AB-2860 Licensed Physicians and Dentists from Mexico programs. (2023-2024)

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Assembly Bill No. 2860

CHAPTER 246

An act to add Article 2.7 (commencing with Section 1645.4) to Chapter 4 of, to add Article 6 (commencing with Section 2125) to Chapter 5 of, Division 2 of, and to repeal Section 853 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 14, 2024. Filed with Secretary of State September 14, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2860, Garcia. Licensed Physicians and Dentists from Mexico programs.

Existing law, the Licensed Physicians and Dentists from Mexico Pilot Program, allows up to 30 licensed physicians and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years, in accordance with certain requirements. Existing law requires the Medical Board of California and the Dental Board of California to provide oversight pursuant to these provisions. Existing law requires appropriate funding to be secured from nonprofit philanthropic entities before implementation of the pilot program may proceed.

Existing law requires physicians participating in the Licensed Physicians and Dentists from Mexico Pilot Program to be enrolled in English as a second language classes, to have satisfactorily completed a 6-month orientation program, and to have satisfactorily completed a 6-month externship at the applicant’s place of employment, among various other requirements.

This bill would repeal the provisions regarding the Licensed Physicians and Dentists from Mexico Pilot Program, and would instead establish two bifurcated programs, the Licensed Physicians from Mexico Program and the Licensed Dentists from Mexico Pilot Program. Within these 2 programs, the bill would generally revise and recast certain requirements pertaining to the Licensed Physicians and Dentists from Mexico Pilot Program, including deleting the above-described requirement that Mexican physicians participating in the program enroll in adult English as a second language classes. The bill would instead require those physicians to have satisfactorily completed the Test of English as a Foreign Language or the Occupational English Test, as specified. The bill would remove the requirement that the orientation program be 6 months, and would further require the orientation program to include electronic medical records systems utilized by federally qualified health centers and standards for medical chart notations. The bill would also delete the requirement that the physicians participate in a 6-month externship. The bill would further delete provisions requiring an evaluation of the pilot program to be undertaken with funds provided from philanthropic foundations, and would make various other related changes to the program. The bill would require the Dental Board of California to, notwithstanding existing requirements to provide specified federal taxpayer information, issue a 3-year nonrenewable permit to an applicant who has not provided an individual taxpayer identification number or social security number if the applicant meets specified conditions.

Commencing January 1, 2025, the bill would authorize the Medical Board of California to issue a limited number of active licenses to eligible applicants to participate in the Licensed Physicians from Mexico Program, as specified. Under the bill, each additional

physician selected for the program would not be eligible to renew their 3-year license.

The bill would require the federally qualified health centers employing physicians pursuant to the program to continue specified peer review protocols and procedures and to work with an approved medical school or an approved residency program, as provided. The bill would also require specified entities to be the points of contact involved in securing required documents, recruiting and vetting candidates, assisting candidates to meet all program requirements, selecting appropriate federally qualified health centers throughout California, ensuring compliance with program provisions, developing policy and clinical workshops, monitoring productivity and increased access to medical care, and assessing the necessity of policy and programmatic improvements. The bill would impose fees in connection with both programs, as specified.

This bill would make legislative findings and declarations as to the necessity of a special statute.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares the following:

(a) The facts and sources cited in this subdivision describe the physician shortages that existed up to 2001 in California and the United States, including an emphasis on the lack of Latino medical students and licensed physicians in proportion to their population in California. These critical and dangerous shortages led to the creation of the Licensed Physicians and Dentists from Mexico Pilot Program.

(1) The 2020 United States Census determined the population of California to be over 39 million people with approximately 16 million being Latino.

(2) From July 1990 to July 1999, California's population increased by approximately 4 million people. Approximately 61 percent of this growth can be attributed to the growth in the Latino population. The Latino population has increased at an average rate of 275,000 persons per year from 1990 to 1999. The Latino population is estimated to have grown in virtually all counties over this period.

