MEDICAL BOARD OF CALIFORNIA
Executive Office

ACCESS TO CARE COMMITTEE

MEMBERS OF THE COMMITTEE

Gary Gitnick, M.D., Chair
Hedy Chang
Shelton Duruisseau, Ph.D.
Gerrie Schipske, R.N.P., J.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

January 28, 2010

Embassy Suites - San Francisco Airport
150 Anza Blvd
Burlingame, CA 94010
(650) 342-4600

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

AGENDA

3:30 p.m. – 4:00 p.m.
(or until the conclusion of Business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order; Roll Call
2. Report and Discussion on the January 13, 2010 Meeting of the Malpractice Study Task Force – Mr. Zerunyan
3. Discussion and Consideration of the Task Force's Recommendation to the Access to Care Committee; Possible Recommendation to Full Board – Mr. Zerunyan
4. Public Comment on Items not on the Agenda
5. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act and to promote access to quality medical care through the Board's licensing and regulatory functions.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Public Meetings Act. The audience will be given appropriate opportunities to comment on any issue before the Board, but the Chair may apportion available time among those who wish to speak. For additional information call Kevin A. Schunke at(916) 263-2368.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Cheryl Thompson at (916) 263-2389 or sending a written request to Ms. Thompson at the Medical Board of California, 2005 Evergreen St, Ste. 1200, Sacramento, CA 95815. Requests for further information should be directed to the same address and telephone number.

State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

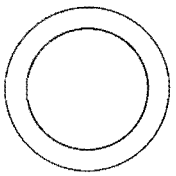
Date: January 21, 2010

To: Board Members

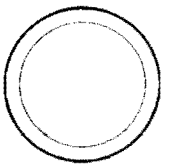
From: Cheryl Thompson

Subject: Access to Care Committee Minutes

The minutes from the October 29, 2009 Access to Care Committee meeting are attached. The minutes are for information only. As they are not on the agenda, they will not be approved or discussed. You may insert them behind the Access to Care Committee tab in your Board packet.



MEDICAL BOARD OF CALIFORNIA
Executive Office



Access to Care Committee
Marriott Courtyard – San Diego Airport /
Liberty Station
Liberty Hall Room
2592 Laning Road
San Diego, CA 92106
October 29, 2009

MINUTES

Agenda Item 1. Call to Order

Dr. Gitnick called the meeting to order at 3:35 pm. Roll was taken; all members were present. Notice had been sent to all interested parties.

Members present:
- Gary Gitnick, M.D., Chair
- Hedy Chang
- Shelton Duruisseau, Ph.D.
- Gerrie Schipske, R.N.P., J.D.
- Frank V. Zerunyan, J.D.
- Barbara Yaroslavsky

Staff present:
- Kim Kirchmeyer, Deputy Director
- Linda K. Whitney, Chief of Legislation
- Kevin A. Schunke, Committee Manager
- Candis Cohen, Public Information Officer
- Janie Cordray, Research Manager
- Abbie French, Telemedicine/Special Projects Manager
- Kurt Heppler, Legal Counsel
- Ross Locke, Business Services Staff
- Kelly Nelson, Legislative Analyst
- Pat Park, Licensing Analyst
- Debbie Pellegrini, Chief of Licensing
- Paulette Romero, Associate Analyst

Members of the Public:
- Julie D'Angelo Fellmuth, CPIL
- Betsy Couch, CPIL Intern
- Brett Michelin, CMA
- Dr. Hay, CMA
- Yvonne Choong, CMA
- Bill Barnaby Sr., The Doctors Company
- Bill Barnaby Jr., The Doctors Company
- Peter Kezirian, CAP

Agenda Item 2. Approval of Minutes of January 29, 2009 meeting

The minutes of the January 29, 2009 meeting were considered. Motion/second/carried Chang/Duruisseau to approve as written.

Agenda Item 3. Discussion on AB 329 – Telemedicine Pilot Program – Ms. French and Dr. Nuovo.

Abbie French, Telemedicine and Special Projects Manager, Medical Board of California (MBC), reported AB 329 Telemedicine Pilot Program was launched July 2009. The MBC is partnering with University of California Davis (UCD) in a three-year program in response to AB 329. AB 329 authorized the Board to establish pilot program to expand the practice of telemedicine for patients with chronic illnesses. The pilot will improve diabetes care management resources for patients and primary care physicians in rural, underserved communities in Northern California.

Ms. French reported the evaluation plan and method application was submitted to the Internal Review Board (IRB). The IRB approval staff is reviewing the application and is expected to have the IRB back to the Board the week of November 2, 2009. The English health coach has been recruited and has already begun training with the education supervisor. UCD has one possible candidate for the bilingual educator and a second interview is pending. If a candidate is not selected, the position will be reposted and the interview process will continue until the right candidate is identified.

The team has drafted the site selection questionnaire that will be sent out to the sites who respond favorably to email solicitation and want to work with the pilot program. Staff has drafted the outline of a curriculum and is waiting for health coaches to come on board for additional suggestions.

James Nuovo, M.D., gave a Power Point presentation detailing how the telemedicine pilot program will work. In short, health professionals need to offer patients a number of options and allow the patient to choose their own treatment plan to achieve a health behavior change. We will use health coaches to teach the practice sites that participate in our pilot how to be a more proactive team, how to develop registries, and how to use coaching tools. We will test this model and use education via telemedicine at a few practice sites by the use of teleconference technology to interact with patients. Our goal is to reach as many telemedicine sites as possible and interface with well over 1,000 patients during this time. We will look at outcomes such as blood pressure, diabetes, and depression. We will find out if practices and patients are interested in this form of communication and we will summarize the findings. In addition, we will conduct CME programs and assist physicians in using these techniques and decision tools for their own practice.

