or office or a group practice to ensure that no clinical decision, as specified, is based solely on the output of a clinical decision support system, as defined, and that a licensed health care professional exercises independent professional judgment when reviewing and approving a clinical decision that is based on the output of a clinical decision support system. The bill would authorize the appropriate professional licensing board to pursue an injunction or restraining order to enforce these provisions to the extent that a violation constitutes the practice of a health care profession without a license. The bill would specify that these provisions do not prohibit the use of artificial intelligence for

documentation and communication that does not involve the application of professional judgment, including automated messages to inform patients of updates to their health records. By placing new requirements on health facilities and clinics, this bill would expand the scope of a crime and would impose a state-mandated local program.

Board staff anticipate an estimated absorbable fiscal impact of $10,576.

Staff Recommendation: Watch

AB 2029 (Sharp-Collins, 2026) Dental plan portal
Introduced: February 17, 2026
Last Amended: March 19, 2026
Location: Assembly Health Committee
Status: Hearing canceled at the request of author

Summary: This bill would require a dental plan or dental insurer to establish a dental portal accessible to a treating dental provider to provide information regarding an enrollee's contract or insured's policy, including the actual payment or reimbursement amounts for covered services. The bill would require the portal to provide accurate, real-time benefit eligibility and benefits information in a clear and understandable format, provide specified information about a corresponding payment, accept attachments in an electronic format, and be made available at no cost to contracted and noncontracted dental providers, among other requirements.

Staff Recommendation: Watch

AB 2292 (Ward, 2026) Disability benefits: certificates
Introduced: February 19, 2026
Last Amended: April 16, 2026
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: This bill aims to remove financial barriers that prevent Californians from accessing disability benefits. By prohibiting "administrative fees" for medical certificates, the bill seeks to ensure that a patient's ability to access State Disability Insurance (SDI) or Paid Family Leave (PFL) is not contingent on their ability to pay an out-of-pocket fee to their healthcare provider. Legislators are targeting a specific gap where patients—often already facing financial strain due to an inability to work—are charged $25 to $100 just to have a form signed or a "recertification exam" performed. The bill views these benefits as a social safety net that should be accessible without "gatekeeper" costs imposed by practitioners.

Under the California Unemployment Insurance Code (specifically UIC section 2708), the term "practitioner" explicitly includes dentists.

- Certification Authority: Dentists are among the licensed professionals authorized to sign the medical certificates required for a patient to receive State Disability Insurance (SDI) or Paid Family Leave (PFL) benefits, provided the disability falls within their scope of practice (e.g., recovery from oral surgery or complications from dental procedures).
- The Prohibitions: Because the bill prohibits a "physician or practitioner" from charging fees for completing these forms or performing recertification exams, California dentists would be legally barred from charging administrative fees for:
    1. The initial disability certificate (DE 2501).
    2. Any continued claim forms or "recertification" exams required to maintain a patient's eligibility.

The introduction of both AB 2292 (Disability certificates) and SB 980 (School/Medical forms) represents a coordinated legislative strategy in California to eliminate "junk fees" in healthcare administration.

Staff Recommendation: Watch

AB 2551 (Elhawary, 2026) Health care coverage
Introduced: February 20, 2026
Last Amended: March 19, 2026
Location: Assembly Appropriations Committee
Status: Referred to Assembly Appropriations Committee Suspense File

Summary: This bill is a transparency and data-collection measure aimed at addressing gaps in mental health and substance use disorder coverage. By amending licensing renewal forms for healing arts providers (including those under the Board) to include questions about contracting status, it helps state officials track network adequacy and provider contracting trends across regions, languages, and specialties. While this bill is rooted in behavioral health, the data it collects is a powerful tool for broader dental policy and consumer protection. By requiring providers to report their contracting status and the types of plans they accept (such as Medi-Cal or commercial PPOs), state officials can move beyond simple headcounts and perform a more sophisticated analysis of network adequacy.

The bill primarily does two things:
1. Insurer Accountability—mandates that health plans and insurers conduct annual surveys of their members to determine why they are seeking behavioral health care out-of-network. This includes tracking out-of-pocket costs and identifying barriers such as a lack of culturally or linguistically competent providers.
2. Workforce Data Expansion—amends existing law regarding the "Healing Arts" boards (the group of professional licensing boards under the Department of Consumer Affairs) to include new questions during the license renewal process. Specifically, it would require licensees to report whether they are "contracted providers" and what types of health care coverage they accept.

While the primary focus of AB 2551 is behavioral health, the bill has a direct and meaningful impact on the Board due to the workforce data requirements.

1. Inclusion via "Healing Arts" Classification—under Business and Professions Code section 502, the Board is classified as a "healing arts" board. Currently, these boards are required to collect or request workforce data (like practice location and languages spoken) during biennial license renewals. AB 2551 expands this mandatory data set to include:
    - Whether the dentist or dental assistant is a contracted provider.
    - The types of health care coverage under which they provide contracted services (e.g., PPO, HMO, Medi-Cal).
2. If passed, the Board would be required to update its license renewal forms and database systems to incorporate these new questions.

If passed, Board Staff anticipate an estimated fiscal impact of $7,444.

Staff Recommendation: Watch

AB 2668 (Fong, 2026) Acupuncture: license requirements and title protection
Introduced: February 20, 2026
Last Amended: March 16, 2026
Location: Assembly Business and Professions Committee
Status: Re-referred to Assembly Business and Professions Committee

Summary: This bill would updates the Acupuncture Licensure Act (Act) and raises the educational floor for future practitioners. Starting January 1, 2032, the bill would mandate that approved programs must confer a doctoral degree (rather than the current master's level entry) and increase total required training hours from 3,000 to 3,300, with specific increases to both didactic and clinical instruction. Additionally, the bill would tighten title protection, specifically regulating the use of "Doctor of Acupuncture and Herbal Medicine" (D.A.H.M.) and strictly limit the titles "licensed acupuncturist" and "LAc" to those holding active, valid licenses under the Act.