(3) The United States General Accounting Office reports that the United States Community Health Centers patients comprise 65 percent ethnic and racial minorities.

(4) Title VI of the Civil Rights Act of 1964 requires any federally funded health facility to ensure persons with limited English proficiency may meaningfully access health care services. Persons with limited English proficiency are often excluded from programs, experience delays or denials of services, or receive care and services based on inaccurate or incomplete information.

(5) The federal Health Resources and Services Administration reports the number of physicians in California grew 17 percent between 1989 and 1998.

(6) The federal Health Resources and Services Administration found in 1998 that only 4 percent of active patient care physicians were Latino.

(7) The Association of American Medical Colleges in 1998 found only 6.8 percent of all graduates from United States medical schools were of an ethnic or racial minority group.

(8) In 1999, only 11 percent of dentists in California were a member of a racial or ethnic minority group with 5 percent being classified as Asian or Pacific Islanders.

(9) In 1996, only 4 percent of dentists in California were Latino.

(10) According to the Institute of Medicine report requested by the United States Congress, research evidence suggests that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently health outcomes. Thus, when sociocultural differences between the patient and the provider are not appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poorer health outcomes, and racial and ethnic disparities in health care.

(11) A Commonwealth Fund of New York study found that: (1) one-third of Latinos said they had problems communicating with their doctors with barriers to this poor communication including language, cultural traditions, and sensitivity; (2) communication is essential to quality health care; and (3) inadequate communication can lead to the perception of inhumane health care service delivery.

(12) The Summit on Immigration Needs & Contributions of the Bridging Borders in the Silicon Valley Project found that approximately 50 percent of participants reported that having a provider that speaks their language will improve the quality of health care services they receive.

(13) Only two states in the country have reported cultural competency standards for care.

(14) No states in the country have reported foreign language competencies for physicians or dentists.

(15) According to the Dallas Morning News, many immigrants travel to Mexico to receive health care due to the cultural and language barriers they encounter in the United States health care system. According to the San Jose Mercury News, 65 percent of the membership of the largest medical association in California reported that if they were required to pay for medical interpreters, they would stop seeing patients that required interpretation services.

(16) According to the Journal of the American Medical Association, in 1999, one medical school had a separate course covering cultural diversity, 109 medical schools included cultural diversity content as part of a required course or clerkship, and 84 medical schools included information on cultural beliefs or practices related to death or dying in a required course or clerkship.

(b) The facts and data set forth in this subdivision reflect physician shortages from 2015 onward, as projected through 2034 nationwide, but do not include the shortage of culturally and linguistically competent medical providers in the nation or California, which seriously exacerbates the problems of accessing medical care in non-English-dominant communities.

(1) Despite the Latino population comprising approximately 38 percent of the people in California in 2015, the percentage of Latino physicians in California was only 7 percent in 2015.

(2) In 2015, the percentage of Doctor of Osteopathic Medicine graduates in California was 3 percent, physician assistants was 20 percent, nurse practitioners was 9 percent, and registered nurses was 20 percent.

(3) According to data reported in the Physicians Almanac, 7 percent of physicians working in the San Joaquin Valley in 2021 were Latina or Latino, whereas the Latino population in that region was 53 percent.

(4) In 2021, Latina and Latino physicians working in the County of Los Angeles accounted for 6 percent of the population, whereas the Latino population in that region was 49 percent.

(5) In 2021, Latina and Latino physicians working in the Inland Empire accounted for 7 percent of the population, whereas the Latino population in that region was 52 percent.

(6) In 2021, Latina and Latino physicians in the Sacramento area accounted for 4 percent, whereas Latinos comprised 22 percent of the population in that region.

(7) The Physicians Almanac reported in 2021 that all of the most populated regions of California where Latinos reside had less than the recommended number of primary care physicians, with only 60 per 100,000 patients.

(8) The region with the highest percentage of doctors who spoke Spanish in 2021 was the Central Coast, with 28 percent, followed by the County of Los Angeles, with 27 percent. There was no detailed information on this data based on Spanish language fluency or knowledge of cultural beliefs and practices related to health care.