Questions from the Committee:

When will this program be ready to go?

Dr. Nuovo: We are ready. Telemedicine sites are identified. We have hired one coach and are in the process of hiring a second. Education modules are complete and ready.

So, when is it going to happen?

Dr. Nuovo: It is likely to be at the beginning of the new year.

If I am a patient, will you be contacting me? I am trying to figure out the logistics.

Dr. Nuovo: How will you get enrolled? The idea is to use the practice sites to identify appropriate patients for this program and show the sites how to encourage their patients to participate.

So, the practice sites have the list of people that they are working with and will work with these people under your supervision?

Dr. Nuovo: That's correct. The concept is to educate and assist these practice sites in adopting and implementing this new model of care that they can carry forward on their own.

I am a patient now and I want to get onto the test site, do I sit down and speak with you through a camera at the practice site?

Dr. Nuovo: Yes. When the patient comes to the clinic, the link is at the practice site and that is how the patient and physician will meet, one on one.

No public comment.

Agenda Item 4. Update on Interested Parties Meeting – Study on Malpractice Insurance for Physicians Offering Voluntary Unpaid Services (AB 2342) - Ms. French

At the January 2009 Board Meeting, we were directed by this committee and the full Board to convene an Interested Parties meeting to discuss the Report on Malpractice Insurance for Physicians Providing Voluntary Unpaid Services. AB 2324 added B&P Code section 2023 requiring the Medical Board of California to study the issue of providing medical malpractice insurance for physicians and surgeons who provide voluntary unpaid services as specified: to indigent patients and medically underserved or critical need population areas of the state and to report its findings to the Legislature.

The Malpractice Study Interested Parties Meeting was held on September 2, 2009 and had a very good turnout. The meeting allowed the stakeholders to hear directly from the report writer, other stakeholders, and ask questions on ways we can move forward on this issue. Overall, stakeholders were interested in protecting physicians who want to volunteer in medically underserved areas in our state, and they also commend the Medical Board for looking into this issue.

Ms French presented a summary of comments made at the Interested Parties meeting. See the Malpractice Interested Parties meeting minutes for more information (http://www.mbc.ca.gov/board/meetings/minutes_2009_09-02_malpractice_study.pdf).

Agenda Item 5. Discussion and Consideration of Future Steps on AB 2342 – Ms. French

The staff would like to recommend that this committee create a special advisory committee to discuss the report regarding Malpractice Insurance for Physicians Providing Voluntary Unpaid Services. This committee would determine if legislation is appropriate, and if so, develop language to propose to the Board in future meetings. The Board can determine if the drafted

language can be Board-sponsored or passed onto a legislative member who could propose legislative language on the issue. Staff recommends that this committee establish a five to eight member advisory committee to address the issues and recommendations of the report.

Each member chosen should be available to meet in January 2010. This advisory committee is unable to meet sooner than January 2010 due to the backlog of physician applications in the licensing section. The Board suggests that the following parties select an individual to represent their business on the advisory committee:

- The Access to Care Committee, a public and physician member.
- Liability insurer
- California Medical Association
- California Hospital Association

Comments from the Committee: No comments.

Public Comments:

Ms. Choong, CMA. CMA is in agreement with the Medical Board's approach to this issue. CMA is generally in support of the staff recommendations. CMA convened a conference with a number of entities to look into the issue in further detail. We have drafted proposed legislation and it is a representation of some stakeholders, but not all. CMA simply wants a solution that is good for the physicians. CMA also reviewed models from other states.

The draft legislation is proposed to remove barriers to care for volunteer physicians. Physicians can apply to the state and the state can approve and/or deny based on physician history. CMA would suggest that if a physician already has liability insurance to simply add the state insurance as secondary coverage. If the physician does not have coverage, then state coverage becomes primary. This program can be viewed as a contract with the physician in that services rendered are agreed upon between the clinic and physician and that services provided are in the physician's area of expertise. CMA does not view this program as being housed within the Medical Board as the Board is not in the business of reviewing claims. General funding for this program could be very difficult. Perhaps programs that benefit from this voluntary physician coverage could donate into the fund. CMA is very clear on one position and that is to not allow a fee to be added to the licensure fee for physicians.

Dr. Hay, CMA: Dr. Hay is very pleased that it appears the Medical Board's mission and CMA's mission mesh in that the goal is to get care to the patients. Most states already provide coverage for volunteer physicians, therefore the need for this type of coverage is apparent. Dr. Hay is in charge of Project Access San Diego. In his discussions with physicians, he has yet to meet a physician who is not interested in volunteering. However, the physicians have a common issue and that is the issue of liability coverage. Those who have their own businesses and those who work for FQHCs have coverage, it is those physicians who have group coverage and/or are retired that this program will help. The risk is very low and there are now 50 Project Access programs. There is still a need for liability insurance, but it is minimal. CMA supports the idea of an advisory committee. CMA supports the recommendation from staff that an advisory committee be formed.

Mr. Michelin, CMA: CMA would like to move forward with working on legislation that they intend on proposing. They do not want to bypass any recommendations of this committee. However,

they are committed to keeping this program legislation moving forward.

Mr. Zerunyan, Committee Member: Who is CMA referring to when you use the term "state" and who do you envision running the program. Has CMA considered using a model such as the Good Samaritan Law in writing legislation regarding Tort reform that may actually reduce the cost?