Impact on the Board and its licensees is minimal but distinct:

- Title Protection Restrictions: The most direct impact involves how a dentist might advertise. Under this bill, a dentist who practices acupuncture but does not hold an acupuncture license would be explicitly prohibited from using the titles "licensed acupuncturist" or "LAc."
- Scope of Practice Remains Separate: This bill would modify the requirements for becoming a Licensed Acupuncturist. It would not repeal or alter Business and Professions Code (BPC) section 4947, which allows dentists to perform acupuncture as part of the practice of dentistry if they have completed the required training approved by the Board.
- Doctoral Designations: Dentists already hold doctoral degrees (DDS or DMD), so the restrictions on the title "Doctor" are less burdensome. However, they would

be prohibited from using the specific new designation "D.A.H.M." unless they have earned that specific degree from an approved acupuncture program.
- No Change to Dental Education: The increase to 3,300 hours applies only to "approved educational and training programs" for acupuncture licensure. It does not automatically increase the continuing education or specialty training hours required by the Dental Board for dentists who use acupuncture as an adjunct to dental procedures.

AB 2668 is designed to regulate the Acupuncture Licensure Act specifically, which applies only to those seeking a license through the Acupuncture Board, and it would not repeal or alter BPC section 4947. That existing statute remains the "gold standard" for dental exemptions, explicitly allowing licensed dentists to continue performing acupuncture as a minor adjunct to their dental practice provided they meet the training requirements already approved by the Board. The "dental carve-out" in BPC section 4947 remains fully intact and legally protected. While this bill focuses on the Acupuncture Board, it reinforces the "siloing" of professional titles, ensuring that patients can distinguish between a dentist performing acupuncture and a Licensed Acupuncturist.

Staff Recommendation: Watch

SB 879 (Laird, 2026) Budget Act of 2026
Introduced: January 9, 2026
Last Amended: N/A
Location: Senate Desk
Status: Read first time

Summary: The California Budget Act of 2026 appropriates funds for the 2026-27 fiscal year, building on Governor Newsom's budget proposal. The California budget process starts with the Governor's January proposal followed by review by the Legislative Analysts Office (LAO), leading to legislative budget bills (Assembly and Senate versions) that get negotiated in conference committees, then passed by both houses for the Governor's signature by the June 15 deadline, with May Revision adjustments for revenue changes, culminating in the final Budget Act for the fiscal year starting July 1st.

Staff Comments: The California Budget Act of 2026, consisting of SB 879 and AB 1563, is the initial framework; the detailed Budget Act will emerge after legislative review, amendments, and the Governor's final approval, with specific agency funding details solidified later in 2026.

Staff Recommendation: Watch

SB 980 (Hurtado, 2026) Access to medical records
Introduced: February 4, 2026

Last Amended: March 16, 2026
Location: Senate Health Committee
Status: Set for hearing on April 22, 2026

Summary: This bill would prohibit a health care provider from charging a fee to a patient for completing health-related forms required by an educational institution for a pupil's participation in school, childcare, or school-sponsored activities.

Because dentists are the primary providers who must sign the Kindergarten Oral Health Assessment (KOHA), they are a major focus of the bill's intent to remove financial barriers for families entering the school system. Currently, California law prohibits health care providers from charging fees for paperwork related to public benefit programs (like Medi-Cal or Social Security). This bill would expand this protection to include health-related forms required by educational institutions. This includes paperwork for:

- Enrollment in K-12 schools, childcare, or universities.
- Participation in school-sponsored activities or sports.

The bill would clarify that while a dentist cannot charge for the "act" of completing the form, they may still require a clinical examination to gather necessary information if the patient's records are outdated.

Historically, the Board explicitly states on its website that it does not handle "fee and billing disputes," as those are usually considered civil contractual matters. A "willful violation" of these provisions is classified as an infraction under Health and Safety Code Section 123114, which would be enforced through local agency prosecution. In addition, because SB 980 would make charging these specific form fees unlawful by statute, it would move the issue from a "private contract dispute" to a "statutory violation." If a dentist maintains a policy of charging for these forms in defiance of the law, the Board will have the jurisdiction to:

- Investigate the complaint as a violation of the Health and Safety Code.
- Issue a Citation or an administrative fine.
- Place the Licensee on Probation if a pattern of "willful violation" is established.

California has invested significantly in the "Smile California" campaign and Medi-Cal dental services. Allowing private administrative fees for state-mandated forms in California undermines the public health goals of the "Smile California" campaign and Medi-Cal dental services by creating financial barriers to access.

The introduction of both AB 2292 (Disability certificates) and SB 980 (School/Medical forms) represents a coordinated legislative strategy in California to eliminate "junk fees" in healthcare administration.

Staff Recommendation: Watch

SB 1150 (Jones, 2026) Cancer data: notifications

Introduced: February 18, 2026
Last Amended: March 25, 2026
Location: Senate Health Committee
Status: Hearing set for April 22, 2026.

Summary: This bill is a transparency-focused bill aimed at keeping patients informed about their medical data. Currently, California law requires healthcare providers to report cancer diagnoses to the California Cancer Registry (CCR), which is a program of the California Department of Public Health (CDPH), for epidemiological tracking. Research from the CCR and academic institutions like UCSF and USC consistently shows that dentists are often the primary point of entry for life-saving cancer diagnoses. This bill would require notice to the patient advising about cancer data reporting.

The bill's author, Senator Jones (a cancer survivor himself), has explicitly stated that the intent is to prevent patients from being "blind-sided" by researchers months later. By mandating the notification at the point of entry, the bill treats the notification like a HIPAA disclosure—it is a "right to know" requirement, not a clinical benchmark that would typically lead to a malpractice suit. The bill does not create new malpractice liability for dentists, but it does clarify their administrative "to-do" list.

Staff Recommendation: Watch

SB 1391 (Wahab, 2026) Department of Consumer Affairs: retired category licenses
Introduced: February 20, 2026
Last Amended: N/A
Location: Assembly Desk
Status: Pending Assembly Committee Referral

Summary: This bill is a transparency measure focused on retired licenses for all DCA. Under current law, the various boards have authority to create a "retired category" of licensure for professionals who are no longer actively practicing but wish to maintain a formal connection to their profession. SB 1391 would add a specific requirement: Any board that offers a retired license category must clearly disclose and provide information about that license on its official website. The bill aims to make it easier for retiring professionals to find information regarding their options for status changes and reduced fees.

The Dental Board does not offer a standalone license labeled "Retired." If you are a dentist looking to retire, you typically choose between:

- Inactive Status: You stop practicing but keep your license. You still pay a renewal fee, but you are exempt from Continuing Education (CE) requirements.

- Reduced Fee (Active or Inactive): If you have practiced in California for 20+ years and are at least 70 years old (or are disabled), you can apply for a Reduced Renewal Fee.
    - Retired/Uncompensated Practice: If you stay in "Active" status but only provide free, uncompensated care (volunteering), your CE requirement is reduced to 30 units instead of the usual 50.