(9) Based on a study published in the Journal of Health Affairs, “Latino and Hispanic groups are underrepresented in medical professions that require advanced degrees and overrepresented in similar professions that don’t require a bachelor’s or higher degree.”

(10) In 2020, the American Community Survey found that, “Mexican Americans made up 10.7 percent of the U.S. workforce but just 1.77 percent of U.S. physicians.”

(11) According to a recent article in the Washington Post from 2023, “Underrepresentation among Latino health care workers is a concern because data suggests racially, and ethnically diverse and culturally competent medical providers can help reduce health care disparities among minority populations. Minority patients with providers who share their race, ethnicity, or language report receiving better care than when they see providers from different racial or language groups. Studies have shown that providers from minority groups are more likely to work in areas with health care shortages, accept Medicaid, and spend more time with patients.”

(12) As of November 1, 2023, California has the nation’s most federally designated Primary Care Health Professional Shortage Areas (HPSAs) with 694, followed by Texas with 436. An HPSA is an area that must have 3,500 in population for one primary care physician.

(13) The Association of American Medical Colleges (AAMC) is a leading voice in medical academia and research. The AAMC issued a significant study in June 2021 on physician shortages in the United States titled “The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.”

(14) In this study, the AAMC projects that the United States could see an estimated shortage of between 37,800 and 124,000 physicians by 2034, including shortfalls in both primary and specialty care.

(15) The study cites the COVID-19 pandemic as exposing “many of the deepest disparities in health and access to health care services and exposed vulnerabilities in the health care system,” according to AAMC President and CEO David J. Skorton, MD.

(16) The AAMC projected the following physician shortages by 2034:

(A) Primary Care (e.g., family medicine, general pediatrics, geriatric medicine): between 17,800 and 48,000.

(B) Surgical Specialties (e.g., general surgery, obstetrics and gynecology, orthopedic surgery): between 15,800 and 30,200.

(C) Medical Specialties (e.g., cardiology, oncology, infectious diseases, pulmonology): between 3,800 and 13,400.

(D) Other Specialties (e.g., anesthesiology, neurology, emergency medicine, addiction medicine): between 10,300 and 35,600.

(17) The President and CEO of the AAMC, David J. Skorton, MD, testified before Congress, stating that “the issue of increasing clinician burnout, which the pandemic has intensified, could cause doctors and other health workers to cut back their hours or accelerate their plans for retirement.”

(18) Despite Congressional efforts in 2021 to introduce bipartisan legislation to increase medical residencies by 2,000 annually for seven years, the shortages identified by the AAMC will come about.

(19) On the matter of workforce diversity, equity, and inclusion (DEI), the AAMC stated in this study as follows:

“The physician workforce lacks sufficient diversity and inclusion (i.e., it lacks diversity overall and in positions of leadership and influence). The AAMC has identified addressing this lack as a core strategic priority. Extensive long-term data-collection work is needed, as is extensive and nuanced research about physician workforce diversity and the anti-racist policies that can combat the endemic structural and systemic racism that harms the current physician workforce, damages the nation’s ability to create a more diverse and inclusive physician workforce, and impedes a diverse population from receiving equitable health care.”

(20) In 1980, the United States Census found an unprecedented growth in the Latino community that would continue beyond the decade. The United States census predicted that Latino demographic trends would have Latinos being the largest minority population in the United States during the first decade of the 2000s.

(21) Latinos were already 19 percent of the state’s population in California in 1980. From 1980 to 1990, the state’s total population grew by 26 percent, but the Latino population increased by 69 percent.

(22) In other words, the need to be more inclusive of Latinos in the health care workforce and the health care needs of Latinos was well known to California policymakers in the 1980s, 1990s, 2000s, and since 2010. However, the academic medical community and health care policymakers made no substantive move to prevent the situation from getting to the point that the AAMC and many other studies on the health care workforce have warned us to take immediate action to resolve this matter.