Mr. Michelin, CMA: CMA is aware of this and it is definitely an issue that is being looked at. As it appears at this time, Good Samaritan laws may not extend to a physician practicing in an organized manner and that is why many other states have separate laws for this issue. CMA has also discussed how and/or if the state can absorb the costs of this program.

Ms. Yaroslavsky, Board President and Committee Member: Ms. Yaroslavsky is unclear as to why this would be housed in the Medical Board and directed by others. Ms. Yaroslavsky completely supports the idea of having insurance waived for volunteer doctors. She would like to see insurance companies pay for this coverage and fund it. Ms. Yaroslavsky is unsure what the role of the committee is and those that might serve on it. Where are we going?

Ms. Whitney, MBC Chief of Legislation: Ms Whitney summarized the issues being discussed and explained how this committee suggestion came about. After the advisory meeting on the malpractice study, Ms. French presented her proposal of how to move this program forward and presented her proposal to the Board. In the meantime, CMA has developed another proposal and Medical Board staff has not yet had time to review the CMA proposal and/or details. Ms. Whitney interprets CMA's comments to mean that they are moving forward, are not finished, but would like to continue working on the program. One issue is how long CMA could wait for the Board to make their recommendations so that it could be introduced during this legislative cycle.

Dr. Gitnick, Committee Member: Is it practical for a committee to be formed when its first meeting is in January 2010. Is it likely that the committee would be able to move forward on language by the end of February 2010?

Ms. Whitney, MBC Chief of Legislation: Yes. A shell can be submitted in February. However, by the middle to end of March, more details need to be submitted to the Legislature.

Dr. Gitnick, Committee Member: Is establishing a committee a good use of time if CMA is already moving forward on this? We also do not want to hold back CMA. Everyone agrees that it should be done, but the question is how.

Mr. Zerunyan, Committee Member: The key is to make sure that interested parties are working together and we all are moving forward on this issue. With the holidays coming, it is also difficult for the committee to meet. Housing of the program could become an agenda item.

Mr. Heppler, MBC Staff Counsel: It appears that a decision has already been made as to who will carry this legislation, when in fact, this decision still has not been made.

Ms. French: You are correct in that the advisory committee was meant to be formed to brainstorm about the models and determine which route is best.

Mr. Michelin, CMA: CMA would prefer a group effort on this issue. If you wish to set up a committee, then CMA will work with that. CMA wishes to work with the committee. Their

proposal was simply to encourage discussion and CMA is flexible in suggestions that may be made.

Dr. Gitnick, Committee Member: If the committee were to appoint a task force to meet with CMA to submit a place holder by February, would this meet CMAs concept of a group effort?

Mr. Michelin, CMA: Yes.

Dr. Gitnick recommends to the Board that a task force be established that would include an invitation to our agency to participate in those discussions, but would also include the stakeholders listed in the report from staff. This task force will meet early in January 2010 and have a place holder in place by the end of February 2010, and will report back to the Board its recommendations. If the committee were to make that motion and pass it today, the Board could vote on it tomorrow.

Dr. Gitnick moves, Ms. Yaroslavsky seconds, moved by group consensus.

Agenda Item 6. Public Comment on Items not on the Agenda

None.

Agenda Item 7. Adjournment

The meeting was adjourned at 4:50 pm.

Access to Care Committee

Agenda Items 2 and 3

Item #2: Report and Discussion on the January 13, 2010 Meeting of the Malpractice Study Task Force – Mr. Zerunyan

Item #3: Discussion and Consideration of the Task Force's Recommendation to the Access to Care Committee; Possible Recommendation to Full Board – Mr. Zerunyan

Agenda Items 2 & 3

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 21, 2010
ATTENTION:	Access to Care Committee
DEPARTMENT:	Executive Office
SUBJECT:	Report from the Task Force on Malpractice Insurance for Volunteer Physicians
STAFF CONTACT:	Kevin A. Schunke, on behalf of Frank Zerunyan

REQUESTED ACTION: Access to Care Committee should adopt the recommendation of the Malpractice Task Force and make a further recommendation to the Board regarding Legislation for the 2010 Session.

STAFF RECOMMENDATION:
The Access to Care Committee should adopt the Task Force's recommendation and recommend to the full board, that the Medical Board sponsor or seek others with whom to co-sponsor legislation to enact a "State Actor-Sovereign Immunity" model similar to that which is used in Florida, a program under which a physician volunteer would be considered a state employee when providing uncompensated care. The Task Force also requests that interested parties share their supporting ideas and make their concerns known to the Board at the earliest opportunity, as to the following elements, which remain resolved but need to be addressed in the final version of any legislation:

1. Funding
2. Administration of the proposed program
3. Operational issues
4. Claimant issues
5. Coverage

EXECUTIVE SUMMARY:

AB 2342 (Nakanishi; Chap. 276, Stats. of 2006) added Business and Professions Code section 2023, requiring the Medical Board of California (Board) to study the issue of providing medical malpractice insurance for physicians and surgeons who provide voluntary unpaid services to medically underserved populations in California. The study was to include, but not be limited to, the cost and process of administering such a program, options for providing medical malpractice insurance and how the coverage could be funded.

The Current Physician Volunteer Environment in California:

The number of uninsured and underinsured Californians continues to grow. In 2001, the number of uninsured was estimated to be 6.3 million; this increased to 6.6 million by 2003. In 2007, approximately 7.6 million Californians relied on a "safety net" of community health centers, public hospitals and clinics for regular care.