Staff Recommendation: Watch

SB 1416 (Wahab, 2026) Physicians and surgeons: dentists: unprofessional conduct
Introduced: February 20, 2026
Last Amended: N/A
Location: Senate Floor
Status: Third reading

Summary: This bill proposes a stricter timeline for physicians, surgeons, and dentists to return overpayments to their patients. Under current law, medical and dental providers have 30 days to issue a refund for duplicate payments (money paid by the patient that was also covered by insurance). SB 1416 would reduce this window to 21 days in the following scenarios:

- Upon Patient Request: The refund must be issued within 21 days of the request (or within 21 days of the provider receiving the insurance payment).
- Upon Provider Discovery: If the patient doesn't request it but the provider becomes aware of the overpayment, they must notify the patient and issue the refund within 21 days.

Failure to comply with this 21-day deadline would be classified as unprofessional conduct, making the provider subject to enforcement action by the Medical Board or Dental Board.

The Dental Board's highest priority is consumer protection. (BPC, § 1601.2.) Ensuring patients are not financially exploited by practitioners fits with this priority. The Dental Board has been supportive of bills that increase transparency and fairness for patients, provided the rules are clear enough for dentists to follow without accidental violations.

A big concern here is that smaller dental practices may struggle with the shortened 21-day turnaround if they rely on manual bookkeeping or have slow-moving third-party billing services.

Staff Recommendation: Watch

SB 1422 (Durazo, 2026) Medi-Cal: eligibility: immigration status
Introduced: February 20, 2026

Last Amended: N/A
Location: Senate Appropriations Committee
Status: Referred to Senate Appropriations Committee Suspense File

Summary: This bill would expand access to full-scope Medi-Cal benefits for undocumented adults in California by removing upcoming restrictions (laws passed in the 2025-26 State Budget that scheduled a pullback on immigrant health benefits). This bill would ensure that undocumented adults over 19 maintain access to comprehensive healthcare, including dental care, rather than being limited to emergency-only coverage.

Key Provisions

- Expansion of Coverage: It would grant full-scope Medi-Cal benefits, including dental, to individuals age 19 and older regardless of immigration status, provided they meet income requirements.
- Reversing Restrictions: It would eliminate a rule set to begin in 2026 that would have restricted this group to only emergency and pregnancy-related care.
- Cost Sharing: Eligible individuals would remain subject to certain limitations, including monthly premiums (typically $30) and specific dental benefit restrictions.

Staff Recommendation: Watch

SB 1433 (Committee on Judiciary, 2026) Maintenance of the codes
Introduced: March 5, 2026
Last Amended: N/A
Location: Assembly Desk
Status: Pending Assignment to Assembly Committees

Summary: This bill is this year's "Maintenance of the Codes" bill, which is an annual piece of legislation with a non-substantive purpose. For the Dental Board, it is a bill that requires passive monitoring.

The Senate Judiciary Committee introduced this bill because the Committee is the designated housekeeper for California's legal infrastructure. In the California Legislature, the Senate and Assembly Judiciary Committees have primary jurisdiction over the administration of justice and the legal system. The system is comprised of 29 different Codes (such as the Business and Professions Code, which governs dentistry). Because "Maintenance of the Codes" bills affect dozens of different legal codes simultaneously (from the Business and Professions Code to the Vehicle Code), they don't fit neatly into a single policy committee like "Health" or "Education." Over time, small errors creep into these laws—typos, outdated cross-references, or grammatical inconsistencies. The Office of Legislative Counsel is required by law to periodically review the codes and recommend "clean-up" changes. These changes are bundled into a single bill, usually titled "Maintenance of the Codes."

Staff Recommendation: Watch

iii. 2025-2026 Two-Year Legislation for Information and Board Consideration

AB 280 (Aguiar-Curry, 2025) Health care coverage: provider directories
Introduced: January 21, 2025
Last Amended: July 15, 2025
Location: Senate – Inactive File
Status: Two-year bill

Summary: Insurers and plans create directories so members can find providers, such as dentists, who participate in their network. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories and require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. A plan or insurer would be subject to administrative penalties for failure to meet the prescribed benchmarks. A plan or insurer would be required to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services.

This bill also would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing which would count toward the in-network deductible and out-of-pocket maximum. A plan or insurer would be required to provide information about in-network providers to enrollees and insureds upon request and limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. A health care service plan, or the insurer, would be required to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate.

On or before January 1, 2026, this bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for plans and insurers to request directory information from providers and establish a methodology to ensure accuracy of provider directories.

Board Position: Watch

AB 350 (Bonta, 2025) Health care coverage: fluoride treatments
Introduced: January 29, 2025
Last Amended: September 5, 2025
Location: Senate – Inactive File

Status: Two-year bill

Summary: This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of age. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified.

Staff Comments: At its May 14-15, 2025, meeting, the Board voted to take a Support position. On May 29, 2025, the Board sent Assemblymember Bonta a Support position letter stating that the Board recognized the value of enhancing fluoride varnish coverage to improve children's oral health in California.

Board Position: Support

AB 371 (Haney, 2025) Dental coverage
Introduced: February 3, 2025
Last Amended: April 24, 2025
Location: Assembly Appropriations Committee – Suspense File
Status: Two-year bill - Dead

Summary: If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits.

This bill would require specified plans and insurers that cover dental services to offer urgent dental appointments within 48 hours of a request, nonurgent dental appointments within 18 business days of a request, and preventive dental care appointments within 20 business days of a request, as specified. The bill would require dentists to be available within 15 miles or 30 minutes from an enrollee's or insured's residence or workplace. The bill would require plans and insurers to report comprehensive information regarding the networks that each dental provider serves, including the plan's or insurer's self-insured network. The bill would require the Department of Managed Health Care or the Department of Insurance to review the

adequacy of an entire dental provider network, including the portions of the network serving plans and insurers not regulated by the respective department.

Board Position: Watch

AB 479 (Tangipa, 2025) Criminal procedure: vacatur relief
Introduced: February 10, 2025
Last Amended: N/A
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: Existing law allows a person who was arrested or convicted of a nonviolent offense while they were a victim of intimate partner violence, or sexual violence, to petition the court, under penalty of perjury, for vacatur relief. Existing law requires, to receive that relief, that the petitioner establish, by clear and convincing evidence, that the arrest or conviction was the direct result of being a victim of intimate partner violence or sexual violence that demonstrates the petitioner lacked the requisite intent. Existing law authorizes the court to vacate the conviction if it makes specified findings.