(23) The AAMC and the majority of all studies on health care workforce shortages have underestimated the impact of physician shortages in the Latino community over the last four decades. They have also underestimated its impact on other communities that are not predominantly English speaking and are at least first- and, at times, second-generation foreign born. The lack of culturally and linguistically competent physicians exacerbates and worsens the physician shortages in these communities for generations. Hence, the poor health profile of Latinos and other ethnic and racial populations in California.

(c) Underscoring the lack of preparation, creativity, and commitment to deal with the needs of a culturally and linguistically diverse society, such as California since the 1980s, and the growing physician shortages in the state, the University of California Schools of Medicine and the three private university medical schools at Stanford University, the University of Southern California, and Loma Linda University do not offer any mandatory cultural or foreign language courses to prepare medical students to serve the diverse populations that reside in California. The actions and policies taken by these medical institutions confirm the need for programs such as the Licensed Physicians from Mexico Program.

SEC. 2. Section 853 of the Business and Professions Code is repealed.

SEC. 3. Article 2.7 (commencing with Section 1645.4) is added to Chapter 4 of Division 2 of the Business and Professions Code, to read:

Article 2.7. Licensed Dentists from Mexico Pilot Program

1645.4. (a) For purposes of this article, the following definitions apply:

(1) “Board” means the Dental Board of California.

(2) “Program” means the Licensed Dentists from Mexico Pilot Program.

(b) The Licensed Dentists from Mexico Pilot Program is hereby created.

(c) (1) This program continues the dentist component of the Licensed Physicians and Dentists Pilot Program, as established in former Section 853, which authorized no more than 30 dentists from Mexico to practice dentistry in California for a period not to exceed three years.

(2) The program shall also maintain an alternate list of program participants.

(d) The board shall issue a three-year nonrenewable permit to practice dentistry to each dentist from Mexico who meets the criteria set forth in this section.

(e) (1) Each dentist from Mexico who is eligible to participate in this program shall comply with the requirements specified in subparagraphs (A) to (C), inclusive, or the requirements contained in paragraph (2):

(A) Be a graduate from the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología).

(B) Meet all criteria required for licensure in Mexico that is required and being applied by the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología), including, but not limited to:

(i) A minimum grade point average.

(ii) A specified English language comprehension and conversational level.

(iii) Passage of a general examination.

(iv) Passage of an oral interview.

(C) Enroll and complete an orientation program that focuses on the following:

(i) Practical issues in pharmacology that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(ii) Practical issues and diagnosis in oral pathology that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(iii) Clinical applications that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(iv) Biomedical sciences that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(v) Clinical history management that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(vi) Special patient care that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(vii) Sedation techniques that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(viii) Infection control guidelines that shall be taught by an instructor who is affiliated with a California dental school approved by the board.

(ix) Introduction to health care systems in California.

(x) Introduction to community clinic operations.

(2) (A) Graduate within the three-year period before enrollment in the program, from a foreign dental school that has received provisional approval or certification by November 2003 from the board under the Foreign Dental School Approval Program.

(B) Enroll and satisfactorily complete an orientation program that focuses on the health care system and community clinic operations in California.

(C) Enroll and satisfactorily complete a course taught by an approved foreign dental school on infection control approved by the board.

(3) Upon satisfactory completion to a competency level of the requirements in paragraph (1) or (2), each dentist participating in the program shall be eligible to obtain employment in a nonprofit community health center pursuant to subdivision (f) within the structure of an extramural dental program for a period not to exceed three years.

(4) Dentists participating in the program shall be required to complete the necessary continuing education units required by this chapter.

(5) The program shall accept 30 participating dentists. The program shall also maintain an alternate list of program applicants. If an active program participant leaves the program for any reason, a participating dentist from the alternate list shall be chosen to fill the vacancy. Only active program participants shall be required to complete the orientation program specified in subparagraph (C) of paragraph (1).