Across all disciplines, California does not have a high percentage of individuals who volunteer their time. According to the website, www.volunteeringinamerica.gov, California has 6.7 million volunteers, who provided 896.4 million hours of service per year between the years 2005 and 2007. Even though this sounds like a great amount of hours and money, California's volunteer rate ranks 42nd among the 50 states and Washington, D.C.

The Medical Board of California reports there are over 125,000 licensed physicians in California. Despite this number, there is an inadequate supply of physicians to care for the ever-increasing California population, especially those patients that have no insurance.

Implementation Models; Other States' Programs:

According to the malpractice insurance study, one of the following liability protection models would work best for the state of California:

1. Statutory Immunity: Change in the Standard of Care. In this model the provider is not liable for common negligence, but only for gross negligence or willful misconduct. This model is used in **Arizona**, which has approximately 20,300 licensed physicians.

   Negligence: Generally, negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm.

   Gross Negligence: The want of even scant care or an extreme departure from the ordinary standard of conduct.

2. Sovereign Immunity: Physicians are considered "State Actors". Under circumstances prescribed by the state, a physician volunteer would be considered a state employee when providing uncompensated care. This model has been implemented in the state of **Florida**, which has approximately 56,100 licensed physicians.

3. State-Run Liability Coverage Program or State-Purchased Insurance. In this case, the state either purchases insurance for physician volunteers or establishes a self-insured pool. This model is used in the state of **Washington**, which has approximately 19,000 licensed physicians).
   A copy of the full report, with details about the models used in other states, is available on the Board's web site or upon request to staff.

FISCAL CONSIDERATIONS:

In the **Arizona** model, a physician would only be liable if he/she committed gross negligence. The cost of insuring the volunteer is substantially less than if the volunteer would be liable for common negligence. The Mutual Insurance Company of Arizona (MICA) offers volunteer insurance coverage to retired physicians who wish to continue providing medical care. The policy only provides coverage to the physician when he/she provides care on a voluntary basis with or without direct remuneration. Guidelines have been established to limit the scope of practice and liability exposure (see page 29 of the study for more information).

If California considered program similar to the **Florida model**, the "State Actor" model, then the report suggests there would be no cost to the state, but the professional liability risk exposure would increase. Since California currently does not purchase medical malpractice insurance for its physician employees, nor does it maintain a risk pool for professional liability claims, it would be difficult to assess a cost of liability for the "state actor" model. The state of Florida does maintain good data about its claims history. Florida reports that the Program's total patient visits for fiscal year 2006-07 was 290,026. In 2006-07,

Florida reports nine claims were filed against the Volunteer Health Care Provider Program. Defense costs were just over $550,000. Settlement costs were $293,000 (more information is available on page 30 of the full study). A copy summarizing that model is attached.

If California adopted legislation that would enable the state to purchase (or reimburse providers for) professional liability insurance premiums, similar to the state of **Washington model**, then there would be additional cost to the state. The state of Washington has an immunity statute. The cost for providing insurance to providers who rendered more than $50,000 encounters was approximately $145,000 for 2008.

The Task Force is aware of the significant issues related to the State's revenue shortfalls and the fiscal implications of moving forward with any new proposal. The Task Force does not mean to imply that a new state program should be created which would further challenge the State's limited resources; instead, all funding sources should be considered as the proposed Legislation moves forward.

PREVIOUS MBC AND/OR COMMITTEE ACTION:

On September 2, 2009, the Medical Board held a Malpractice Study Interested Parties meeting which allowed all interested stakeholders to hear directly from the report writer, ask questions, and give feedback on ways we can move forward with this issue. The minutes from that meeting are attached.

On October 29, 2009, staff was directed by the Access to Care Committee and the full Board to establish a Malpractice Study Task Force. The Task Force was asked to solicit public comments, discuss the issues and recommendations of the Malpractice Study, and to determine if legislation is appropriate. Individuals from the following groups would be selected to serve on the Task Force:

- Access to Care Committee – a public and a physician member
- Liability Insurers
- California Medical Association
- California Hospital Association

A meeting of the Task Force was convened in Los Angeles on January 13, 2010. (The recent meeting date has precluded staff from preparing the minutes.) Over twenty persons attended the meeting, including several physicians who provide volunteer services and representatives of clinics that would benefit from the services of volunteer physicians. After receiving public input from attendees, the Task Force members entered into an in-depth discussion of the various options presented, not only considering the pros and cons, but also the viability of each in California.

The Task Force votes to request the Access to Care Committee to adopt the aforementioned recommendation (page 1 of this memo) and make a further recommendation to the full Board to sponsor or co-sponsor legislation during the 2010 Legislative Session.

Attachments:

1. Minutes of September 2, 2009 Malpractice Study Interested Parties meeting
2. Description of Sovereign Immunity/State Actor Model Used in Florida

MODEL TYPE: Sovereign Immunity: "State Actor"

FLORIDA

Florida Department of Health: Volunteer Health Services Program
The Florida Department of Health (DOH) administers the Volunteer Health Services Program in the Division of Health Access and Tobacco. The program supports the department's volunteer efforts in eleven regions throughout the state. A DOH volunteer coordinator is assigned to each region. Regional coordinators work with DOH entities, community, and faith based health care providers to promote access to quality health care for the medically underserved and uninsured residents of Florida through the commitment of volunteers.

The Volunteer Health Services Program accomplishes its mission through two volunteer programs authorized by Chapters 110 and 776, Florida Statutes.

The Chapter 110 volunteer program, an internal state agency program, provides opportunities for anyone who wants to donate goods and/or their services to those in need under the supervision of the Department of Health. A variety of volunteer opportunities are available in many DOH facilities to individuals with clerical, administrative, technical and professional skills.