This bill would require the court, before it may vacate the conviction, to make findings regarding the impact on the public health, safety, and welfare, if the petitioner holds a license, as defined, and the offense is substantially related to the qualifications, functions, or duties of a licensee. The bill would require a petitioner who holds a license to serve the petition and supporting documentation on the applicable licensing entity and would give the licensing entity 45 days to respond to the petition for relief.

Board Position: Watch

AB 485 (Ortega, 2025) Labor Commissioner: unsatisfied judgments: nonpayment of wages
Introduced: February 10, 2025
Last Amended: July 1, 2025
Location: Senate Appropriations Committee – Suspense File
Status: Two-year bill

Summary: Existing law generally prohibits employers from continuing to conduct business in the California if they have an unsatisfied final judgment for nonpayment of wages, unless the employer has obtained a bond from a surety company and filed that bond with the Labor Commissioner, as prescribed.

This bill would require a state agency, if an employer in an industry that is also required to obtain a license or permit from that state agency is found to have violated the unsatisfied judgment provision, to deny a new license or permit or the renewal of an existing license or permit for that employer. The bill would require the Labor

Commissioner, upon finding that an employer is conducting business in violation of that provision, to notify the applicable state agency with jurisdiction over that employee's license or permit.

Staff Comments: This bill would require the Board to deny a new license or permit, or the renewal of an existing license or permit, upon notice by the Labor Commissioner of its finding that an employer is conducting business in violation of the unsatisfied judgment requirements. If the Board is required to deny licenses and permits, it may impact the Board's revenue. It is difficult for Board staff to estimate how this bill could impact Board revenue because the Labor Commissioner does not consistently aggregate and publicly report this data in a centralized, easily accessible format. However, Board staff anticipate the impact to be minimal.

Staff notes there is no process in the bill for the Board to issue the initial or renewal license or permit if the employer subsequently comes into compliance with the unsatisfied judgment requirements. Further, the Board does not provide lists of license or permit applicants to the Labor Commissioner, so it is unclear how the Labor Commission would know whether the employer had applied for a Board-issued license or permit. The Board may wish to communicate these issues to the author for clarification.

Board Position: At its May 14-15, 2025, meeting, the Board voted to take an Oppose Unless Amended position on AB 485 to clarify Board action on the initial or renewal license or permit following subsequent compliance by the employer and resolve the issue of Labor Commissioner awareness of license or permit applications submitted to the Board. On May 29, 2025, the Board sent an Oppose Unless Amended position letter to Assemblymember Ortega regarding these concerns. The bill was amended on July 1, 2025, but the amendments do not resolve the concerns raised by the Board in its Oppose Unless Amended position letter.

AB 667 (Solache, 2025) Professions and vocations: license examinations: interpreters
Introduced: February 14, 2025
Last Amended: September 5, 2025
Location: Senate – Inactive File
Status: Two-year bill

Summary: This bill would, beginning July 1, 2026, require certain boards under the jurisdiction of the Department of Consumer Affairs (DCA) to permit an applicant who cannot read, speak, or write in English to use an interpreter to interpret the English written and oral portions of the license examination, as applicable, examination if the applicant meets all other requirements for licensure, as specified.

This bill would require an interpreter to satisfy specified requirements, including not having the license for which the applicant is taking the examination, and would prohibit the assistance of an interpreter under certain circumstances, including when English

language proficiency is required for the license. The bill would also require those boards to post on their internet websites that an applicant may use an interpreter if they cannot read, speak, or write in English, the examination is not offered in their preferred language, and they meet all other requirements for licensure.

Staff Comments: The bill was amended to remove DCA Division 2 (healing arts) boards. However, Board staff recommend monitoring to ensure the language is not added back due to examination security concerns.

Board Position: Watch

AB 787 (Papan, 2025) Provider directory disclosures
Introduced: May 6, 2025
Last Amended: June 23, 2025
Location: Senate Appropriations Committee – Suspense File
Status: Two-year bill

Summary: Insurers and plans create directories so members can find providers, such as dentists, who participate in their network. This bill would require a health plan or insurer to include in its provider directory a statement advising an enrollee or insured to contact the plan or insurer for assistance finding an in-network provider and for an explanation of their rights regarding out-of-network coverage. A plan or insurer would also be required to acknowledge the request within one business day if contacted for assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days for a request deemed urgent by the enrollee or insured and 5 business days for a request deemed nonurgent by an enrollee or insured.

Board Position: Watch

AB 837 (Davies, 2025) Ketamine
Introduced: February 19, 2025
Last Amended: March 27, 2025
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: Existing law, the California Uniform Controlled Substances Act, categorizes controlled substances into five designated schedules, places the greatest restrictions on those substances contained in Schedule I, and generally places the least restrictive limitations on controlled substances classified in Schedule V. Existing law categorizes ketamine as a Schedule III controlled substance. Existing law, with a specified exception, makes it a crime to possess for sale or sell ketamine. Existing law makes a violation of that provision punishable by imprisonment in the county jail for a period of not more than one year or in the state prison.

This bill would instead make a violation of that provision punishable by imprisonment in the county jail for a period of not more than one year or for 3, 4, or 5 years. The bill would also make it a crime to transport, import, furnish, administer, or give away, offer to transport, import, furnish, administer, or give away, or attempt to import or transport ketamine into this state, except as specified. The bill would make a violation of these prohibitions punishable by imprisonment in the county jail for 3, 4, or 5 years.

Board Position: Watch

AB 872 (Blanca Rubio, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances
Introduced: February 19, 2025
Last Amended: April 10, 2025
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: This bill seeks to address perfluoroalkyl substances (PFAS). This bill, beginning January 1, 2028, would prohibit a person from distributing, selling, or offering for sale a covered product, as defined, that contains intentionally added PFAS, as defined, unless the Department of Toxic Substances Control has issued a regulatory response for the covered product pursuant to the Green Chemistry program or the prohibition is preempted by federal law. The bill would authorize a manufacturer of a covered product to petition that department to evaluate a covered product and would require that department to evaluate and provide a regulatory response for a covered product under the Green Chemistry program, as specified. The bill would authorize that department to identify and categorize commercially active PFAS present in products distributed in California, as specified.

Board Position: Watch

AB 873 (Alanis, 2025) Dentistry: dental assistants
Introduced: February 19, 2025
Last Amended: July 9, 2025
Location: Senate Business, Professions and Economic Development Committee
Status: Two-year bill.