(6) (A) Additionally, an extramural dental facility may be identified, qualified, and approved by the board as an adjunct to, and an extension of, the clinical and laboratory departments of an approved dental school.

(B) As used in this subdivision, “extramural dental facility” includes, but is not limited to, any clinical facility linked to an approved dental school for the purposes of monitoring or overseeing the work of a dentist licensed in Mexico participating in this program and that is employed by an approved dental school for instruction in dentistry that exists outside or beyond the walls, boundaries, or precincts of the primary campus of the approved dental school, and in which dental services are rendered. These facilities shall include nonprofit community health centers.

(C) Dental services provided to the public in these facilities shall constitute a part of the dental education program.

(D) Approved dental schools shall register extramural dental facilities with the board. This registration shall be accompanied by information supplied by the dental school pertaining to faculty supervision, scope of treatment to be rendered, arrangements for postoperative care, the name and location of the facility, the date operations shall commence at the facility, and a description of the equipment and facilities available. This information shall be supplemented with a copy of the agreement between the approved dental school and the affiliated institution establishing the contractual relationship. Any change in the information initially provided to the board shall be communicated to the board.

(7) The program shall also include issues dealing with program operations, and shall be developed in consultation with representatives of community clinics, approved dental schools, or the National Autonomous University of Mexico School of Faculty Dentistry (Facultad de Odontología).

(8) The board shall provide oversight review of the implementation of this program and the evaluation required pursuant to subdivision (j). The board shall consult with dental schools in California that have applied for funding to implement and evaluate this program and executive and dental directors of nonprofit community health centers wanting to employ program participants, as it conducts its oversight responsibilities of this program and evaluation. Implementation of this program may not proceed unless appropriate funding is secured from nonprofit philanthropic entities. The board shall report to the Legislature every January during which the program is operational regarding the status of the program and the ability of the program to secure the funding necessary to carry out its required provisions. Notwithstanding Section 11005 of the Government Code, the board may accept funds from nonprofit philanthropic entities.

(f) Nonprofit community health centers that employ participants shall be responsible for ensuring that participants are enrolled in local English-language instruction programs and that the participants attain English-language fluency at a level that would allow the participants to serve the English-speaking patient population when necessary and have the literacy level to communicate with appropriate hospital staff when necessary.

(g) For purposes of this program, the fee for a three-year nonrenewable dental permit shall be five hundred forty-eight dollars ($548). A permitholder shall practice only in the nonprofit community health center that offered the permitholder employment and the corresponding hospital. This three-year nonrenewable permit shall be deemed to be a permit in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state, and local health programs.

(h) The three-year nonrenewable permit shall terminate upon notice by certified mail, return receipt requested, to the permitholder’s address of record, if, in the board's sole discretion, it has determined that either:

(1) The permit was issued by mistake.

(2) A complaint has been received by either board against the permitholder that warrants terminating the permit pending an investigation and resolution of the complaint.

(i) (1) Notwithstanding subdivisions (a) to (d), inclusive, of Section 30, the board shall issue a three-year nonrenewable permit pursuant to this section to an applicant who has not provided an individual taxpayer identification number or social security number if the board staff determines the applicant is otherwise eligible for a permit only under the program pursuant to this section, subject to the following conditions:

(A) The applicant shall immediately seek both an appropriate three-year visa and the accompanying social security number from the United States government within 14 days of being issued a medical license under this section.

(B) The applicant shall immediately provide to the board a social security number obtained in accordance with subparagraph (A) within 10 days of the federal government issuing the social security card related to the issued visa.

(C) The applicant shall not engage in the practice of dentistry pursuant to this section until the board determines that the conditions in subparagraphs (A) and (B) have been met.

(2) The board, if it determines that an applicant has met the conditions in paragraph (1), shall notify the applicant that the applicant may engage in the practice of dentistry under the permit in accordance with this section.

(j) All applicable employment benefits, salary, and policies provided by nonprofit community health centers to their current employees shall be provided to medical and dental practitioners from Mexico participating in this pilot program. This shall include nonprofit community health centers providing malpractice insurance coverage.