The Volunteer Health Care Provider Program, s. 766.1115, F.S., allows private licensed health care provides to volunteer their services to the medically indigent residents of Florida with incomes at or below 200% of the Federal Poverty Level and be under the state's sovereign immunity. Through a contract, a provider can be designated an "agent of the state" and have sovereign immunity for uncompensated services rendered to clients determined eligible and referred by DOH. Under this program, providers have the option to volunteer in freestanding clinics or to see eligible clients in their private offices or corporate facilities.

Florida Statute Chapter 110.501-110.504
110.501 Definitions.--As used in this act:
(1) "Volunteer" means any person who, of his or her own free will, provides goods or services, or conveys an interest in or otherwise consents to the use of real property pursuant to chapter 260, to any state department or agency, or nonprofit organization, with no monetary or material compensation. A person registered and serving in Older American Volunteer Programs authorized by the Domestic Volunteer Service Act of 1973, as amended (Pub. L. No. 93-113), shall also be defined as a volunteer and shall incur no civil liability as provided by s. 768.1355. A volunteer shall be eligible for payment of volunteer benefits as specified in Pub. L. No. 93-113, this section, and s. 430.204.

(2) "Regular-service volunteer" means any person engaged in specific voluntary service activities on an ongoing or continuous basis.

(3)"Occasional-service volunteer" means any person who offers to provide a one-time or occasional voluntary service.

(4) "Material donor" means any person who provides funds, materials, employment, or opportunities for clients of state departments or agencies, without monetary or material compensation.

110.502 Scope of act; status of volunteers.--
(1) Every state department or state agency, through the head of the department or agency, secretary of the department, or executive director of the department, is authorized to recruit, train, and accept, without regard to requirements of the State Career Service System as set forth in part II of this chapter, the services of volunteers, including regular service volunteers, occasional-service volunteers, or material donors, to assist in programs administered by the department or agency.

(2 Volunteers recruited, trained, or accepted by any state department or agency shall not be subject to any provisions of law relating to state employment, to any collective bargaining agreement between the state and any employees' association or union, or to any laws relating to hours of work, rates of compensation, leave time, and employee benefits, except those consistent with s. 110.504. However, all volunteers shall comply with applicable department or agency rules.

(3) Every department or agency utilizing the services of volunteers is hereby authorized to provide such incidental reimbursement or benefit consistent with the provisions of s. 110.504, including transportation costs, lodging, and subsistence, recognition, and other accommodations as the department or agency deems necessary to assist, recognize, reward, or encourage volunteers in performing their functions. No department or agency shall expend or authorize an expenditure therefor in excess of the amount provided for to the department or agency by appropriation in any fiscal year.

(4) Persons working with state agencies pursuant to this part shall be considered as unpaid independent volunteers and shall not be entitled to unemployment compensation.

110.503 Responsibilities of departments and agencies.--Each department or agency utilizing the services of volunteers shall:

(1) Take such actions as are necessary and appropriate to develop meaningful opportunities for volunteers involved in state-administered programs.

(2) Comply with the uniform rules adopted by the Department of Management Services governing the recruitment, screening, training, responsibility, use, and supervision of volunteers.
(3) Take such actions as are necessary to ensure that volunteers understand their duties

and responsibilities.

(4) Take such actions as are necessary and appropriate to ensure a receptive climate for citizen volunteers.

(5) Provide for the recognition of volunteers who have offered continuous and outstanding service to state-administered programs. Each department or agency using the services of volunteers is authorized to incur expenditures not to exceed $100 each plus applicable taxes for suitable framed certificates, plaques, or other tokens of recognition to honor, reward, or encourage volunteers for their service.

(6) Recognize prior volunteer service as partial fulfillment of state employment requirements for training and experience pursuant to rules adopted by the Department of Management Services.

110.504 Volunteer benefits.--
(1) Meals may be furnished without charge to regular-service volunteers serving state departments, provided the scheduled assignment extends over an established meal period, and to occasional-service volunteers at the discretion of the department head. No department shall expend or authorize any expenditure in excess of the amount provided for by appropriation in any fiscal year.

(2) Lodging, if available, may be furnished temporarily, in case of a department emergency, at no charge to regular-service volunteers.

(3) Transportation reimbursement may be furnished those volunteers whose presence is determined to be necessary to the department. Volunteers may utilize state vehicles in the performance of department-related duties. No department shall expend or authorize an expenditure in excess of the amount appropriated in any fiscal year.

(4) Volunteers shall be covered by state liability protection in accordance with the definition of a volunteer and the provisions of s. 768.28.

(5) Volunteers shall be covered by workers' compensation in accordance with chapter 440.

(6) Incidental recognition benefits or incidental nonmonetary awards may be furnished to volunteers serving in state departments to award, recognize, or encourage volunteers for their service. The awards may not cost in excess of $100 each plus applicable taxes.
(7) Volunteers, including volunteers receiving a stipend as provided by the Domestic Service Volunteer Act of 1973, as amended (Pub. L. No. 93-113), shall be covered by s. 768.1355, the Florida Volunteer Protection Act.

Florida Statute 766.1115
766.1115 Health care providers; creation of agency relationship with governmental contractors.--

(1) SHORT TITLE.--This section may be cited as the "Access to Health Care Act."

(2) FINDINGS AND INTENT.--The Legislature finds that a significant proportion of the residents of this state who are uninsured or Medicaid recipients are unable to access needed health care because health care providers fear the increased risk of medical negligence liability. It is the intent of the Legislature that access to medical care for indigent residents be improved by providing governmental protection to health care providers who offer free quality medical services to underserved populations of the state. Therefore, it is the intent of the Legislature to ensure that health care professionals who contract to provide such services as agents of the state are provided sovereign immunity.