Summary: As amended on July 9, 2025, AB 873, sponsored by the California Dental Association (CDA), would amend Business and Professions Code (BPC) section 1725 to establish a maximum $300 fee cap for review of each approval application or reevaluation for a course provided pursuant to BPC sections 1753.52 (interim therapeutic restorations and radiographic decisionmaking (ITR/RDM course)), 1754.5 (radiation safety course), and 1755 (electronic infection control course). Board staff note the amendments to BPC section 1725 would not resolve the Board's implementation

issues with the ITR/RDM, radiation safety course, and electronic infection control course raised during the Board's November 2024 and February 2025 meetings as the application fee maximums do not reflect the actual costs to the Board to review and evaluate the ITR/RDM and radiation safety course applications ($7,330) and electronic infection control course ($1,350), or include the Board's request to increase the other dental assisting course fee maximum to $8,000.

The bill would amend BPC section 1750 to change the deadline for a dental assistant to successfully complete a Board-approved eight-hour course in infection control. Pursuant to the Board's Sunset bill (Senate Bill (SB) 1453 (Ashby, Ch. 483, Stats. 2024)), as of January 1, 2025, a dental assistant must successfully complete an infection control course prior to performing any basic supportive dental procedures involving potential exposure to blood, saliva, or other potentially infectious materials. AB 837 would require the infection control course to be completed on or before 60 days from the date of first employment at the dental office, and require the employer of a dental assistant to provide bloodborne pathogen training, as specified, prior to the dental assistant's potential exposure to blood, saliva, or other potentially infectious materials and annually thereafter. The Board discussed the proposed amendments submitted by CDA to the infection control course deadline requirement, but the Board took no position on those amendments.

The bill also would specify the infection control course completed by the dental assistant must be a Board-approved eight-hour course as part of a Board-approved registered dental assisting education program, a stand-alone course approved by the Board pursuant to regulation, or a course with six hours of didactic instruction and at least two hours of laboratory instruction using video or a series of video training tools, all of which may be delivered using asynchronous, synchronous, or online learning mechanisms or a combination thereof, that is approved by the Board pursuant to the requirements in BPC section 1755.

AB 873 also would make technical corrections to BPC section 1750.1 (dental assistant duties) citations and 1753.52 (ITR/RDM course). The bill would amend BPC sections 1753 and 1753.5 to correct registered dental assistant in extended function (RDAEF) duties as requested by the Board at its May 2025 meeting.

The bill would amend BPC sections 1754.5 and 1755 to incorporate the Board's requested course curriculum and application process amendments approved by the Board at its February 2025 meeting, as negotiated with the author's office and sponsor.

The Board approved several other legislative proposals at its November 2024 and February 2025 meetings to resolve other SB 1453 issues. Board staff worked with the author's office and CDA to incorporate the Board's amendments in AB 873, including:

- Amending BPC sections 1628 and 1633 regarding dentist licensure requirements;

- Amending BPC section 1635.5 regarding licensure by credential pathway requirements;
- Amending BPC section 1638.1 regarding elective facial cosmetic surgery (EFCS) Permits; and
- Amending BPC section 1724 to remove the application fee for the portfolio pathway that was previously repealed.

However, these aforementioned amendments approved at the November 2024 and 2025 meetings were not included in the July 9, 2025, version of the bill.

Staff Comments: Until the ITR/RDM, radiation safety, and electronic infection control course and related fee statutes are amended to resolve the previously identified implementation issues, these courses cannot yet be approved by the Board for course providers to offer to students.

Board Position: At its May 14-15, 2025, meeting, the Board voted to take a Support if Amended position to include the Board's additional legislative proposals to resolve SB 1453 issues. On May 23, 2025, the Board sent a Support if Amended position letter Assemblymember Alanis. However, on July 14, 2025, the author cancelled the hearing of this bill making it a two-year bill.

AB 966 (Carrillo, 2025) Dental Practice Act: foreign dental schools
Introduced: February 20, 2025
Last Amended: April 7, 2025
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: Beginning January 1, 2024, existing law requires foreign dental schools seeking approval by the Board to complete the international consultative and accreditation process with the Commission on Dental Accreditation of the American Dental Association. Existing law maintained the approval of any foreign dental schools whose program was renewed by the board prior to January 1, 2020, through any date between January 1, 2024, and June 30, 2026, through that renewal date.

This bill would instead maintain the approval of any foreign dental school whose program was approved by the Board prior to January 1, 2024, until the school is denied accreditation by the Commission on Dental Accreditation of the American Dental Association (CODA) and the school does not appeal, the school has been issued a denial by CODA following the completion of the appeals process, or the school withdraws its application for CODA accreditation. The bill would require license applicants who graduated from a foreign dental school with extended Board approval to agree to practice dentistry in specified practice settings. The bill would require the Board, as part of the Board's first Sunset review report following January 1, 2032, to report specified information regarding workforce data of licensees and graduates of foreign dental schools with extended approval, as specified.

Staff Comments: This bill would require significant statutory and regulatory changes and staff time preparing the new workforce report required under the bill and increase staffing resource costs. This bill also may result in decreased consumer protection resulting from licensees, who graduated from a foreign dental school that had not been audited or otherwise reviewed for educational requirements compliance for many years. The bill also may result in a foreign dental school maintaining Board approval without Board oversight of compliance with existing regulatory requirements for a long time, as long as the school had applied for CODA approval. Although the bill sponsor submitted proposed revisions to the bill, those revisions do not resolve the Board's stated concerns.

Board Position: At its May 14-15 2025 meeting, the Board voted to take an Oppose Unless Amended position on AB 966. On May 20, 2025, the Board sent an Oppose Unless Amended letter to Assemblymember Carrillo.

AB 1107 (Flora, 2025) Cigarette and Tobacco Products Licensing Act of 2003: nitrous oxide: licensure

Introduced: February 20, 2025
Last Amended: Revised April 8, 2025
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: Nitrous oxide is a colorless, odorless to sweet-smelling inorganic gas that was first used in surgical and dental anesthesia in the mid-1800s. Existing law, the Cigarette and Tobacco Products Licensing Act of 2003, requires the California Department of Tax and Fee Administration to issue a license to a retailer to engage in the sale of cigarettes or tobacco products upon receipt of a completed application and payment of certain fees unless any of certain exceptions apply. Existing law subjects licenses issued by the act to suspension or revocation for specified violations. Existing law prohibits a person from dispensing or distributing nitrous oxide to a person if the distributor knows or should know that the person is going to use the nitrous oxide for certain unlawful purposes and that person proximately causes great bodily injury or death to that person or another person. Existing law also requires a person who dispenses or distributes nitrous oxide to record each transaction involving the dispensing or distribution of nitrous oxide in a written or electronic document, as specified. Existing law makes a violation of either of these provisions a misdemeanor.