(k) Beginning 12 months after this pilot program has commenced, an evaluation of the program shall be undertaken with funds provided from philanthropic foundations. The evaluation shall be conducted by one dental school in California and either the National Autonomous University of Mexico or a foreign dental school approved by board. If the evaluation required pursuant to this section does not begin within 15 months after the pilot project has commenced, the evaluation may be performed by an independent consultant selected by the Director of Consumer Affairs. This evaluation shall include, but not be limited to, the following issues and concerns:

(1) Quality of care provided by dentists under this pilot program.

(2) Adaptability of these practitioners to California dental standards.

(3) Impact on working and administrative environments in nonprofit community health centers and impact on interpersonal relations with medical licensed counterparts in health centers.

(4) Response and approval by patients.

(5) Impact on cultural and linguistic services.

(6) Increases in medical encounters provided by participating practitioners to limited-English-speaking patient populations and increases in the number of limited-English-speaking patients seeking health care services from nonprofit community health centers.

(7) Recommendations on whether the program should be continued, expanded, altered, or terminated.

(8) Progress reports on available data listed shall be provided to the Legislature on achievable time intervals beginning in the second year of implementation of this pilot program. An interim final report shall be issued three months before termination of this pilot program. A final report shall be submitted to the Legislature at the time of termination of this pilot program on all of the above-described data. The final report shall reflect and include how other initiatives concerning the development of culturally and linguistically competent medical and dental providers within California and the United States are impacting communities in need of these health care providers.

(l) Costs for administering this pilot program shall be secured from philanthropic entities.

(m) Program applicants shall be responsible for working with the governments of Mexico and the United States in order to obtain the necessary three-year visa required for program participation.

SEC. 4. Article 6 (commencing with Section 2125) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 6. Licensed Physicians from Mexico Program

2125. (a) For purposes of this article, the following definitions apply:

(1) “Board” means the Medical Board of California.

(2) “Program” means the Licensed Physicians from Mexico Program.

(b) (1) The Licensed Physicians from Mexico Program is hereby created.

(2) The board shall approve physician candidates from Mexico for program participation.

(c) (1) This program extends the physician component of the Licensed Physicians and Dentists from Mexico Pilot Program, as established in former Section 853, which authorized up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology from Mexico to practice medicine in California for a period not to exceed three years.

(2) The program shall also maintain an alternate list of program participants.

(d) The board shall issue a nonrenewable three-year physician’s and surgeon’s license to each licensed physician from Mexico who meets the criteria set forth in this section.

(e) Each physician from Mexico, to be eligible to participate in this program, shall comply with all of the following:

(1) Be licensed, certified or recertified, and in good standing in their medical specialty in Mexico. This certification or recertification shall be performed, as appropriate, by the Consejo Mexicano de Ginecología y Obstetricia, A.C., the Consejo Mexicano de Certificación en Medicina Familiar, A.C., the Consejo Mexicano de Medicina Interna, A.C., the Consejo Mexicano de Certificación en Pediatría, A.C., or the Consejo Mexicano de Psiquiatría, A.C.

(2) Before leaving Mexico, have completed all of the following requirements:

(A) Passed the board review course with a score equivalent to that registered by United States applicants when passing a board review course for the United States certification examination in each of the physician’s specialty areas and passed an interview examination developed by the National Autonomous University of Mexico (UNAM) for each specialty area. Each family practitioner who includes obstetrics and gynecology in their practice and shall not perform deliveries in California unless they have performed 50 live birth deliveries, as required by United States standards, confirmed by written documentation by the supervising department chair, hospital administrator, or hospital chief medical officer. Each obstetrician and gynecologist from Mexico shall be a fellow in good standing of the American College of Obstetricians and Gynecologists.