(3) DEFINITIONS.--As used in this section, the term:

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor. This contract shall allow the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor. The contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services under this section, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.

(b) "Department" means the Department of Health.

(c) "Governmental contractor" means the department, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this

section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.
12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.
The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(e) "Low-income" means:

1. A person who is Medicaid-eligible under Florida law;

2. A person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or

3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

(4) CONTRACT REQUIREMENTS.--A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the

requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider under contract with the state may not be named as a defendant in any action arising out of medical care or treatment provided on or after April 17, 1992, under contracts entered into under this section. The contract must provide that:

(a) The right of dismissal or termination of any health care provider delivering services under the contract is retained by the governmental contractor.

(b) The governmental contractor has access to the patient records of any health care provider delivering services under the contract.

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if the incidents and information pertain to a patient treated under the contract. The health care provider shall submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities under this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Patient selection and initial referral must be made solely by the governmental contractor, and the provider must accept all referred patients. However, the number of patients that must be accepted may be limited by the contract, and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

(e) If emergency care is required, the patient need not be referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.

(f) Patient care, including any followup or hospital care, is subject to approval by the governmental contractor.

(g) The provider is subject to supervision and regular inspection by the governmental contractor.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.--The governmental contractor must

provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28. With respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the federally funded community health center is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28.

(6) QUALITY ASSURANCE PROGRAM REQUIRED.--The governmental contractor shall establish a quality assurance program to monitor services delivered under any contract between an agency and a health care provider pursuant to this section.

(7) RISK MANAGEMENT REPORT.--The Division of Risk Management of the Department of Financial Services shall annually compile a report of all claims statistics for all entities participating in the risk management program administered by the division, which shall include the number and total of all claims pending and paid, and defense and handling costs associated with all claims brought against contract providers under this section. This report shall be forwarded to the department and included in the annual report submitted to the Legislature pursuant to this section.

(8) REPORT TO THE LEGISLATURE.--Annually, the department shall report to the President of the Senate, the Speaker of the House of Representatives, and the minority leaders and relevant substantive committee chairpersons of both houses, summarizing the efficacy of access and treatment outcomes with respect to providing health care services for low-income persons pursuant to this section.

(9) MALPRACTICE LITIGATION COSTS.--Governmental contractors other than the department are responsible for their own costs and attorney's fees for malpractice litigation arising out of health care services delivered pursuant to this section.

(10) RULES.--The department shall adopt rules to administer this section in a manner consistent with its purpose to provide and facilitate access to appropriate, safe, and costeffective health care services and to maintain health care quality. The rules may include services to be provided and authorized procedures. Notwithstanding the requirements of paragraph (4)(d), the department shall adopt rules that specify required methods for determination and approval of patient eligibility and referral and the contractual conditions under which a health care provider may perform the patient eligibility and referral process on behalf of the department. These rules shall include, but not be limited to, the following requirements:

(a) The provider must accept all patients referred by the department. However, the

number of patients that must be accepted may be limited by the contract.

(b) The provider shall comply with departmental rules regarding the determination and approval of patient eligibility and referral.

(c) The provider shall complete training conducted by the department regarding compliance with the approved methods for determination and approval of patient eligibility and referral.

(d) The department shall retain review and oversight authority of the patient eligibility and referral determination.

(11) APPLICABILITY.--This section applies to incidents occurring on or after April 17, 1992. This section does not apply to any health care contract entered into by the Department of Corrections which is subject to s. 768.28(10)(a). Nothing in this section in any way reduces or limits the rights of the state or any of its agencies or subdivisions to any benefit currently provided under s. 768.28.

MEDICAL BOARD OF CALIFORNIA
Executive Office

MALPRACTICE STUDY
INTERESTED PARTIES MEETING

September 2, 2009

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815
(916) 263-2389

MINUTES

Agenda Item 1 Welcome and Introductions

Ms. French welcomed everyone to the interested parties meeting and introduced the Medical Board staff that was present.

Staff Present:

Kimberly Kirchmeyer, Deputy Director
Linda Whitney, Chief of Legislation
Abbie French, Telemedicine/Special Projects Manager
Candis Cohen, Information Officer
Janie Cordray, Research Program Specialist II

Report Writer:

Anna Orlowski, JD, UC Davis Chief Health System Counsel

Members of the Audience:

Alicia From, California Medical Association
Cheryl Brandwood, Placer-Nevada/Yuba-Sutter Medical Society
Yvonne Choong, California Medical Association
Hal Dasinger, The Doctors Company
Alvaro Fuentes, Community Clinic Consortium
Richard A. Deutsche, ACCMA County Medical Society
Donald Waters, Alameda-Contra Costa Medical Association
Victor Christy, CAPP
Zennie Coughlin, Kaiser Permanente
Bruce Merl, M.D., Kaiser Permanente
Kristine Wallach, Sierra Sacramento Valley Medical Society
Bill Sandberg, Sierra Sacramento Valley Medical Society
Serena Kirk, California Primary Care Association
Crystal Silva, Department of Consumer Affairs
Tim Shannon, California Association of Professional Liability Insurers
Peter Kezirian, Cooperative of American Physicians
Leona Siadek, The Doctors Company
Bill Barnaby Sr. & Jr., The Doctors Company

Agenda Item 2 Overview of AB 2342 and purpose of meeting

Ms. French advised the audience about the format of the meeting and gave a brief history about AB 2342. This bill specifically directed the Board to study the issue of providing medical malpractice insurance for physicians who provide voluntary unpaid services to the medically underserved and to report its finding to the Legislature. In January 2008, the Medical Board staff was directed by the Access to Care Committee and Full Board to convene an interested parties meeting to discuss the study on Malpractice Insurance for Physicians Providing Voluntary, Unpaid Service and to come up with legislative solutions that could be passed onto a legislative member who could propose legislation on this issue. Ms. French turned the meeting over to the report writer, Ms. Anna Orlowski, JD, who gave a brief overview and highlights of the malpractice study.