This bill would require a court to order the suspension, for up to one year, of the business license of a person who knowingly violates either of those provisions after having been previously convicted of a violation of the respective provision, except as specified. This bill would specify violations subjecting licenses to suspension or revocation include, among others, the crimes above, as specified. The bill would exempt from the license issuance requirement the issuance of a license to a retailer who has

been convicted of specified crimes relating to the distribution of nitrous oxide, including the misdemeanors described above.

Board Position: Watch

AB 1130 (Berman, 2025) Dentistry: outreach and support program
Introduced: February 20, 2025
Last Amended: June 23, 2025
Location: Senate – Inactive File
Status: Two-year bill

Summary: This bill would require the Board to develop, implement, and maintain an outreach and support program to recruit students from underserved communities in the state to pursue education and licensure in the field of dentistry. The bill would establish duties the Board would be required to carry out in that regard, including conducting at least two outreach activities per year focused on students from underserved communities. The bill would require the Board to provide a summary of actions taken pursuant to the bill's provisions as part of its report to the Legislature through the sunset review process.

Staff Comments: Board staff estimate $179,856 in costs for an Associate Government Program Analyst position and travel costs to implement and maintain the outreach and support program in the first budget year. In the next budget year, Board staff estimate $159,000 for ongoing costs for the Associate Government Program Analyst position.

Board Position: Watch

AB 1215 (Flora, 2025) Hospitals: medical staff membership
Introduced: February 21, 2025
Last Amended: N/A
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: Existing law, enforced by the Medical Board of California, makes it unprofessional conduct in the regular practice of medicine in a specified licensed general or specialized hospital having five or more physicians and surgeons on the medical staff without required provisions governing the operation of the hospital, including, among other things, a provision that membership on the medical shall be restricted to physicians and surgeons and other licensed practitioners competent in their respective fields and worthy of professional ethics. Existing law also makes it unprofessional conduct in the regular practice of medicine in a licensed general or specialized hospital having less than five surgeons on the medical staff without required provisions governing the operation of the hospital, including, among other things, a provisions that membership on the medical staff shall be restricted to physicians and

surgeons and other licensed practitioners competent in their respective fields and worthy of professional ethics.

This bill would clarify the membership restriction provisions of other licensees to specifically list dentists, podiatrists, clinical psychologists, nurse anesthetists, and nurse midwives.

Board Position: Watch

AB 1298 (Harabedian, 2025) The Department of Consumer Affairs
Introduced: February 21, 2025
Last Amended: N/A
Location: Assembly Desk
Status: Two-year bill - Dead

Summary: This was a spot bill relating to professions and vocations.

Board Position: Watch

AB 1307 (Ávila Farías, 2025) Licensed Dentists from Mexico Pilot Program
Introduced: February 21, 2025
Last Amended: July 8, 2025
Location: Senate Business, Professions and Economic Development Committee
Status: Two-year bill

Summary: This bill would repeal and replace the existing Licensed Dentists from Mexico Pilot Program and instead requires the Board to issue a three-year nonrenewable permit to practice dentistry to an applicant who meets specified criteria and require participants in the program to comply with specified requirements. The bill would authorize participants to be employed only by federally qualified health centers that meet specified conditions and would impose requirements on those centers. The bill would require an evaluation of the program to be commenced beginning one year after the program has commenced, as specified, and would prescribe the information to be included in that evaluation. The bill would require the costs for the program to be fully paid for by funds provided by philanthropic foundations.

Staff Comments: At its May 14-15, 2025 meeting, the Board voted to take an Oppose Unless Amended position on AB 1307 describing its specific concerns. Board staff met with Assemblymember Ávila Farías' office and the bill sponsor to address the Board's concerns. Based on the July 8, 2025 amendments to the bill that addressed the Board's concerns, the Board sent a letter on July 9, 2025, withdrawing its Oppose Unless Amended position. Board staff worked with Assemblymember Ávila Farías' office and the bill sponsor on the latest amendments to the bill to resolve the Board's concerns.

Board Position: Watch

AB 1431 (Tangipa, 2025) Personal income taxes: credit: medical services: rural areas
Introduced: February 21, 2025
Last Amended: April 28, 2025
Location: Assembly Chief Clerk
Status: Two-year bill - Dead

Summary: The Personal Income Tax Law allows various credits against the taxes imposed by that law. This bill, for taxable years beginning on or after January 1, 2025, and before January 1, 2032, would allow a credit against the taxes imposed by that law to a qualified taxpayer in an amount equal to the qualified income earned by the qualified taxpayer for medical services performed in a rural area in the state, not to exceed $5,000 per taxable year, as specified.

Board Position: Watch

AB 1434 (Michelle Rodriquez, 2025) Health care boards: workforce data collection
Introduced: February 21, 2025
Last Amended: N/A
Location: Assembly Desk
Status: Two-year bill - Dead

Summary: Existing law requires specified boards, including the Board of Registered Nursing and the Respiratory Care Board of California, to collect certain workforce data from their respective licensees and registrants for future workforce planning at least biennially. This bill would make nonsubstantive changes to those provisions.

Staff Comments: Existing law “spot bill” but monitoring for changes.

Board Position: Watch

AB 1461 (Essayli, 2025) Department of Consumer Affairs: regulatory boards
Introduced: February 21, 2025
Last Amended: N/A
Location: Assembly Desk
Status: Two-year bill - Dead

Summary: Existing law provides for the licensure and regulation of various professions and vocations by boards and other entities within DCA. Existing law establishes procedures for removing from office a member of a DCA board or other DCA licensing

entity based on certain conduct by that member. This bill would make nonsubstantive changes to those provisions.

Board Position: Watch

iv. 2026 Priority Legislation for Presentation and Board Consideration

AB 1760 (Arambula, 2026) Dentistry – SPONSOR
Introduced: February 9, 2026
Last Amended: N/A
Location: Assembly Committee on Appropriations
Status: To be heard in the Assembly Appropriations Committee on April 15, 2026. On consent calendar

Summary: This Board-sponsored bill consolidates technical, non-controversial, and substantive cleanup items approved by the Board—in public meetings between November 2024 and February 2026—to refine various provisions of the Dental Practice Act (DPA) and ensure statutory language aligns with current regulatory standards and consumer protection needs.