(B) (i) Satisfactorily completed an orientation program approved by the board in connection with the Licensed Physicians and Dentists from Mexico Pilot Program, as established in former Section 853, and that includes medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices, medication documentation and reconciliation, the electronic medical records system utilized by federally qualified health centers, and standards for medical record documentation to support medical decisionmaking and quality care. This orientation program may be changed by a committee of at least five chief medical officers at federally qualified health centers employing program licensees to ensure that the orientation program contains the requisite subject matter and meets appropriate California law and medical standards where applicable.

(ii) Satisfactorily completed the Test of English as a Foreign Language by scoring a minimum of 85 percent or the Occupational English Test with a minimum score of 350, and provided written documentation of their completion to the board.

(C) Representatives from California and the UNAM in Mexico that executed and implemented the provisions of the former Physicians and Dentists from Mexico Pilot Program shall be the points of contact involved in securing required documents, recruiting and vetting candidates, assisting candidates for this program in Mexico to meet all program requirements, selecting appropriate federally qualified health centers throughout California, ensuring compliance with program provisions, developing policy and clinical workshops, monitoring productivity and increased access to medical care, and assessing the necessity of policy and programmatic improvements.

(3) Upon satisfactory completion of the requirements in paragraphs (1) and (2), and after having received their nonrenewable three-year physician’s and surgeon’s license, each licensee shall be required to obtain continuing education pursuant to Section 2190. Each physician shall obtain 25 continuing education units per year for three years of program participation, which shall be subject to random audits by the board to ensure compliance. The board may issue a citation and administrative fine against a licensee who fails to comply with the requirements of this paragraph.

(4) The federally qualified health centers employing physicians from Mexico shall continue the peer review protocols and procedures as required by the federal government. The federally qualified health centers shall work with a California medical

school approved by the board pursuant to Section 2084 or a residency program approved by the Accreditation Council for Graduate Medical Education to conduct 10 secondary reviews of randomly selected patient encounters with each licensee per six-month period, and the reviews shall be transmitted to the approved medical school or medical institution with an approved residency program in PDF format. The secondary reviews shall be undertaken every six months of each year for the three years that the physicians from Mexico are employed by federally qualified health centers. The faculty reviewers in family medicine, pediatrics, internal medicine, psychiatry, and obstetrics and gynecology from the California medical school approved by the board pursuant to Section 2084 or the residency program approved by the Accreditation Council for Graduate Medical Education shall provide feedback to the federally qualified health centers of the findings of their secondary reviews. The faculty and federally qualified health center chief medical officers shall jointly develop no less than two quality assurance (QA) seminars for all physicians from Mexico to attend during the six months of secondary reviews conducted. The purpose of the approved medical school or medical institution with an approved residency program secondary peer reviews shall be to provide feedback on compliance with medical standards, protocols, and procedures required by the federal government and assessed by the monthly or quarterly peer reviews conducted by federally qualified health centers. The associated costs for the secondary reviews and QA seminars shall be the responsibility of the federally qualified health centers on a pro rata basis.

(5) The federally qualified health centers employing physicians in the program shall be required to have medical quality assurance protocols and be accredited by The Joint Commission, National Committee for Quality Assurance, or Accreditation Association for Ambulatory Health Care.

(6) Participating hospitals shall have the authority to establish criteria necessary to allow individuals participating in this program to be granted hospital privileges in their facilities, taking into consideration the need and concerns for access to patient populations served by federally qualified health centers and attending doctors from Mexico, especially in rural areas that do not have hospitals staffed to provide deliveries of newborns.

(7) A licensee shall practice only in the nonprofit community health center that offered the licensee employment and the corresponding hospital. This three-year physician's and surgeon's license shall be deemed to be a license in good standing pursuant to the provisions of this chapter for the purpose of participation and reimbursement in all federal, state, and local health programs. These programs shall include the Medicare Program, the fee-for-service and managed care delivery systems of the Medi-Cal program, and private insurance. A physician from Mexico shall not be denied credentials by a health plan because the physician is a participant in this state program and did not receive their medical education and training in the United States. The nonrenewable three-year physician's and surgeon's license issued pursuant to this program shall be referred to as a Physician's and Surgeon's from Mexico License and shall not include any additional notations beyond the current numerical identifiers that the board applies.