In summary, Ms. Orlowski discussed how California is one of the seven remaining states in the U.S. that have yet to enact any meaningful legislation that relieves the providers who render voluntary, unpaid care to patients from paying the high cost of professional liability insurance. Of 43 states that do have models they really vary considerably.

Ms. Orlowski tried to categorize the examples in the study. One category would be the immunity changes for individuals who are volunteering their services so they would be immune from regular negligence, and a higher standard of gross negligence or willful misconduct must be found in order for that individual to be held liable for malpractice. That is one type of model but within that model there are many subsets.

Similarly there is a state actor model in which under certain very prescribed situations an individual, when providing free or low cost services to individuals, would be considered a state actor and therefore would be insured and indemnified as a state employee for any acts and omissions.

The other category has to do with states providing some form of low cost insurance for physicians who are providing specified types of care. Again, there are subsets to this and some limitations in the type of provision of care, type of settings, type of services, and type of patients.

There are some models that appear better than others depending on what direction California intends to move. In addition things change every day. For example, when the report was written, the state of Montana did have a system of immunity for physicians that provide volunteer unpaid services to individuals such that one would have to prove a gross negligence or willful misconduct in order to prove liability against that physician. They have subsequently added another statute just this year, July 2009, which specifically focuses on retired physicians. Essentially they are getting a health core system together of retired physicians to provide services to patients, and in this model Montana provides the same immunity but it permits physicians to provide low cost care (Medicare and Medicaid patients) and the physicians are able to charge up to $10 per service.

Agenda Item 3 Discussion of the Malpractice Insurance Report - Open Discussion

Ms. French opened the meeting up for discussion and comments on the malpractice study. Below are some highlights of the stakeholder's comments. All stakeholders expressed interest in helping the Medical Board of California move forward with this issue.

Richard A. Deutsche, Retired Physician, ACCMA County Medical Society:

- Alameda and Contra Costa County have many retired physicians who no longer have malpractice insurance. These doctors would be delighted to offer free medical care at no cost; however these physicians are not going to pay premiums for insurance in order to render free uncompensated care.
- Three states, Virginia, Georgia, and Wisconsin have a program in place where physicians rendering free care to needy patients are deemed to be agents of the state, therefore, defended by that state. This program should be initiated by the state of California and should not be funded by increasing license fees for all doctors.
- Liability suits in the above program have been very rare among the states that insure volunteer physicians.
- He encouraged consideration of a program that covers other health care professionals rendering free medical care, including dentists, which is particularly important due to the elimination of dental care for MediCal patients.
- In summary, no physician will volunteer to give free medical care if he or she cannot receive free professional liability insurance at no cost to the doctor. One of the ways to obtain this coverage is to make the physician an agent of the state of California and thereby defended by the state.

Albert Fuentes, Community Clinic Consortium (Contra Costa/Solano Counties): A membership of four clinics that provide services for both counties within 23 health service sites.

- In 2008 these clinics provided services to 98,000 individuals, of which 77,000 were at, or below, 100% of the federal poverty guidelines. Currently their organization is part of a two county effort to improve access to specialty services for uninsured working individuals in both counties.
- Over the next three years this project will be a high priority for their organization and their clinics. Their effort though, is predicated on their ability to recruit volunteer physicians to provide services at their sites.
- He stated they are extremely supportive of any measures that are taken to help their efforts in facilitating effective recruitment and retention of volunteer specialists who improve access to specialty care services in the counties where they serve working families who are uninsured.

Bruce Merl, MD., Kaiser Permanente Medical Legal Director:

- Their medical group is insured by Kaiser Health Plan, a separate corporate entity. It is a closed system and the health plan provides liability coverage for all physicians in the normal scope of practice of their work.
- It is his job to approve or disapprove requests for Kaiser Physicians to go out and do volunteer work for 501(c)(3) corporations. They have 6,000 physicians, and an enormous number of them are willing to go out and deliver free medical care to the various entities who fall under 501(c)(3). He approves hundreds every year and has no idea how many patients are actually seen under this program but the physicians represent a wealth of opportunity for delivery of care for people.
- He wanted to point out, that in all his experience, the hundreds and hundreds of physicians that do this and in the tens and hundreds of thousands of incidences of care that have been delivered, they have not had one lawsuit.
- The scope of the care is somewhat limited. They are not doing deliveries unless under emergency, but to the extent that they deliver care at the primary care level, which is virtually most of it, they have virtually no experience with claims and torts against them.
- He stated, because the experience rate in this program is so low, for many reasons which might be speculated on, it might be possible to negotiate a claims based premium with one or more of the carriers, which would reduce the price from which the study indicates which would be a normal insurance premium rate for internists or anyone else.

Yvonne Choong, California Medical Association: CMA's general position for physicians who provide voluntary care has been very supportive, but they want to make sure it is done right. CMA's committee on professional liability has been studying this issue and they have been advising their members about this report and they definitely have a vested interest on how this turns out.