While these items are typically addressed during the Sunset Review process, waiting for the Board's next cycle in 2028–2029 would leave in place several statutory impediments and inconsistencies for effective administration of the DPA. This bill serves as a comprehensive omnibus vehicle to optimize the Board's efficiency and protect the public in the following ways:

1. Resolving Dental Auxiliary Course Implementation Delays
The Board is currently facing legal impediments that have stalled the implementation of modernized curriculum for two foundational dental assisting courses: the Radiation Safety (X-ray) Course and online Infection Control Course.

- Problem: The Board's last sunset bill, SB 1453 (Ashby, Chapter 483, Statutes of 2024), established new radiation safety and infection control course statutes requiring Board approval of course providers. However, the statutes lack clear approval process provisions and course instruction requirements.
- Solution: These amendments would resolve the course approval and instruction requirements so the Board can implement the new statutes.

2. Rectifying Inadvertent Technical Errors in SB 1453
The 2024 Sunset Bill inadvertently introduced cross-referencing errors and omitted specific duties for Registered Dental Assistants in Extended Functions (RDAEF).

- Problem: These errors create legal ambiguity for practitioners and supervisors regarding RDAEF scope of practice.
- Solution: This bill would restore lost RDAEF duties and correct technical flaws to harmonize the law with current dental office practice.

3. Modernizing Licensure and Permits
This proposal would clean up "statutory clutter" by conforming statutes with changes made in SB 1453 and dentist licensure examination administration:

- Elective Facial Cosmetic Surgery (EFCS) Permit: Conforms the credentialing committee review provisions with the new permit categories created under SB 1453 and establishes credentialing committee member removal provisions.
- Obsolete Pathways: Removes statutory references to the "Portfolio Examination" pathway repealed by SB 1453.
- Remedial Education: Conforms examination retake procedures with national examination administrator requirements.

4. Administrative Efficiency
By streamlining the "Licensure by Credential" process for out-of-state dentists and removing redundant insurance requirements, this bill would reduce administrative overhead.

Staff Recommendation: Sponsor

AB 1952 (Berman, 2026) Dentistry: Dental Hygienists: Licensure
Introduced: February 13, 2026
Last Amended: April 22, 2026
Location: Assembly Appropriations Committee
Status: Assembly Appropriations Committee

Summary: This bill, sponsored by the California Dental Association (CDA), aims to increase access to oral health professionals by creating an alternative, competency-based licensure pathway for internationally trained dentists (ITDs) to become licensed as Registered Dental Hygienists (RDH) without completing a full accredited dental hygiene program. Similar legislation has been enacted in 8 states, Connecticut, Indiana, Florida, Maine, Massachusetts, New York, Virginia, Vermont, and currently pending in Michigan, Oklahoma, and Rhode Island.)

The pathway would be administered by the Dental Hygiene Board of California (DHBC), which serves as the dental hygienist licensing authority. Key requirements would include:

Education and Equivalency

- The applicant must hold a degree from a nonaccredited (international) dental school. Verification from Educational Credential Evaluators (ECE) confirming academic equivalence of the applicant’s dental degree to a United States dental hygiene degree would be required.

Examinations (must be completed within the preceding 5 years)

- The National Board Dental Hygiene Examination (NBDHE).
- The California Law and Ethics examination, as prescribed by the DHBC.

Coursework (must be completed within the preceding 2 years, except Basic Life Support (BLS) which must be current)

- A 2-unit California Dental Practice Act course approved by the Dental Board of California.
- An 8-unit infection control course approved by the Dental Board of California.
- A soft-tissue curettage, local anesthesia, and nitrous oxide-oxygen analgesia course approved by the DHBC. (The bill allows eligibility to enroll in this combined course once other core requirements are documented.)
- Current, valid certification in BLS, consistent with specified California regulations.

Licensing Process

- The applicant would submit the completed application form and fees to the DHBC.
- Once all requirements are satisfied, including successful completion of the NBDHE, the DHBC would certify the applicant as eligible to take the dental hygiene examination given by the American Board of Dental Examiners (ADEX).
- Upon successful completion of the ADEX and completed application and all fees, the Board would grant an RDH license to the applicant.
- The pathway emphasizes that the DHBC focuses on hygiene-specific scope, legal/ethical standards, and overall competency for RDH practice.

This structure streamlines entry for qualified internationally trained dentists into the hygiene workforce while maintaining safeguards through board-approved education, examinations, and verifications.

Staff Comments: On March 13, 2026, the DHBC adopted an Oppose Unless Amended position on this bill seeking, instead, the bill be amended to require the Board to establish a restricted license category authorizing internationally trained dentists to practice dental hygiene.

Staff Recommendation: Support

AB 2625 (Solache, 2026) Dental Practice Act: Foreign Dental Schools
Introduced: February 20, 2026
Last Amended: N/A
Location: Assembly Business and Professions Committee
Status: Assembly Business and Professions Committee

Summary: This bill would amend the DPA (BPC, §§ 1628, 1634.1, 1636.5, and repeal/add § 1636.6) regarding approval of foreign dental schools.

Current Law Context:
California previously allowed the Board to approve certain foreign dental schools. AB 1519 (Low, Chapter 865, Statutes of 2019) shifted dental school approval to national

standards: beginning January 1, 2020, the Board no longer accepts new applications for foreign school approval. Instead, schools must complete the international accreditation process with the Commission on Dental Accreditation (CODA) of the American Dental Association or a comparable accrediting body approved by the Board. Schools that were Board-approved before January 1, 2020, had temporary extensions of approval (through dates up to June 30, 2026, depending on prior renewals).

What the Bill Would Do:

- Maintain Board approval of a foreign dental school previously approved before January 1, 2020, provided the school applied for CODA (or equivalent) accreditation by January 31, 2026, and while the accreditation process remains ongoing.
- Require the school to submit status updates to the Board starting January 1, 2027, and every six months thereafter.
- Tie graduate eligibility for licensure to the school's approval status at the time of the student's enrollment (rather than solely at graduation), to avoid situations where students who began programs under approved status become ineligible if approval lapses before they complete their degrees.
- Apply only to schools already in the pre-2020 pipeline; it does not reopen approval for new foreign schools.

The bill aims to address the extended timelines for CODA's international accreditation process (historically 12+ years in documented cases for the first two approved international schools). Proponents highlight that roughly 900 graduates from the two currently affected schools (Universidad de La Salle Bajío in Mexico and the State University of Medicine and Pharmacy "Nicolae Testemiţanu" in Moldova) are practicing in California. Critics or cautious observers may raise concerns about maintaining state-specific approval pathways during a transition to uniform national standards, potential impacts on oversight quality, and incentives for schools to complete accreditation.