(f) (1) Notwithstanding subdivisions (a) to (d), inclusive, of Section 30, the board shall issue a nonrenewable three-year physician's and surgeon's license pursuant to this section to an applicant who has not provided an individual taxpayer identification number or social security number if the board staff determines the applicant is otherwise eligible for a license only under the program pursuant to this section, subject to the following conditions:

(A) The applicant shall immediately seek both an appropriate three-year visa and the accompanying social security number from the United States government within 14 days of being issued a medical license under this section.

(B) The applicant shall immediately provide to the board a social security number obtained in accordance with subparagraph (A) within 10 days of the federal government issuing the social security card related to the issued visa.

(C) The applicant shall not engage in the practice of medicine pursuant to this section until the board determines that the conditions in subparagraphs (A) and (B) have been met.

(2) The board, if it determines that an applicant has met the conditions in paragraph (1), shall notify the applicant that the applicant may engage in the practice of medicine under the license in accordance with this section.

(g) (1) (A) Between January 1, 2025, and January 1, 2029, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 155 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 30 of the 155 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2025, and December 31, 2025, except that the board may accept up to 15 applications after December 31, 2025, and before January 1, 2028.

(2) (A) Between January 1, 2029, and January 1, 2033, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 195 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 195 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2029, and December 31, 2029, except that the board may accept up to 19 applications after December 31, 2029, and before January 1, 2032.

(3) (A) Between January 1, 2033, and January 1, 2037, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 225 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 225 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2033, and December 31, 2033, except that the board may accept up to 22 applications after December 31, 2033, and before January 1, 2036.

(4) (A) Between January 1, 2037, and January 1, 2041, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 255 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 255 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2037, and December 31, 2037, except that the board may accept up to 25 applications after December 31, 2037, and before January 1, 2040.

(5) (A) Between January 1, 2041, and January 1, 2045, the board shall coordinate with the representatives described in subparagraph (C) of paragraph (2) of subdivision (e) to ensure that no more than 275 program participants have a current and active license at the same time.

(B) During the time period described in subparagraph (A), no more than 40 of the 275 licenses may be issued to physicians whose primary area of practice is psychiatry.

(C) During the time period described in subparagraph (A), an applicant shall submit an application to the board between October 1, 2041, and December 31, 2041, except that the board may accept up to 27 applications after December 31, 2041, and before January 1, 2044.

(6) A physician’s eligibility pursuant to this subdivision is subject to the physician complying with all of the requirements set forth in this section.

(h) All applicable employment benefits, salary, and policies provided by nonprofit community health centers to their current employees shall be provided to medical practitioners from Mexico participating in this program. This shall include nonprofit community health centers providing malpractice insurance coverage.

(i) Each program applicant shall be responsible for working with the governments of Mexico and the United States in order to obtain the necessary three-year visa required for program participation.

2126. (a) The following fees apply to the licensure of physicians and surgeons authorized by this article:

(1) The application and processing fee shall be the amount specified in subdivision (b) of Section 2435.

(2) The initial license fee shall be one and one-half times the amount specified in subdivision (c) of Section 2435.

(3) The fee for the Controlled Substance Utilization Review and Evaluation System (CURES) shall be three times the annual fee specified under subdivision (a) of Section 208.

(4) The fee for the Steven M. Thompson Physician Corps Loan Repayment Program shall be one-and one-half times the amount specified in subdivision (a) of Section 2436.5.

(b) The fees required by this section shall be deposited into the Contingent Fund of the Medical Board of California, except that the fee described in paragraph (3) of subdivision (a) shall be deposited into the CURES Fund.

(c) Any unencumbered funds collected by the board pursuant to former Section 853 shall be deposited into the Contingent Fund of the Medical Board of California.

SEC. 5. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique and immediate need for physicians and dentists in California that have the cultural competency, language fluency, and requisite expertise to treat the large Latino patient population.