- Their main concern with the current system is that essentially physicians are paying for the privilege for providing uncompensated care. In the best case scenarios some counties have essentially adopted the state actor program where they will insure the individual physicians, but this definitely varies from county to county. They have physicians that practice in different counties and this really creates a lot of problems in trying to figure out what their status is.
- They surveyed some of their county medical societies as well and the arrangements they have. Some have adopted an emergency care ordinance whereby they declare a county emergency and then the physician can be insured by the county, however it is very cumbersome.
- Their goal in terms of how this process works out, would be to see a final product that is really very simple. They want a program that will encourage volunteerism among physicians and will be provided at no cost to volunteer physicians. They believe physicians are already providing uncompensated care and should not be asked to bear additional cost. They want a program that has flexibility for physicians to volunteer services in a wide range of settings. As mentioned, some federal health clinics do offer

state actor immunity, however this varies and there are many limiting parameters in the situations which physicians can provide this type of care and still be insured.

- CMA wants to address concerns regarding liability for malpractice lawsuits as well.
- One other issue they wanted to bring up is the fiscal side of this which has not been discussed. In the report it mentions that the cost to provide liability coverage for the volunteer physicians would be approximately $3 million dollars. They understand there are differences if this is done through a private carrier or if the state essentially self insures on this. CMA did some research to get an idea of what the level of incurred costs are for other states that have enacted a state actor program. Their research found that Florida, which has a self-insured program in operation since 1992 has an annual cost of $45,000 a year in paid claims and defense costs, which is a fairly small amount of money.
- In addition, the idea that there could be a raise in license fees to pay for such a program, needs discussion. California physicians are already in a sense paying for part of the cost for voluntary care in that volunteer physicians have their licensing fees waived by the Medical Board so the costs for providing services (licensing, renewal, discipline etc..) is essentially being shifted onto all the other physicians who are paying full licensing fees. It works out to be approximately $2.7 million dollars in waived fees or about $22 dollars per physician. This is another number to keep in mind as the discussion moves forward.

Tana Lorah, San Diego County Medical Society Foundation: Project Access San Diego assists patients who cannot afford medical services and do not have insurance or qualify for public health insurance programs. This charitable program is a physician-led community partnership of coordinated charity care including volunteer physicians, hospitals, pharmacists and other healthcare providers countywide.

- They recruit volunteer physicians and a barrier that they have noticed is doctors are more than willing to volunteer their time, but who is going to pay for their malpractice insurance? Many of their volunteers who have the time and expertise are either semi-retired, retired or per diem employees and they do not qualify for medical malpractice insurance without paying more then what they pay now. The TORT act will only cover a physician if they work more than 32.5 hours in their practice which defeats the purpose of being retired.
- They would like to commend the report and appreciate MBC looking into this issue. They would like us to help find a way to protect physicians who want to volunteer and protect the medically underserved in our state.

James Hay, Family Physician in San Diego, Officer of the California Medical Association and the immediate past President of the San Diego Medical Society Foundation:

- He appreciates the report and options discussed and the fact the MBC is paying attention to this issue. The CMA is very interested in working with MBC in making something happen with this.

- He believes the state-actor approach is the right one for many reasons; one being that it is not a tax on the MBC or physicians and of all the options discussed it is the least costly way to provide coverage for volunteer physicians.
- CMA does not support the physician immunity model, but definitely supports the idea that there needs to be coverage.
- He hopes that when, and if, something gets crafted from this that it is not just for designated clinics but it is also designated for physicians or designated offices. There is also entity liability, where the entity who is organizing also has liability. They hope all these issues are addressed.

Tim Shannon, California Association of Professional Liability Insurers (representing MIEC and NORCAL Mutual):

- He provided definitions of terminology being discussed. Claims-based policy: when a physician is insured, they are insured for any claim that is made during the policy period. Medical malpractice insurance has a very long tail, meaning a physician could retire and find out a claim was made after they had retired. So most physicians have to purchase "tail" coverage to cover them for claims made after their policy expires. Some insurance companies provide, if a physician has been with the company for a certain number of years, tail coverage without having to pay a further premium.
- There is a market for providing medical malpractice insurance for volunteer physicians after they retire. What NORCAL does, if someone wants to participate in volunteer care, they will still provide tail coverage for them but they will require the physician pay a small premium to cover the cost of what they will be doing. NORCAL currently does this with retired physicians.

Serena Kirk, California Primary Care Association (representing more than 800 community clinics across the state):

- In California their community clinics provide more than 10 million medical encounters each year for more than 4 million low income patients (1.5 million of those are Medi-Cal patients, 1.2 million are uninsured).
- Many of their clinics across the state experience great difficulty in recruiting and retaining physicians in their underserved areas so the use of volunteer physicians is incredibly important.
- For many of their smaller clinics (Non-Federal Qualified Health Center (FQHC)) the use of volunteer physicians is far more prevalent. For example, in Los Angeles, one of their free clinics uses more than 60 volunteer physicians in order to provide basic care. For them, especially with all the budget cuts they are experiencing (non-FQHC, do not receive stimulus dollars), they need all the money they can get to put towards direct services. It would be of great assistance if they did not have to provide coverage in addition to the budget issues.
- They would like to see Medi-Cal and Medicare patients covered in addition to the uninsured. Many of their clinics provide care to 50% of Medi-Cal patients.

- They would support either option that is being explored as far as the liability immunity protection or establishing some sort of malpractice insurance program.
- Their clinics would be more than willing to pay a nominal fee ($200) suggested as an option in order to have this coverage, but urges MBC to continue to explore the other funding options as well.