Staff Recommendation: Watch

SB 936 (Blakespear, 2026) Nitrous oxide: sales
Introduced: January 29, 2026
Last Amended: April 8, 2026
Location: Senate Appropriations Committee
Status: Set for hearing on April 27, 2026

Summary: This bill seeks to further prohibit the sale and distribution of nitrous oxide. While it is a misdemeanor in California to inhale nitrous oxide for intoxication, it is legal to purchase for legitimate culinary or automotive uses. This loophole has allowed smoke shops to continue selling it.

Experts, including Stanford Medicine addiction specialists, have described the addiction to large nitrous tanks (often called "Galaxy Gas") as severe and comparable to crack

cocaine. There is a significant and well-documented increase in nitrous oxide ("laughing gas" or "whippits") abuse in California, particularly among teenagers and young adults. Retailers, including smoke shops, convenience stores, and online platforms are selling large, often flavored, canisters that have been linked to severe health issues, hospitalizations, DUI arrests, fatal traffic accidents, and a rise in addiction. In response to this, many California cities and counties are passing local ordinances to restrict sales, as state-level regulation has struggled to keep up. A peer-revied, July 2025 JAMA Network Open study revealed the California Poison Control System reported 271 calls for nitrous oxide in 2024-2025. Fatalities from nitrous oxide poisoning increased by over 500% between 2010 and 2023 nationally, with a significant concentration of this trend appearing in California.

This bill would prohibit the sale and distribution of any container that can hold more than 8 grams of nitrous oxide or from which an individual may directly inhale and would also prohibit the sale and distribution of a nitrous oxide that has, or is marketed as having, the taste or smell of any food. The bill would prohibit the sale and distribution of a device that allows an individual to inhale from the container or hold nitrous oxide for the purposes of inhalation. The bill would punish a violation of these provisions as an infraction and authorize a court to suspend the business license, including a license to sell tobacco products or cannabis, if the business has a prior conviction for violating these prohibitions.

Nitrous oxide is routinely used in dental offices for legitimate purposes. This bill explicitly exempts this activity by stating that the prohibition and penalties do not apply to nitrous oxide or a nitrous oxide container that “is sold to a licensed medical or dental practitioner to be administered or prescribed as part of the care or treatment of a disease, condition, or injury.” Therefore, this bill will not impede a dentist’s ability to obtain and continue to use nitrous oxide in their offices.

Staff Recommendation: Support

SB 1311 (Wahab, 2026) Licensed professions
Introduced: February 20, 2026
Last Amended: March 26, 2026
Location: Senate Floor
Status: Third reading

Summary: Pursuant to SB 1453, unlicensed dental assistants must complete an 8-hour infection control course before performing any basic supportive dental procedures that involve potential exposure to blood, saliva, or other potentially infectious materials. Employers are responsible for ensuring compliance. Many dental practices, particularly in rural or underserved areas, have faced challenges finding timely in-person or approved courses, leading to hiring delays and staffing shortages.

SB 1311 would expand the acceptable ways for unlicensed dental assistants to meet the infection control requirement by allowing the following options:

1. Completion of the Dental Assisting National Board (DANB) Infection Control examination as an alternative to a full course.
2. A Board-approved eight-hour course provided by a Board-approved RDA or alternative RDA program.
3. A stand-alone eight-hour Board-approved infection control course.
4. A six-hour infection control course, with at least four hours of didactic instruction, as specified, and at least two hours of laboratory instruction using video or a serios of video tools that may be delivered online, offered by the CDA or a provider approved by the California Dental Association (CDA), American Dental Association's Continuing Education Recognition Program, or the Academy of General Dentistry's Program Approval for Continuing Education.

The bill also would shift the employer's duty to ensure the dental assistant has successfully completed one of the above options (course or exam) before allowing them to perform exposure-prone duties and declares urgency for quicker implementation.

According to CDA, many dental practices have reported difficulty finding available 8-hour in-person courses, particularly in rural areas. By allowing the DANB exam and virtual video-based training, the bill would create an alternative pathway for unlicensed dental assistants to enter the California workforce.

Staff Comments: Board staff note that SB 1311 does not change any criteria or oversight requirements of the Board's current infection control course obligations and is the byproduct of concerns originally raised by the Board and subsequent stakeholder discussion on AB 873 (Alanis, 2025). This bill also contains an urgency clause, which means it requires a two-thirds majority vote of the Legislature to pass and if signed by Governor Newsom would take effect immediately. Staff also note that the virtual video-based optional training authorized by SB 1311 does not require in-person laboratory instruction. Board staff also note that the Board-sponsored bill, AB 1760, would add additional minimum didactic instruction provisions not included in SB 1311. However, SB 1311 is the operative legislative vehicle to establish a virtual video-based infection control training course and would result in striking similar provisions contained in AB 1760.

Staff Recommendation: Support

SB 1445 (Committee on Business, Professions and Economic Development, 2026)
Healing Arts
Introduced: March 17, 2026
Last Amended: N/A
Location: Senate Appropriations Committee
Status: Set for Hearing on May 4, 2026

Summary: This is an omnibus "healing arts" bill authored by the Senate Business, Professions and Economic Development Committee. The bill acts as a legislative "cleanup" vehicle, bundling technical, non-controversial changes for multiple professional boards into one package to simplify the legislative process.

SB 1445 also contains helpful cleanup items for the Board. The following is a summary of the sections transitioned from the Board sponsored bill (AB 1760) into the Committee Bill (SB 1445):

- **BPC 1621:** Removes reference to the portfolio examination repealed by SB 1453.
- **BPC 1632.6:** Repeals outdated references to the "portfolio examination" pathway for dentists, which is no longer in use.
- **BPC 1724:** Removes the application fee for the portfolio examination repealed by SB 1453.
- **BPC 1750.1:** Corrects dental assistant duties inadvertently changed by SB 1453.

Staff Recommendation: Support

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

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MEMORANDUM

DATE	April 17, 2026
TO	Members of the Dental Board of California
FROM	Mirela Taran, Administrative Analyst Dental Board of California
SUBJECT	**Agenda Item 23.:** Future Agenda Items and Next Meeting Dates

Background

Mr. Docherty will provide a verbal report of items for consideration for a future board meeting and upcoming meeting dates.

Action Requested

No action requested.